like a programme. So, with these reservations clearly declared, the only comment I can make is that this publication offers more of the same.

The parameters of the group ethos are briefly set out at the start and session one launches straight in at the deep end, requiring the child to re-experience the death and discuss it with the other group members. The programme pursues a predictable course through an exploration of emotional responses, memories of the funeral and the effects of grief upon the individual and the family. The text instructs the child to complete each exercise and the layout of each page clearly expects this instruction to be followed.

The text assumes that the child is part of a nuclear family and makes reference to changes perceived in parents, siblings and extended family. This aspect could present a significant problem for any group member who had been bereaved of one of these people. The text also assumes that this family is Christian. Both these features restrict the workbook's use with children not living with their birth families and they compromise its applicability with multi-cultural groups.

In its favour: the layout is clean, the language clear and each section has a list of books relevant to that session. There are plenty of books of this type around and this is one more to be added to the pile. BC

Peta Hemmings
Senior Practitioner

THE HEART OF GRIEF

Thomas Attig

Oxford, UK: Oxford University Press, year??. Price ????. ISBN 0 19511 873 1

Thomas Attig is an American applied philosopher with a special interest in bereavement. In the *Heart of Grief* he argues that the purpose of grief is to develop an enduring, loving relationship with the deceased. He believes that many people think that 'proper' grief requires a complete severing of their connections with the deceased. Attig includes many personal stories to illustrate how death does not erase the past and how people keep love alive while accepting the reality of loss. He gives examples of helpful rituals and ways of remembering and acknowledging the legacies of

LETTER TO THE EDITOR

Antidepressants for bereaved people?

Dear Editors

I have been a subscriber to Bereavement Care for more than 10 years and find it an invaluable resource in my work with bereaved people. I was particularly intrigued to read in Colin Murray Parkes' article 'After a terrorist attack' in the Winter 2001 issue (**20**(3): 35-36) that 'contrary to popular belief, [antidepressants] seldom interfere with grieving and may facilitate it'. I have certainly been operating under the popular belief syndrome, as all I seem to read comes out in favour of the placebos being as effective as the medication. I would therefore be most interested to read any research that supports the use of antidepressant medication with bereaved people.

I would have to say that in my own bereavement counselling practice, although 90% of clients are some time or another prescribed antidepressants by their GP, less than 1% find any beneficial effects from them, and indeed the side-effects seem to exacerbate the symptons of grief. However, over the last five or six years I have observed a dramatic increase in the prescribing of antidepressants to bereaved people. So I would be most interested to explore this subject in much greater detail and would be obliged if you could point me in the direction of any reading material.

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Dr Parkes replies

As far as I know nobody has yet proposed using or even testing antidepressants for helping people with uncomplicated grief, although that time may come. There are, however, a minority whose lives may be saved by the appropriate use of these drugs if, for instance, they are depressed people at risk of suicide.

The most recent review of the research evidence on the use of antidepressants in bereavement known to me is Raphael, Minkov and Dobson's chapter 26 on 'Psychotherapeutic and pharmacological intervention for bereaved persons' in *Handbook of Bereavement Research: Consequences, Coping and Care.* (Stroebe MS, Hansson OR, Stroebe W, Schut H [eds]. Washington, DC, USA: American Psychology Association, 2001). An earlier review which reached similar conclusions is by Jacobs in a chapter on 'Pharmacological treatment of the complications of bereavement' in his book *Pathologic Grief* (Washington DC, USA: American Psychiatric Press, 1993). At that time Jacobs expressed the opinion that more problems result from under-use of antidepressants than from their misuse. Both of these chapters conclude that there are many bereaved people who will benefit from the proper use of the right medication. Among the drugs available, antidepressants are the most likely to be of help.

Two of the problems with antidepressants are first that they take two to three weeks to work and, second, that they often give rise to side-effects (which vary from one drug to another and from one person to another but are seldom serious). These are at their worst during the first week or so of taking the medication. As a result many patients give up the drug before it has had a chance to succeed in relieving their symptoms. This accounts for some of the bad reports which one hears from patients. Because of the side-effects GPs are often reluctant to prescribe high enough doses for the drug to succeed and this too may lead to disillusionment when, a month after starting the medication, the patient feels no better. The sensible action would be to go back to the GP who may then increase the dose, but many people give up at this point.

Another problem lies in the very nature of depression. Bereaved people who are suffering major depression (a condition which itself needs proper medical diagnosis) are most in need of antidepressants. Yet one of the features of major depression is a deep feeling of despair and hopelessness. People in this state of mind cannot believe that anything could possibly help them so they are the least likely to persist with any treatment. Problems of this kind may well explain the poor results which you report from your counselling practice.

In prescribing any drug the doctor has to decide: What is the diagnosis for which the drug is being prescribed? Do the benefits expected from the drug outweigh the dangers and side-effects likely to occur? This is not always easy and requires fine judgement. But doctors are trained to take such decisions and remain the best judges of the need for medication. If a drug is needed, it is the the doctor's responsibility to explain to the patient why and to prepare them for any likely side-effects. Some doctors are not good at doing this and, to be fair, people vary so much in their response to medication that it is difficult to know exactly how they will react and hence what they should be prepared for.

Counsellors can help a great deal by encouraging patients to ask questions, to express to the doctor any doubts or fears which they may have and, most important, to take the medication as prescribed. If problems then arise, the patient should be encouraged to return to the doctor or, if they have lost faith, to seek a second opinion. If necessary the counsellor may offer to accompany the client on their next visit to the doctor in order to act as their advocate and make sure that both sides understand the problem. Much damage can be done by counsellors who pretend to expertise which they lack or who assume that a client is in the right without learning the doctor's point of view.

COLIN MURRAY PARKES

Responses from other readers on this important and controversial topic would be greatly welcomed. Eds.