INTERNATIONAL CONFERENCE

JERUSALEM 11-14 NOVEMBER 1985

Knowledge spreads along predetermined pathways and it is interesting to trace the cultural diffusion of ideas by studying attendance at international conferences. Among the 200 papers which were read at the Jerusalem conference 64 were from the USA, 64 from Israel, 27 from Scandinavia/ Netherlands/Belgium, 24 from the United Kingdom and 20 from other countries (mostly Canada and Australia). I looked in vain for speakers from Iron Curtain countries or third world countries and there was only one speaker from France. All papers were read in English (there were no translation facilities).

Gentiles were in a minority among speakers and participants. Consequently I learned a great deal about the special problems of bereavement for the Jewish people. The conference was ably hosted by the Israeli Ministry of Defence and opened by the Minister himself (Mr. Rab'n). Several papers described the measures which the ministry had taken to provide support to widows bereaved in the Israeli wars. Widows helped in the professionally-led groups set up by the ministry have gone on to lead their own "mutual help" groups for those bereaved in later conflicts.

Israel has become the destination for successive waves of Jewish immigrants and cultural bereavement was seen as complicating the reaction to bereavements by death among Ethiopian, Cambodian and Iraqui Jews arriving in Israel. Their problems are relatively recent but it was sadder yet to learn that many of an earlier wave of immigrants, the survivors of the Nazi holocaust, are still suffering and that their problems are being passed on to succeeding generations. No less than 7 papers dealt with the long term effects of the holocaust and although there were several suggestions for treating these (e.g., by mutual help groups, "video memorials", etc.) one cannot be optimistic about their chances of success.

Other special types of bereavement which received attention were bereavement by suicide (5 papers), bereavements by AIDS, shoot-outs with police, (Gersons reported 50% of police officers developed lasting psychiatric symptoms) death of pets and bereavements by death in the families of mentally handicapped and schizophrenic patients.

Of special note was Michael Brownstein's study of the reactions of psychiatrists to the suicide of a patient. All felt guilty and upset and only one out of ten had attempted to provide support to the bereaved family. This is the more worrying when one recognises the special problems which follow this type of death and which were well described by Wroblenski. The death rate from suicide in teenagers has increased by 300% in the USA in recent years (Scherago) and these deaths are even more traumatic to the family than suicide in older people. On the other hand Moritz showed that survivors cope best with suicides that can be viewed as philanthropic. One of the aims of therapy is to help people to find meaning in the suicide.

Some exciting results are coming out of research into the physiological effect of bereavement. Thus Pennington of St. Louis has shown low muscle tone and elevated lymphocyte counts in the blood of newly bereaved widows compared with those bereaved for more than 2 years.

Widows who were depressed (on the Beck Scale) had higher lymphocyte counts than non-depressed and the most depressed also showed elevation of plasma cortisol (a hormone secreted by the adrenal cortex).

Selby Jacobs from Yale, confirmed that the excretion of cortisol in the urine was increased in bereaved people whose grief was intense and prolonged. He also found that people who expressed a high intensity of grief during an interview with a psychiatrist underwent an increase in prolactin levels in the blood (by comparison with their pre-interview level). Prolactin is a pituitary hormone.

Although these correlations are not high enough to justify us using them as measures of emotional response they do hold out promise of an explanation for some of the physical health problems that follow bereavement.

Other clinical papers of interest included Pfeifer's finding that patients attending psychiatric clinics with agitated depressive states are commonly found to have suffered the loss of a parent in childhood. They have reacted to this by a continued fantasy relationship or identification with the parent. Subsequent agitation is said to reflect fears of imminent death befalling the survivors. The therapist, says Pfeifer, must act as a stable "secondary reference point", reducing anxiety and allowing the true situation to be explained.

Another clinical study by Saltzer claimed that in families where attachment between the parents is weak children may be seen as extremely important. When they reach the age when they need to individuate from the family these children may find it very hard to become autonomous. As in Pfeifer's paper Saltzer sees the therapist as a catalyst who will help both generations to work through their grief at the losses which underly such difficulties.

