Stress Disorder, was highest four months after a road traffic accident.

Depression was also most marked four months after road traffic accidents but declined thereafter. On the other hand depression tended to increase between four and 14 months in parents and spouses of people who had suffered a long illness. In these case the early reaction was often one of relief. At four months after bereavement, 36% of spouses suffered acute to severe depression and at 14 months, 22% were still depressed. Other relatives showed less depression with siblings and children least. Suicidal ideation was seldom severe but many spouses and parents agreed that they wished they were dead.

Bereavement by suicide was most often associated with feelings of guilt, but strong guilt was rare. At the four-month interview those bereaved by suicide were more likely to feel stigmatised by their bereavement and their social functioning was worse than the rest, but these differences had disappeared 10 months later. There was a substantial number of those bereaved by suicide whose reaction was one of relief.

Unfortunately, the measures of health used in this study were a hodge-podge of psychological and physical symptoms which correlated more closely with 'anger' than they did with 'consumption of medication'. This raises, yet again, the question whether there is any such thing as 'general health'. Certainly, in this study a lot of variance of this score remained unexplained and it is difficult to understand the reason for those correlations that did exist – apart from the obvious correlation between poor health and older age.

In this, as in other studies, the majority of bereaved people came through the stress of bereavement without suffering any permanant deterioration in psychological adjustment. How then are we to recognise the minority who will get into difficulties if they are not offered appropriate counselling? Cleiren shows that closeness of attachment, intensity of anger and lack of support predicted poor outcome across all types of loss. In addition, widows and widowers were most at risk after unnatural deaths or if they had suffered a large drop in income. Parents losing a child were at special risk if they had pre-existing health problems (mothers being at more risk than fathers). Adult children who had lost a parent were most at risk if they had maintained close and frequent contact with that parent (daughters being more vulnerable than sons). Finally, siblings were most at risk if they were young and blamed themselves for an unexpected death.

Most grief improved between four and 14 months after bereavement but persisting grief was more likely in parents who blamed themselves for their child's death, particularly if this child was of the opposite sex. This confirms clinical impressions that chronic grief often has a self-punitive quality.

The author suggests that the good adjustment made by most widows may reflect the relatively generous financial provision that is made for this group by the Dutch State and by social tradition in Holland. Despite this, there would seem to be a need for improving the provision of practical help and information for bereaved people there. Those who lacked these types of help experienced more severe loss reactions, worse health and worse social functioning than those with practical and informational support. Extreme reactions at the four month period are a strong indicator of future problems.

It is a pity that Cleiren did not include a sample of unselected bereaved people in his study as there are obvious dangers in extrapolating from his overall findings. This said, he has made a significant step forward in bereavement research and his use of well-established instruments makes comparison with other studies possible and appropriate and confirms his view that many of those who suffer traumatic bereavements will go on to develop Post Traumatic Stress Disorders.

The book includes a useful review of the theoretical and research literature (although this reviewer was surprised to find his own work labelled 'psychoanalytic') and should be read by all serious scholars of bereavement. It should be stocked by all major medical, nursing, psychological, sociological and social work libraries.

Colin Murray Parkes
Senior Lecturer in Psychiatry

ABSTRACTS

Developing Strategies to Assist Sudden-Death Families: A 10-Year Perspective

Williams M, Frangesch B. *Death Studies* 1995; **19** (5): 475-87.

In 1983, nurses in a 600-bed, acute care hospital in the Midwest of the USA initiated a holistic programme designed to help survivors, family or friends after a sudden death, perhaps from suicide, homicide or an accident. The intervention begins at the moment of death and lasts for two months. The aim is to provide a structured, supportive link with the survivor(s), through listening, crisis intervention, help with the grieving process and community referral, mainly (after the initial crisis) by means of telephone calls. The programme, which seems to be an extremely caring one, has functioned well, and has fuelled the determination of the people involved to continue it in the future.

An Integrative Model of Grief

Moos NL. *Death Studies* 1995; **14** (4): 337-64.

Much emphasis has been placed on individual grief reactions following the death of a family member. However it is becoming increasingly apparent that families, and the interaction within them, play a large part in the process of grieving. By combining individual and family conceptualisations of grief tasks, the author establishes a model of family grief that shows the interrelationship of these processes. Her clearly written, thoughtful and interesting article highlights the importance of family processes in the individual's perception of the death, as well as the influence of each family member in the overall grief reactions and coping strategies of the family system.

Evaluation of Bereavement Anniversary Cards

Hutchison SMW. *Journal of Palliative Care* 1995; **11** (3): 32-4.

It is the practice of St Columba's Hospice in Edinburgh, Scotland to send a bereavement card, 12 months after the death of someone who has been in their care, to close relatives and friends as a gesture of support. Wishing to know how the recipients felt about these cards, the hospice sent out to a hundred of them a questionnaire asking for their reaction. Nearly all the recipients replied that they welcomed the cards, though a few of them thought, wrongly, that it was a means of asking for donations to the hospice. The main conclusions of this brief article are that the cards are comforting and appreciated but that they should be sent as part of broader support, and that the misunderstanding with regard to donations should be clarified.

Death of an Institutionalised Parent: Predictors of Bereavement

Pruchno RA, Moss MS, Burant CJ, Schinfeld S. *Omega* 1995; **31** (2): 99-119.

The authors of this article, all of whom work in geriatric centres, analyse the degree of grieving likely to be experienced by adult children following the death of a parent in a long-stay care facility. From their research they postulate that the length of stay, the parent's cognitive status, depression, and the child's feelings about the parent living in a nursing home, all provide guidelines in predicting the degree to which the child is likely to experience sadness, a sense of comfort in memories of the dead parent and a sense of relief that the parent's suffering is ended. The data suggest that the nursing home is an ideal place for bereavement intervention programmes.

Sheila Hodges and John Bush

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Richmond, Surrey TW9 1UR, UK
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Fax 0181-940 7638

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Bereavement Care is published three times a year in Spring, Summer and Winter.

All prices are inclusive of airmail postage. Payment may be made by cheque, money order or credit card (Mastercard, Eurocard, Access, Visa).

Most back numbers available at £3.00 plus 35p postage (UK).

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Packs of selected articles from past issues grouped in themes are available from the publishers at prices from £2.85 to £6.50.

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ISSN 0268–2621

Printed by Doppler Press, Brentwood, Essex CM14 4RX, UK