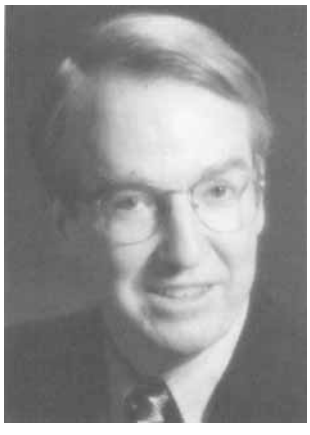
Current challenges for bereavement care



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Bereavement care is at a developmental crossroads. Grief has been the subject of countless publications and much research over the last decades, but how best to help people after a death must inevitably remain a complex issue. Many previously accepted theories and models of practice and training are now being challenged. Here some provocative questions are posed to initiate debate and help us look again at the assumptions behind our methods.

In the UK, Cruse Bereavement Care is over 40 years old; across the Atlantic in North America, ADEC (the Association for Death Education and Counseling) has just commemorated its 25th year. During the lifetimes of these two voluntary organisations much has been learned about bereavement, grief and mourning. Both organisations routinely monitor standards for the training and certification of those doing bereavement care, seeking to hold up best practice. Over the years, evidence-based studies, qualitative and narrative reports and commentary have enriched their work. Unlike in the 1960s, practitioners can now easily access information from the explosion of books and articles published in recent years or *via* the internet. The potential for continuing education expands with each new workshop or conference.

While volume and growth do not necessarily equate with maturity, these opportunities for conversations about bereavement have encouraged scholars and practitioners to consider bereavement care in fresh ways. One consequence of such conversations is that, increasingly, articles are appearing questioning our preconceptions, our theories and the role of counselling[1,2,3,4]. The more we learn, the more sophisticated our questions can be, but sophistication can sometimes cause people to overlook or dismiss simple, but profound, truths. Perhaps bereavement care is at a stage where a review of assumptions and practice motifs is to be expected.

The questions that follow are intended to be used for self-reflection and review of our practices, singly or in discussion groups. The more that people ask appropriate but tough questions about practice, the greater the potential for better practice. Clear, easy and ready responses should, I believe, be viewed with suspicion. Team support is vital to our work, but support together with accountability can be an even more powerful mix.

EDITOR'S NOTE

Although professionals trained in the care of bereaved people are still few and far between, those who do exist tend to view volunteers with suspicion and to attempt to limit their roles. Volunteer bereavement counsellors are put on the defensive and there has been a tendency, in recent years, for them to increase the length of their training at both basic and advanced levels.

***Bereavement Care*, never averse to controversy, here publishes a paper by Ted Bowman which challenges this trend. We hope that it will provoke a lively discussion of the important issues which he raises.**

Are volunteer counsellors 'para-professionals' or should they know their place? What are the limits to their roles? Should the training of volunteer counsellors be increased or decreased? Should they be called counsellors? If not, what should they be called? Are the professional counsellors currently available to bereaved people able to provide more expert help than the volunteers who attempt to fulfil these roles? Further contributions on these issues will be welcomed. *CMP*

SHOULD TECHNIQUE SUPERSEDE RELATIONSHIP?

Many years ago, colleagues at the University of Minnesota developed a research-based couples communication programme. With few modifications to the core principles or basic process, the programme continues in use throughout the world today. Early on, it was discovered that the separation and divorce rates for couples who completed the programme were higher than the norm for their peers. Pursuing causes for such a result, it was found that, among other factors, the couples were simply more skilled in their ways for telling their partners what they didn't like about the relationship. Communication tools and techniques alone, however skilfully used, did not necessarily enhance relationship[5].

Writing about bereavement care, psychiatrist Peter Lomas comments:

> The limitation of technique is at no time more apparent than when the therapist [or bereavement worker] is faced with naked grief, when someone is crying helplessly in the grip of an experience that is too painful for words, when the therapist can say nothing that would not seem presumptuous or trivial. Perhaps he might put an arm round the person; even that may seem not much of a thing to do. It could, however, be of some use if the despairing person feels to be in the presence of someone to whom, at that moment, any idea of a technical response would seem utterly foreign to the occasion[6].

Lomas went on to suggest that the importance of technique can be reinforced in supervision:

> Even more formidable is the dread of appearing to be sententious, sentimental, or pretentious if we try to describe our experience in terms other than that of technique[7].

