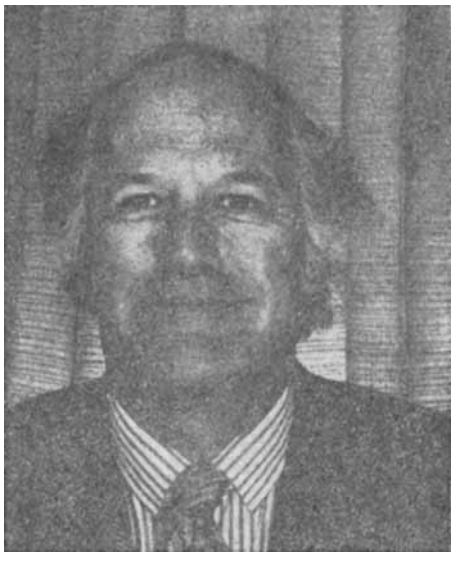
An Evaluation of the Training of

by
Dr. David Le Poidevin, MB ChB, DPM, MRCPsych

Consultant Psychotherapist,
Grampian Health Board



The training of bereavement counsellors needs to be evaluated from time to time to make sure it is achieving the desired outcome. Dr David Le Poidevin's study of a Cruse course for bereavement counsellors in Scotland indicates that volunteers from both lay and professional backgrounds developed a sound grasp of current views on bereavement processes and would make appropriate referrals where necessary.

Editor

During this century a large body of psychiatric literature has been compiled about bereavement and its effect on health, its phenomenology, its varied presentations and how it may be helped. Freud[1], Lindemann[2] and Bowlby[3] are probably the most frequently quoted of the earlier writers. Parkes, basing his work on that of Bowlby, has extensively explored this subject and his followers have used Attachment Theory as a theoretical model for understanding and counselling bereaved persons[4]. Most recently Mawson et al[5] introduced the Guided Mourning approach based on the work of Ramsay[6]. A few years earlier Liebermann described results of 19 cases of morbid grief with the same techniques which he called Forced Mourning, which was Ramsay's original term. These techniques seem most useful where there is an avoidance of grief work. Raphael uses Crisis Theory as a basis for early intervention, and has suggested that this approach is particularly appropriate for anticipated abnormal reactions.

In a review article Parkes (1985) stated that in Britain the only national organisation to provide bereavement counselling on a wide scale is Cruse[4]. In 1986 a Cruse working party itself reviewed the workings of the organisation and exhorted its branches to take steps to improve the quality of training for its counsellors. In Scotland work is under way on a national level to meet this challenge. In practice, however, as Parkes implies[4], training schemes have depended upon the goodwill of local rather than national experts, and this study is an attempt to evaluate the effectiveness of one local branch in training its counsellors in ways it set out to do.

How the training is given

The Aberdeen branch runs training courses on an ad hoc basis. These are planned and run by its Counselling Sub-Committee consisting of counsellors accredited by the organisation, chaired and led by a consultant psychiatrist. Counsellors are volunteers and work in their own time. They happen to consist in approximately equal numbers of those who have been widowed and those who have not. The counsellors are drawn both from those who have some kind of professional background in the caring professions and those who have not. There is no minimum standard laid down for educational qualifications and counsellors are recruited both from academic and from entirely non-academic backgrounds. Most of the counsellors are women.

National headquarters issues a series of documents relevant to the training and supervision of Cruse counsellors but it is possible that this local branch has developed its own idiosyncratic methods.

This study concerns itself with those counsellors recruited to the organisation who remain actively involved in counselling at the time of the study. Fourteen of the 16 participants took part in the study.

The training of Cruse counsellors in Aberdeen has tended to evolve in the following form. Initially a training course is held and the numbers are limited to about 30. This course is not specifically aimed at potential Cruse counsellors but is extended to all who indicate an interest in learning more about bereavement and its management. An initial selection form is used and the sub-committee reserves the right to restrict entry. Preference would tend to be given to those who indicate an intention to make use of this training for some kind of future practice.

The initial course consists of some eight sessions, beginning with either a lecture or a presentation lasting approximately three-quarters of an hour. This is followed by small-group seminars with an appointed leader to discuss the content of the presentation, each leader having a remit to encourage the group members to explore their own personal reactions to the topic and how it affects them. The session concludes with a plenary meeting with reports from the individual groups and a brief discussion period. Topics covered include theories and descriptions of normal and abnormal bereavement: a presentation by a child psychiatrist discussing observations of bereavement in both children and parents; personal testimonies by people who have been bereaved; the use of video material; and a lecture from the National Director of Cruse. An attempt is made to keep the membership of the small groups constant so that towards the end of the course there can be some exploration of personal gains and losses through the group experience.

