each applicant should be interviewed in depth and that the feelings evoked by past losses be explored. If people are in touch with their feelings about such matters, but no longer overwhelmed by them, they will probably make good counsellors. On the other hand, the applicant who is still very 'tender' or who has dealt with past losses by walling them off emotionally will make a poor counsellor.

We should be suspicious of people who tell us that they know the answer to bereavement, for bereavement is so complex a topic that there is no one answer that will suit everyone. On the other hand a person who shows willingness to hang in with people despite the absence of an answer to their problems will probably make a good counsellor.

No matter how rigorously applicants have been selected it is important to pay attention to these issues in the course of training. While books and didactic training have a place, it is only experience that enables us to test out and to develop our ability to cope with emotional issues. Role-play, self-awareness training and, in due course, supervised counselling experience are all valuable ways of doing this. They enable those who are capable of developing counselling skills to do so and they also make it clear that some people are not yet ready to take on the responsibilities of a counsellor. For this reason full accreditation should not be offered until training is complete and a final selection process undertaken.

In the present state of our knowledge there is no research which indicates that help given by full-time professional counsellors is superior to that provided by well-selected and trained volunteers, although common sense suggests that higher levels of training should be beneficial if only to a minority of clients with special difficulties.

In many countries there are organisations that provide accreditation for bereavement counsellors. These include **The Association of Death Education and Counselling** in the USA, **The National Association for Loss and Grief** in Australia and New Zealand and **Cruse Bereavement Care** in the UK. Although criteria for accreditation vary from country to country the above named organisations do seem to meet reasonable standards.

CONCLUSION

Counselling for bereaved people has proved its worth but, like all effective interventions, it is not universally beneficial and may even do harm. In order to maximise the benefit and minimise the harm, attention should be paid to the selection of clients; the selection, training and supervision of counsellors; and the provision of a spectrum of services to meet the varied needs which are encountered.

Members of health care teams have the opportunity and, indeed, the responsibility to assess bereavement risk in family members before or at the time of a death and should be trained to do this.

Those who offer service to bereaved people should be selected, trained and supervised by accredited organisations.

The need is so great and the potential benefit so well-founded that it is time for national standards to be agreed and for national plans to be drawn up and implemented.

References

1. Parkes, CM. Evaluation of a bereavement service. *Journal of Preventive Psychiatry* 1981; **1**: 179-88.
2. Raphael B. Preventive intervention with the recently bereaved. *Archives of General Psychiatry* 1977; **34**: 1450-1454.
3. Parkes CM. Bereavement: Studies of grief in adult life (3rd edn). London, UK, New York, USA: Routledge, 1996.
4. Lindemann E. The symptomatology and management of acute grief. *American Journal of Psychiatry* 1944; **101**:141.
5. Beck AT. 'Cognitive therapy of depression: new perspectives'. In: Clayton PJ, Barrett AE (eds). Treatment of Depression: Old controversies and new approaches. New York, USA: Raven Press, 1983.
6. Schut HAW, Stroebe M, van den Bout J, de Keijser J. Intervention for the bereaved: gender differences in the efficacy of two counselling programs. *British Journal of Clinical Psychology* 1997; **36**: 63-72.
7. Schut H, de Keijser J, van den Bout J, Stroebe MS. Cross-modality grief therapy: description and assessment of a new program. *Journal of Clinical Psychology* 1997; **52**(3): 357-365.

Picasso's *Science and Charity*

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Visiting the Picasso Museum in Barcelona recently, I came upon this picture (reproduced on the cover of this issue) for the first time. It was painted in 1897 when Picasso was 15 years old and is a good illustration of his enormous talent which was to dominate the whole of 20th century art. Picasso here paints a young mother at the point of death – her eyes are turning up. Her young child watches her from the nurse's arms. The mother is attended by the doctor who must, at the point at which the painting freezes time, have just realised that he has lost his patient. The nurse is proffering a drink that she will never taste.

Why should Picasso have chosen such a poignantly sad subject to paint? The previous year his beloved sister, Conchita, had died of diphtheria, at the age of seven. Picasso had made a vow when she fell ill that he would give up drawing and painting permanently if God would spare her, a measure of his devotion to her. He was already struggling with the agnosticism and anti-clerical feelings which were part and parcel of his rebellion against his father who, an indifferent painter and teacher himself, was rather overbearing and authoritarian in his direction of the young Picasso's talent. Father was, in fact, the model for the doctor. It may not be too fanciful to imagine that the loss of Conchita stimulated the adolescent Picasso to feel he had to use the talent he nearly vowed away to pay tribute to her – to thank her, so to speak, for not making him have to hold to his vow – by depicting a deathbed scene.

I marvelled at the perfection of technique that Picasso had attained by the age of 15 and it helped me to understand why he spent the rest of his long life at the cutting edge of experiment. But most of all I was moved by the insight this young person had into the plight of the child. The child looks down without emotion upon his mother, not yet comprehending the momentous event that will deprive him forever of her care. The nun is not looking at the child; she is holding him with one arm, rather casually and without emotion, almost ignoring him, even though she is aware of what he is about to lose. The doctor pays no attention to him at all and the mother cannot look at him as she is at the point of death. The source of light comes from in front of and above the child, lighting him and the nurse. Our eye is drawn to him by the light and the white of the nun's coif. He is alone. Neither science nor charity can restore his mother to the child and, of all the people in the room, he alone is bereaved.