Council. This resulted in an intensive workshop, the result of which was the publication "Midwives and Stillbirth"[5]. It demonstrates the problems and difficulties that midwives encounter in their everyday work and provides guidelines on how to meet the needs of bereaved parents and their own needs. This recognition of the emotional difficulties professionals experience in dealing with peri-natal bereavement was demonstrated by the "Loss of Your Baby" booklet with its container cover of advice for doctors, midwives and nurses outlining the main problems involved. This booklet has been widely distributed to midwives and is being increasingly used by them.

Perhaps the greatest achievement was the response of the President of the Royal College of Obstetricians and Gynaecologists to the suggestion that the College do something about Obstetricians in peri-natal bereavement. Sir Rustam Feroze set up a working party under the chairmanship of the Hon. Secretary—Mr. Robert Atlay, to produce guidelines for Obstetricians in the subject. The committee consisted of a midwife, a health visitor, a general practitioner, a paediatrician and a representative of SANDS including another Obstetrician. The booklet[6] was produced in 1985 and has been issued to every practising Obstetrician in the country. We all agreed that the Consultant Obstetrician was a key person in the support for parents who lose a baby in the peri-natal period.

**The experience was enriching but difficult, and taught me a great deal of what parents feel and experience; what the failure meant and what they felt about the future.**

From all reports, consumers and professionals alike, there has been a dramatic change when a peri-natal death occurs. It has aroused considerable interest, so much so, that Esther Rantzen produced two TV documentaries called "The Lost Babies"[7] which brought home the message vividly as to what a peri-natal loss means to families and professionals.

Whilst the practice has changed and families are being helped as they were never helped before, there is still room for improvement and research. The Peri-natal Bereavement Research Group at the Tavistock Clinic led by Drs. Bourne and Lewis in their involvement with families who have been affected by a peri-natal bereavement, has demonstrated how far reaching the effect can be, not only on the immediate family but on second and third generations. Grief is a bad enough experience and a challenge to the integrity of the family, but the realisation that intervention can play an important role in preventing further harm to a family and its individual members, confirms the necessity for all this work. The benefits can be of many sources. Anyone in contact with the family can help and play a part in restorative therapy.

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# MORTUARY MINISTRATIONS

by **DR. A. J. W. TAYLOR,** Professor of Clinical Psychology, Victoria University, Wellington, New Zealand.

**The expanding work of Cruse and similar organisations shows that people in need of bereavement counselling can confidently turn for help as and when they are ready, and as and when it is available. Readiness depends on their (a) having overcome the stage of denial (b) having sufficient insight to be concerned about the level of their suffering and its effects on their daily lives, and (c) the value they place upon talking to a trained outsider about their emotional problems. The availability of help depends on the structure and facilities of voluntary and statutory grief Counselling Services, and the distribution, accessibility, selection, training and support of appropriate staff.**

Numerous authorities have focused on different aspects of the readiness of those in need (e.g. Worden, 1983; Osterweis, Solomon & Green, 1984) and on the phenomenon of death itself (e.g. Simpson, 1979; Enright, 1983; Kalish, 1985). Others have focused on the provision of services and the work of counsellors (e.g. Spiegel, 1973; Peplan & Goldston, 1984). The point of the present article is to offer

* a conceptual framework to cover the variety of people who might be in need,
* to suggest some modifications in services to meet their need, and
* also to suggest another location in which bereavement counsellors might make the first contact with those who need help.

All three matters referred to arose out of clinical and research experience following the DC10 crash on Mt. Erebus in Antarctica on 28th November, 1979 (Taylor & Frazer, 1981). On that sad occasion all 257 passengers and crew died, and their scattered remains were gathered and brought back to the mortuary at the Auckland Medical School for identification and return to relatives for burial. As a result the mortuary became the focal point for everyone concerned with the disaster—including the augmented mortuary staff, embalmers, reporters, politicians and grieving relatives. Clinical and managerial services were provided to help the staff to cope with the enormity of their three months of immediate work, and a 20 month follow-up (Taylor & Frazer, 1982). Observations were also made about the inadequacies of space, structure, and function of the mortuary itself that compounded the stress experienced by those who worked there (Taylor, 1984).