Although many approaches to counselling and therapy with the bereaved were discussed, there were only two papers which allowed for a scientific evaluation of their effectiveness. Kleber and Brom (University of Wageningen, Netherlands) divided 88 "patients who had experienced a major loss and were troubled by serious disorders" to three different types of treatment (Hypnotherapy, trauma desensitization and psychodynamic therapy). They also studied an untreated control group. On follow-up all three treated groups had benefited by comparison with controls, but none of them stood out as better than the others.

Lester Sireling from St. George's Hospital, London, described a similar study in which 20 patients with "morbid grief" were assigned to two groups. One group were treated with Ramsey's "Guided Mourning" technique, being confronted with a wide range of reminders of their loss. The other group were advised to avoid reminders. Both groups were given "grief education, support and advice". On follow-up both groups had improved, but the "guided mourning" group showed rather more improvement in behaviour, distress, anxiety and depression. This confirms Mawson's earlier finding that guided mourning, to a limited extent, enhanced the improvement arising from other methods. A larger sample might have shown more striking results.

ON GRIEF AND BEREAVEMENT

Both of these studies lump together patients with pathological grief as if they were a homogeneous group who could all be expected to respond to the same treatment. But this assumption is belied by clinical experience and Kleber is right in concluding that the most important result of this kind of study may well be an improvement in our criteria for selecting which treatment to offer to which patients.

Approaches which deserve closer scrutiny would include the use of open groups which run on a continuous basis, but allow members to enter and leave at will, (described by Leick et al), marathon groups lasting for 2 days and one night (Ruth Malkinson) and the prescription of structured rituals of leave-taking in which the therapist negotiates a series of formal exercises (or rituals) to assist the bereaved to review and then disentangle themselves from unsatisfactory ties to the deceased (Onno va der Hart).

From the numerous other papers I picked up some quotations which seem worth repeating:—

Herman Feifel (USA) "Recognition of the legitimacy and healing powers of grief can move us to a greater sharing of our common humanity all too eroded in the present world".

Janet Haddington (UK) "The worst enemy of a bereaved person can be a best friend or professional worker who seeks either to deny the need to grieve or make bereavement a condition which pushes the bereaved into a sick role".

Sandra L. Bertman (USA)—quoting a Chinese proverb—"You cannot prevent the birds of sorrow from flying overhead; But you can prevent them from building nests in your hair".

DR. COLIN MURRAY PARKES,
Senior Lecturer in Psychiatry

IMPRESSIONS OF THE CONFERENCE AND OF ISRAEL

Some reservations about the Conference—but none about Jerusalem or Israel. Visiting both was a profound and magnetic experience, particularly the Old City of Jerusalem with its narrow streets, persuasive traders, unfamiliar smells and rich history—another world, another age; Masada the almost impregnable rock fortress of Herod and the tragic Zealots, rearing up from the shores of the Dead Sea; the desert hills, harsh and mostly barren, but with surprises in ravines and dusty villages; the familiar, but often inaccurately seen in imagination, sites and places, Jewish and Christian; and the impact of the Yad Vashem Memorial to those who died in the Holocaust Museum with its horrifying reminder of deaths and griefs.

The Conference ran from a reception on the Sunday evening to a formal close on the Thursday evening. In between 200 papers—too many for meaningful absorbtion, some basic and, sadly, at times not all well presented; one main discussion group each day which proved very helpful as there was very limited time for discussing the papers in the sessions they were presented—3/4 20 minute papers in 90 minutes; and one plenary each day, again with a mixed bag of quality in terms of what was said and how it was said.

Many valuable new links were made in the informal times over coffee or a meal.

This was one of the most mobile Conferences in that participants went into more than one group in each session, choosing one talk in one group, another in a second or third. I listened to papers on the mourning process; techniques in counselling; staff burnout in the perspective of grief theory; leave taking rituals; predicting outcome; problems of suicide and survivors; conveying messages in the Emergency Room; the impact of the Mexico earthquake: community as a coping resource in bereavement; bereavement and anxiety disorders; grief and loss among elderly people; the training of counsellors; and helping unresolved grief. I led one of the daily discussion groups and chaired the session in which I gave my paper on Cruse—A Model for Bereavement Care.