At the end of each course, the participants are invited to apply to become Cruse counsellors. Usually about 12 to 15 people do so, and after selection interviews and further consultation, the numbers formally appointed by the organisation have been about seven or eight.

Training after the course can be loosely described as a form of

supervision although consultation might be a more appropriate term. These sessions are conducted on a monthly basis by a supervisor who, in our case, is a psychiatrist. At these meetings general issues and experience with individual cases are discussed in detail.

After becoming accredited, the new counsellors are attached to experienced counsellors to gain experience by sitting in on the various activities of the branch in which counselling takes place.

In this branch, individual counselling is offered both in central premises and on occasions in people's homes. Group counselling also takes place. The most popular sessions are those held during normal working hours, but for the minority who are not able to attend, group counselling is offered outside these hours.

A small number of counsellors have experience of working with the Parents' Circle, which consists of bereaved parents whose children tend to be of primary school age, though there is no rigid rule about this. This small number of counsellors also has experience of dealing with bereaved children.

A system has been established whereby newer counsellors can approach more experienced counsellors whom we designate counselling supervisors, and in real emergency they have direct access to the consultant psychiatrist. In general it takes about a year from the beginning of training before a counsellor undertakes any bereavement counselling within the organisation without direct access to a colleague of more experience.

Evaluation

For the evaluation, each counsellor was invited to complete a questionnaire with a standard covering letter explaining what was required. A questionnaire was considered a more appropriate tool than a semi-structured interview since all the subjects are personally known to the author. However, ample space was left in the questionnaire for written comments and many respondents took advantage of this facility. The questionnaire attempted to assess to what extent the counsellors have assimilated the course, their attitudes to various aspects of the training and their views of their clients.

It was also hoped to gauge their level of skill to some degree by including five case profiles and asking the subjects to rate the usefulness of 20 different interventions or approaches on a five point scale in each case. Three of the case profiles, designated A, C and E, were intended to indicate a possible abnormal bereavement reaction and cases B and D probably conformed to the concept of a normal bereavement reaction. Apart from basic information, nearly all the remaining 50 questions were rated on a five point scale from 'very unhelpful' to 'very helpful'. An effort was made to randomise the 'ideal' response of the designer. In addition there was a mini-questionnaire on helpful counselling qualities. In only one question concerned with theory were the counsellors informed that they need not tick or circle every item. Without exception they followed instructions and there were no spoiled papers.

Matrices were used to analyse the data and although the use of statistical tests was considered it seemed doubtful if they would add to the study. Searches through the data appeared to reveal some very definite findings, but in such a small group sub-groupings could not be identified by any valid statistical test. Despite the disparate backgrounds and previous experience of the subjects there was little to suggest any obvious sub-groupings.

Findings

Training

There was general satisfaction with the training given, but it was rather unlikely, given that the researcher was the trainer and that the researcher and the subjects continue to work together, that strident criticisms would be voiced. Nevertheless, four of the 14 counsellors suggested that role play would have added much to the training given and two expressed doubts about the system of consultation in an emergency. Some would have liked more time for small-group discussion in the early training course and some felt the plenary discussions were not very useful, though the large-group sessions were clearly valued by others.

"Cruse, although a voluntary organisation, is intimately connected not only with psychiatry but with general practice and if its counsellors adopt a psychotherapeutic stance, which those in this study appear to do, then one may consider bereavement counselling a suitable test for the future of psychotherapy in the National Health Service."

Knowledge

As a group, the counsellors displayed a fairly sophisticated knowledge of bereavement processes and of what is required in a person dealing with the bereaved. For example, a question which suggested that a breezy, confident manner was a helpful quality in a person acting as a telephone contact for the bereaved resulted in a resounding negative response. The view that 'children seldom grieve' also had no takers. A degree of uncertainty was expressed over whether

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SUMMARY

The author reports the work of the voluntary organisation Cruse, which offers services to the bereaved, with particular reference to the Scottish branch serving Aberdeen and District.

A description is given of the local training scheme for bereavement counsellors, who are recruited from both well educated and less well educated members of the community, from those who are widowed and those who are not. Only a minority have any previous training in or experience of Counselling or Psychotherapy.

Because all the subjects in the study are well known to the author the only practical test considered was a postal questionnaire. Fourteen of 16 active counsellors in the branch completed the study. The possible responses in most cases are on a five point scale. Questions cover various aspects of the training given, knowledge of bereavement processes and the attitudes of the counsellors. There is a section on qualities of helpful counsellors. In addition there are five case profiles: three intended by the author to indicate possibly "difficult" bereavements and two to indicate probable straightforward reactions. Subjects were asked to rate their opinions on the helpfulness of 20 suggested "interventions". This section gives some scope for the assessment of skill.