A consideration of the aircrash in relation to other kinds of disasters led to the development of a taxonomy of disasters, and a consideration of the body recovery and identification workers to the development of a taxonomy of victims

(Taylor, in press). The one led to a matrix in which the natural, industrial and humanistic causes, interacted to cover the various types of disaster from avalanches to chemical explosions and warfare. The other led to a six-fold classification in which the victims could be those directly affected, their close family and friends, the rescue and recovery personnel, the grieving community, the pathological voyeurs and mobsters, and other tangential groups. The argument was that different disasters could create similar victim groups, each of which might have special needs.

In the case of the Mt. Erebus crash, the main clinical and research study focused on the third category of victim—the rescue and recovery workers from various emergency, law enforcement, and professional groups. The study was sponsored by the NZ Commissioner of Police, Mr. R. J. Walton, and it produced a response from 78% of those who were eligible.

## Families

Unfortunately there was no comparable study mounted for the families and friends of the primary victims. The nearest approach to a study of such people who were living in the Auckland Region was conducted by a speedily created Grief Crisis Team at Carrington Hospital (Muir & Polkinghorne, 1980). It obtained 37 volunteers, set out instructions for telephone counselling and home visits, arranged a full roster for the first 72 hours and an on-call service for the next three weeks. It put out radio, TV and press advertisements and then stood by. The response was in the form of 461 telephone calls of which 337 (70%) were from potential helpers (including some professionals who construed the crisis service an encroachment on their territory!). Ninety-seven calls (21%) were from friends and neighbours of the bereaved, and 27 (6%) were actually from the bereaved. Of the latter, 19 sought practical assistance for everyday problems that they were now obliged to tackle themselves, and the remaining eight asked for emotional support.

## Enquiries

The publicity also led the Police working in the mortuary to approach members of the grief crisis team for an opportunity to talk with them about the changes in their attitudes, behaviour and feelings that arose from their post-disaster work there. That approach, and the multitude on enquiries that were made to the mortuary by relatives, particularly from groups like the Japanese, complete with their own Shinto priest from overseas, as compared to the modest response to the more conventional type of telephone counselling service that was established—led me to consider (i) the psychosocial functions of a mortuary (ii) the appointment of bereavement counsellors to work there, and (iii) the value of helping the helpers.

### (i) FUNCTIONS OF A MORTUARY

In recent years mortuaries in New Zealand have come to serve a medico-legal purpose almost exclusively. They are situated in close proximity to hospitals, and they provide facilities for the detailed examination of all cases of accidental and unnatural death.

The Coroners' courts are open to the public—although few people seem to avail themselves of the opportunity unless they have some personal acquaintance with the deceased. But the mortuaries are not open to the public except by invitation to specific people whom it is thought might be able to help to identify the deceased.

The laboratory function of the mortuary is well described by Knight (1984), and included with the anatomical, clinical, legal, microbiological and physiological procedures of his manual are some welcome comments on the emotional needs and the religious obligations of people with regard to their relatives (Knight, 1984, pp.42-47). But it is clear that for the grieving and the various religious rites to begin in the mortuary, as well they might, some changes would need to be introduced. The psycho/socio/religious functions of the mortuary require formal recognition, and such space and facilities as might be appropriate for family and small groups of various religious persuasions. Better access provision is required for such participants, nearer the public area rather than the laboratory areas.

The physical and professional rearrangements would create insurmountable problems only for inflexible professionals resistant to change. Those pathologists who themselves have experience of the anguish, conflict and frustration of relatives around a mortuary after a major disaster, and have developed the insight, interdisciplinary breadth of knowledge, and the senstiivity of a Gonzalez-Crussi (1985), would favour the extension of psychosocial mortuary function now suggested.