The main benefit from the Conference, for me, came not so much from what was said, although things will no doubt become helpful and more significant as time goes by, but from who was met and the ideas generated in this way.

In his summary Professor Shamai Davidson (an Oxford graduate who is Medical Director of a Community Psychiatric Service in Israel)—he spoke at our Bereavement Following Violence Conference—singled out Cruse for special mention as an organisation with a lot to offer other countries. The Advisory Committee for this Conference has invited Cruse to organise the next one in London—in 1988!

DEREK NUTTALL
Director of Cruse

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"Love is not changed by Death
And nothing is lost and all in the end is harvest."

(Edith Sitwell)

Agnes Whitaker, our production editor, and editor of Cruse Chronicle, chose the title of her anthology for the bereaved from this poem, and as we mourn her premature death we remember those words. Our tribute to her is on page 11.

She was excited, as all of us were at the Jerusalem Conference on Grief and Bereavement, to meet so many people who were doing good work in our field and we publish in this issue some of our impressions of the Conference. From the contacts we made a group was formed, which we hope will begin to develop a policy for responding to disasters on an international level: this follows the initiative of Cruse is proposing a national disaster service. Our aim would be to offer psychological support to the victims and their families, at least as good as the physical succour that is provided.

In this issue too we look at the special needs of the elderly who are bereaved, and at the clergy's role in bereavement. Paul Longbottom's study comes from one Church of England diocese. "Bereavement Care" invites readers from other places and other faiths to agree or disagree with his conclusions. Please let us hear from you.

EDITOR

Cover picture: The Widow's Mite

Acknowledgement to the Keeper of the Heberden Coin Room, Ashmolean Museum, and the Religious Tract Society ('The Money of the Bible' by G. C. Williamson pub. 1894).

More modern numismatists (Donald S. Smyser 1958) suggest the Jannaeus lepton could not have survived 80 years of circulation, and identify the coin of Archelaus, a puppet ruler from Rome from 4 B.C-6 A.D. as a more likely mite.

SOCIAL SECURITY BILL

By Paul Lewis,
Director Youthaid

From April, 1988 there will be major changes in social security. Many women who become widows after this date will get less than they would under the present system. And women who are already widows and get supplementary benefit or housing benefit may be worse off. In the long term there are also plans to cut in half the earnings related pension paid to a widow from her late husband's national insurance contributions.

The changes are being introduced in a Social Security Bill which is currently going through Parliament.

WIDOWS BENEFITS

The changes in widows benefits will principally affect younger women. At the moment every woman who is widowed under pension age with or without children gets a Widows Allowance of £53.60 (£54.20 from 28th July) for the first 26 weeks of widowhood. After that a woman who is widowed without dependent children gets a full widows pension of £38.30 a week if she is at least 50 when she is widowed. If she is aged 40-49 she gets a reduced pension. Under 40 she does not get a pension. A widow with children gets a benefit of £38.30 (called Widowed Mothers Allowance) whatever her age until her youngest child reaches 16 or, if they live at home, 19, even if they are not dependent. When this allowance ends, she gets widows pension pending on her age **at the time.**

The Bill will make three main changes. First, the Widows Allowance will be replaced by a tax-free lumpsum of £1,000 called a Widows Payment. Widows pension, or widowed mothers allowance, will start from the week of bereavement.

Secondly, the age at which a woman without children gets a widows pension will be raised from 50 to 55 and all the ages for reduced pensions will be raised by five years too. So a woman who loses her husband when she is aged 40-44 will no longer get a pension and women widowed at 45-54 will get less pension than they now do.

Thirdly, a widow who has a child under 19 living at home will only get widowed mothers allowance if the child is dependant and in full-time education.

The effect of these changes will be dramatic. Women widowed or first receiving widows pension at age 40-51 will lose in every year from widowhood to the age of 60. The greatest 'losses' will be felt by those aged 40-44 who will lose all entitlement to widows pension. A woman widowed at 44 will lose entitlement to £19,234 between widowhood and the age of 60. About 800 women are widowed at 44 each year and nearly 13,400 are aged 40-51 and will lose from the new arrangements. Women widowed under 40 without children will also lose. They will just get the £1,000 Widows Payment which is worth £462 less than six months Widows Allowance would have been.