As a group the counsellors had a sound grasp of current views on bereavement processes and had a unified view on helpful counsellor qualities. They had relatively little interest in theory, despite the fact that it had been taught, and insisted that qualities in the counsellors were of more importance. The single most important quality emerging from analysis of the data was empathy. Half the group appeared to recognise the potentially disturbed case profiles and suggested referral to a psychiatrist of all three cases, whereas the overwhelming majority suggested that the two "straightforward" reactions would not be helped by such an intervention. It is of interest that the group overwhelmingly recommended the supply of literature about bereavement to those referred.

Table 1—Counsellors' responses when asked to rate their opinions of five theoretical approaches to bereavement counselling.

Theoretical Approaches	Rating					No. of responses
	Very unhelpful	Unhelpful	No definite opinion	Helpful	Very helpful	
Detachment Theory			3 (1)*	5		8
Guided Mourning		1	2	5 (1)		8
Positive Care-giving			1	6 (2)	3 (1)	10
Attachment Theory			1	7 (1)	1	9
Crisis Theory		1	1	4		6

* Numbers in brackets refer to counsellors with previous experience of counselling with other organisations.

anger is part of a normal bereavement reaction or whether nursing a sick relative through a prolonged illness suggested a difficult time ahead, but mutilating death, suicide and a stormy marriage were all strongly recognised as prognosticators of possible severe reactions. Most of the counsellors thought remarriage of a widowed person within five years unlikely, and they disagreed with the notion that bereavement necessarily undermines the personality.

Attitudes

The respondents gave a fairly unified view of what represented 'good' qualities in counsellors and rejected the maverick options included in the questionnaire. They considered empathy the single most important quality, judging not only from the mini-questionnaire but from the possible interventions in case profiles and from other items in the main questionnaire. Nevertheless, there were suggestions that empathy is more difficult if the client is detached or remote, or emotionally very demanding or angry. Supplying literature on bereavement was also fairly highly rated. However, almost a third of the counsellors seemed hesitant about the term 'confrontation' and when to apply it or use it, and this may suggest the possibility of faulty teaching on this subject.

Consistency in responses

There are two pairs of questions in the main questionnaire which ask virtually identical questions using different wordings. However, all responders gave internally consistent answers.

General comments on the matrices

There was a general absence of stereotyped responses in both sets of matrices. Certain approaches, e.g. indicating that taking care to show that you understand or giving the bereaved person a supply of literature were fairly unanimous recommendations, although other interventions in the case profiles were more varied. This suggests that this group of counsellors are capable of responding flexibly and spontaneously to the needs of clients, if their behaviour as counsellors is the same in real life situations as it is in response to the questions.

Findings on specific interventions

One of the interventions in the case profiles invites counsellors' comments on the usefulness of discussion of childhood and parents in each particular case. The counsellors saw this intervention as particularly helpful in one case, and this response shows positive discrimination of the use of this intervention in a case where apparent family relationships are difficult and where, by implication, relationships within the family of origin may have been somewhat fraught in the past.

Another intervention — 'suggest referral to a psychiatrist'—attempts to investigate whether this group can discriminate normal from abnormal bereavement reactions. This intervention assumes that one would be more likely to refer someone suffering from pathological grief to a psychiatrist, and that one would not refer a normal grief reaction to this service.

Two of the cases (B and D) were seen by the counsellors as particularly inappropriate for psychiatric referral, and while there is a fairly wide scatter of responses in cases A, C and E, nearly half suggest that referral would be helpful compared with only two responses (one each) for cases B and D from the 14 counsellors who replied.

Analysis of replies suggests that the counsellors in this sample were less influenced by theoretical considerations than by the idea that successful counselling was related to personal qualities in the counsellor.

In view of this group's lack of interest in theory, it is interesting to note their response to the question asking them to rate opinions of the usefulness of five theoretical approaches to bereavement counselling (Table 1). 'Detachment Theory' is an invented concept and it is possible that some respondents confused this with Attachment Theory, which had been promoted in recent courses at the Aberdeen branch. Because we have received relatively few referrals from those bereaved less than three months, we have tended not to place emphasis on Crisis Theory. Hesitancy in the use of confrontation may be related to insufficient attention being given to the application of Guided Mourning as a useful technique in situations where there is avoidance of grief work.

Empathy

The sample seemed to find it easier to empathise with case A, who was a distressed elderly person whose husband had committed suicide and who had been unpopular with her family. They also found it easy to empathise with case B who was a relatively young man struggling to bring up a young family following the loss of his wife but with good family support from his sister, after he had shown initial signs of being overwhelmed by the stress. Although these are no more than very cautious interpretations of possible trends, there were less very helpful responses in case C who is clearly angry, case D who is clearly rather detached and case E who has proved very demanding to her general practitioner over a period of years.