### (ii) BEREAVEMENT COUNSELLING

The chaos and tensions surrounding a mass tragedy, and the tightly-checked despair of the family faced with an accidental death are both seen at the mortuary. Those reactions mark the onset of the well known sequence of bereavement reactions (Parkes, 1972; Kubler-Ross, 1975, Bowlby, 1980) and with timely encouragement there and then, it might be possible to help more people to express rather than to repress and to deny them. Such at least has been the experience of both voluntary and professional workers in the health field.

It would follow that the sooner encouragement can be given for the bereaved to begin their grief-work, and the sooner they can be put in touch with support groups, the better it will be for them. More than that, the helpers might become more aware of the stresses and strains on the families and friends of, for example, those who had committed suicide, and those from specific cultural minorities: and with that information they could foster greater understanding of their needs, develop better supportive services, and also promote more research.

The plea for a trained person on the spot with both counselling and research skills is not made lightly, in view of certain difficulties experienced recently when trying to obtain basic information from the mortuary records about people who had committed suicide (Taylor & Cummings, 1985). At that time there were no national statistics on the subject kept as a matter of normal routine by a single government department—even though the topic ranked 13th in frequency in the mortality tables. Were trained counsellors available on the mortuary staff they would be more able to obtain data systematically for agreed research proposals, and so remedy the present deficits.

The placement of bereavement counsellors directly where they are most needed, would not only make practical sense, but it would be in the best tradition of health care. One such appointment was made to the Sydney Mortuary by the New

*(continued on p. 20)*

South Wales Health Commission in 1981, and the indications are that it is successful.

Obviously the question arises as to the best background preparation, formal training and support such bereavement counsellors might need. And consideration will need to be given to the variety of work, and the kind of supervision and debriefing such appointees might need to help them not to be overwhelmed by the constant depth of tragedy that will come their way.

The placement of bereavement counsellors directly where they are most needed would be in the best tradition of health care.

(iii) HELPING THE HELPERS

The appointment of grief counsellors might induce more of the present company of professionals who deal with death to face more of the emotional consequences of their work. It is true that there is an increasing number of seminar-discussions on the topic in training schools for clergymen, doctors, police, nurses and social workers, to name the groups most likely to be involved; there is also an increasing number of journal articles and books available on the topic. But neither the police, nor doctors seem to address the topic explicitly in their training. Even one of the major textbooks on pathology makes no mention of the emotional aspects of the specialty or the specialists themselves (Gresham & Turner, 1979).

The implication is not that the professionals have come to harm, but that even they, as well as those who might not have survived the 'hazing' of unprepared exposure to corpses that are often mutilated, might find their occupations less stressful if help were offered to them. There is still too great a tendency for professionals to deny their own emotional needs, even while encouraging others not to neglect theirs. Too often the professionals assume the armour of the formidable, indomitable and unflinchable, despite the emotional costs of maintaining a defensive shield.

As yet, there is only a general, rather than a specific, prescription for the kind of help that might be made available. For the uninitiated it involves a process of desensitisation through slides and video tape instruction: the deliberate adoption of whatever defensive imagery the professionals find familiar—such as regarding the human remains as broken dolls, toys, tailors' dummies, and animal carcass. But it would need to be followed by a process of resensitisation through routine de-briefing discussions that allow the realignment of thoughts, feelings and behaviour for non-mortuary purposes.

At present the support procedures for staff might seem to lack definition, but there is some research currently underway with Police recruits in Wellington. The professionals are vicarious victims, the third category outlined above, whose humanity requires them to identify with the relatives but whose professional satisfaction and psychological stability requires them not to become absorbed. Were trained grief counsellors available in the mortuary as the first point of contact for many families, another point for some, and the only point for many, they would be able also to help the other professional groups to cope with the emotional aspects of their own work.

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