Some women will gain. Women widowed at 55-59 will find that the £1,000 Widows Payment and twelve months widows pension is worth more than the six months Widows Allowance followed by six months widows pension. They will be £582 better off in the first year. After that their position will be the same. Women widowed over 60 will be in the same position as those younger women if their husband had not retired. Otherwise their position will not be changed by the new proposals.

All these changes will only affect women who become widowed after April 1988. But many women who are already widowed will also be worse off. The Social Security Bill introduces changes in Housing Benefit and in Supplementary Benefit and for many people "changes" is a polite word for "cuts".

First, Supplementary Benefit will be replaced by a new benefit called Income Support. All the extra weekly amounts for heating, diet, and other items will be abolished and water and sewage rates, and 20% of your domestic rates, will also have to be paid out of basic benefit. The rate of basic benefit will be enhanced by a premium for those with children and lone parent premium for widows and other one-parent families.

In addition, grants for items such as furniture and clothing will be ended and replaced by loans repayable out of the benefit over a period of a year or so.

Those who work and get Family Income Supplement will find it replaced by Family Credit. This credit will be paid by the employer, not directly by DHSS.

Finally, Housing Benefit will be reduced. A total of £450m is to be saved, largely from owner occupiers who currently get a small amount of help with their rates.

The effect of these changes will depend on circumstances. No figures for widows are available. But overall the Government estimates that about 3.8 million people who now get these benefits will be worse off and about 2.1 million will be better off.

Jerusalem Conference

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The Papers that I chose to go to were largely concerned with the responses of children to the loss of parents and there were outstanding research presentations by Dr. Pynoos from Los Angeles, a Paediatrician involved in offering emergency mental health services to children and who has done interesting work on the responses of children who see their parents murdered and (the Paper delivered at this Conference) on the effects on children of seeing one of their mates shot dead in a playground by a sniper.

He was able to show that the children who were most intimately involved in the playground suffered the highest incidence of mental health disorders subsequently, the ripples getting weaker and weaker as the children were less and less involved, but that even for the children who were at home on that day, the effects were quite considerable. He made a good argument for having a Clinic in each area which was able to mobilise itself swiftly in response to such emergencies and is currently evaluating the intervention programme that they used in this incident.

Prof. Shamai Davidson

We are deeply saddened to report the death of Dr. Shamai Davidson, so active in the Jerusalem Conference. He died in March.

Dr. Kranzler from Columbia, New York, is involved in a research programme to look at the bereavement responses of 3 to 6 year olds and has devised some interesting new techniques involving the use of drawings of primary affects (fear, anger, joy and sorrow) which children can identify with and then choose, when asked, which is most like what they are feeling. The reliability of this work seems high and it's a promising new technique for working with very young bereaved children.

Dr. Toubiana of the Psychology Department of Tel Aviv University described the prompt response of the Clinical Psychology Department to civilian disaster in which a bus carrying school children was caught on a railway line and in collision with a train. 22 children died and the event was witnessed by children in coaches that were following. They described individual short interventions given at the school in which the use of creative drawing appeared to improve the immediate outlook for the children. The work was carefully evaluated, and again fits in with the Los Angeles work indicating that there are effective techniques for reducing the level of psychopathology following bereavement, particularly in mass disasters.

Dr. Ayalon, a Clinical Psychologist working at Haifa University with Clinical Psychology colleagues, has devised a programme for preparing children to cope with disaster following terrorist attacks on schools in the border areas. Her techniques were demonstrated experientially in a fascinating workshop and although they have not yet been evaluated, indicate a promising preventative method which may have applications in Britain.

My Paper reporting my second-year follow-up results of a Family Therapy Intervention with Bereaved Children was well received and is, in fact, the first intervention study of its kind with children.

Other Papers I attended were of less relevance to children. The most outstanding were Dr. Palgi, an Anthropologist from Tel Aviv University, talking about brief reactions in cultural context and describing some of the variety of grief reactions in the varying peoples that go to make up the population of Israel; and Dr. Colin Murray Parkes from the London Hospital, who spoke on Bereavement Care in Britain.

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