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Discussion

In interpreting the results of this study, the intention is to try to learn something about the characteristics of these counsellors, the training they have received and their response to it. The results suggest that they appear to have a reasonable grasp of bereavement processes, can probably largely separate normal from abnormal bereavement reactions, and they rate empathy as the single most important ingredient in counselling.

They regard counsellor qualities as more important than method, but there is some tendency to show uncertainty in knowing when to confront. This suggests that in future courses, issues surrounding avoidance and how to deal with it should be more fully discussed.

The usefulness of supplying information in the form of literature about bereavement processes which this sample commends may be of wider interest to counsellors and psychotherapists. It aligns them with the view of Yalom and his followers who commend giving information beforehand to educate participants in a particular therapy.

Recently McGrath and Lowson investigated economic arguments about psychotherapy in the United Kingdom's National Health Service[8]. One of the two main areas in which they considered cost arguments must be satisfied was in the general medical field. Cruse, although a voluntary organisation, is intimately connected not only with psychiatry but with general practice and if its counsellors adopt a psychotherapeutic stance, which those in this study appear to do, then one may consider bereavement counselling a suitable test for the future of psychotherapy in the National Health Service.

References

1. Freud S. Mourning and Melancholia.' In: Strachey J (ed). Standard edition of the Complete Works of Sigmund Freud (Vol 14). London: Hogarth.
2. Lindemann E. The symptomatology and management of acute grief. *American Journal of Psychiatry* 1944, **52**; 322.
3. Bowlby J. Grief and mourning in infancy and early childhood. *Psychoanalytic Study of the Child* 1960; **15**: 9-52.
4. Parkes CM. Bereavement: review article. *British Journal of Psychiatry* 1985; **146**: 11-17.
5. Mawson D, Marks IM, Ramm L, Stern RS. Guided mourning for morbid grief; a controlled study. *British Journal of Psychiatry* 1981; **138**: 185-193.
6. Ramsay RW. Bereavement: a behavioural treatment of pathological grief. In: Trends in Behaviour Therapy III (Sjoden PO, Bates S, Dockens WS (Eds)). New York: Academic Press.
7. Liebermann S. Nineteen cases of morbid grief. *British Journal of Psychiatry* 1978; **132**: 159-163.
8. McGrath G, Lowson K. Assessing the benefits of psychotherapy: The economic approach. *British Journal of Psychiatry* 1987; **150**: 65-71.

The Anguish of Being in Need

by

Michael Stewart, MA, CQSW

Independent Counsellor and Training Consultant



Photo: Courtesy of 'Social Work Today'

Those who offer help to the victims of disasters may be surprised and disappointed to find that their generosity is not immediately appreciated. In this paper Michael Stewart, who provided counselling to victims of the fire at the Bradford Football Club, explains why it is that people in need of counselling may find this difficult to accept.

Editor

Survivors and victims of disasters are distinguishable from the rest of us by the random way in which they happen to be in the wrong place at the wrong time. In this sense we are right to feel fortunate. It could have been us.

However, we are not only spared the pain of a thousand shocks by not being in that football stand, or on that ferry, in transit through King's Cross, or a resident of rural Berkshire. For them there has been a more insidious, more testing examination. How would we cope with an offer of psychological or emotional help, perhaps from a social worker or a counsellor? How do we rate our ability to cope and what state do we have to be in before we are able to acknowledge our need?

The great majority of people seen by professional and volunteer helpers following a disaster are unacquainted with the world of therapy and counselling. Often for the first time in their lives, they are reminded of their vulnerability. When disaster strikes, our human, everyday rhythms are disturbed. We face death, injury and the virtual destruction of our world as we know it. Our normal coping strategies appear to us as inadequate, even pathetic in the face of unthinkable fragmentation and loss.

Suddenly, humans have to adjust to a new reality. The world is vulnerable. We are vulnerable. Everything can change in an instant, in the twinkling of an eye. Buildings can be reduced to rubble, landscapes devastated, human tissue destroyed, whole communities transformed into apocalyptic images. In short, we are shown the frailty of life itself.

People react to these experiences with shock, disbelief, denial, anger and wonder. For most normal people it means having extremes of feelings unfamiliar in ordinary, everyday life. It can seem like madness.

Notwithstanding the horror of their experiences, survivors are reluctant to ask for help. They fear the stigma of having help in a society which believes in the ideal of independence. If you have a problem you deal with it yourself. It is all right to consult a solicitor if you are being divorced or a doctor if you have a broken leg. But it is not all right to feel "low" in yourself. The ethic is that one must soldier on. Feeling low is a sign of weakness, and weakness is for the weak. The fear of stigma is often felt more powerfully than the need for help. If we seek help our self-esteem will be diminished. Our ideal of being able to cope will be