Reinforcing Lomas' argument, bereft father Nicholas Wolterstorff observed that even what could be construed as inept words were acceptable when the heart conveyed compassion and care. 'Some blurted out strange, inept things. That's OK too. Your words don't have to be wise. The heart that speaks is heard more than the words spoken[4].'

This is not a diatribe against technique. Strange, inept words are not always seen as harmless and the training of volunteers must always include some attention to technical skills. However, anecdotal accounts abound of the importance of relationship in grief and bereavement care. Ethicist Daniel Callihan contends that caring should never be put in a

secondary position[8]. Robert Veninga's research[9] indicates that those who survive a tragedy will be able to point to at least one person who stood by them, supported them, and gave them a sense of hope.

Look over a training curriculum. How much time is dedicated to caring and relationship building? How much time is allotted to technical skills, information about complicated bereavement, referral, and the like? What is the message to volunteers when much of the time in training is given to practice of skills? To be sure, these emphases can be inextricably tied to relationship and caring, but how much time is given to the importance of presence with the bereaved as the foundation of bereavement care? To paraphrase educator Parker Palmer, good caring cannot be reduced to technique; it comes from the identity and integrity of the bereavement worker. Palmer also suggested that technique is what is used until the real carer arrives[10]. How can we monitor the use of techniques and processes so that we do not, unintentionally, allow them to get in the way of connection with the griever?

ARE WE OVER-TRAINING VOLUNTEERS?

Orientation and training of volunteers is essential. Whatever the service – one-to-one support, leading bereavement groups, telephone assistance and information, or written materials – volunteers deserve adequate preparation, support and recognition. Caring relationships can be very complex.

According to Catherine McCann, caring requires a combined use of the head and heart[11] – in other words, the whole person. Dale Larson's research showed that high empathy and caregiver stress usually go together. Empathy, he suggests, is a double-edged sword, simultaneously a great asset and a point of real vulnerability. Carers who become very involved in their clients' grief need to have access to information, critical feedback, and support in order for the power of their empathy to be useful over time[12]. Even two major proponents of self-help groups acknowledged that it was important for group facilitators to acquire a basic understanding of self-help group dynamics, to access various group models, and engage in routine review and evaluation of the groups[13].

These and other aspects of caring and the training of volunteers could be developed more fully. However, at a minimum, training for bereavement volunteers and professionals should include core information about grief and bereavement, perspectives on interacting with the bereaved, knowledge of community resources, and the importance of building a relationship. Furthermore, all training should clarify how on-going support and supervision of carers and trainers will be done.

Screening of volunteers is also essential[4]. Even the best of training and support needs to be matched with carers who have the potential to perform their tasks. In particular, it is crucial that volunteers can distinguish between their own grief and that of those for whom they are providing care. Sympathy is a genuine response to someone else's pain; empathy, on the other hand, can mean that someone else's pain becomes your own. Carers who have difficulties with their sympathy/empathy boundary, as described by Larson above, or people too close to their own grief, may need to be screened out or reserved for the future.

What is of more concern than possible under-training is the potential consequence of over-training volunteers. Two overlapping problems that can result are looked at here.

Bereavement care in a social context

Since death and bereavement are normal life events, we must be very careful that the help we give reflects this. Many voluntary organisations are moving away from a local neighbourhood and self-help emphasis to increasing specialisation and professionalisation, separating those in need from their community. In the provision of bereavement care there is, increasingly, one class of people – the bereaved – and another class – the helpers. While we are responsibly preparing the helpers for their work, we need to be careful not to foster a situation where it becomes commonplace for bereaved people to think and act as if their grief requires a trained volunteer or professional(Bowman T. Training for bereavement work. Unpublished paper).

Cruse Bereavement Care, for example, requires 40 hours of basic (and more for specialised) training of volunteers, who are currently termed counsellors, a label many would be reluctant to give up. It can be argued that when a volunteer programme requires more than 20 hours of training the volunteer, intentionally or not, is transformed into a para-professional, regardless of title. Add a status label like 'counsellor' and a normal response to a kindly acquaintance can be compromised. It is not, 'Oh, here comes my neighbour' but, rather too often, 'Here comes the bereavement worker'. People may travel away from where they live to attend a bereavement group in another district. Such actions can unintentionally undermine the fabric of community support. Death can become 'difficult to talk about', 'not normal', no longer something integrated into the fabric of community support. Training local volunteers can lead, it appears, to an increasing separation of death from normal neighbourhood life.

Specialised services

Australian grief educator Judith Murray advocates that the full range of counsellors, professional and volunteer, should be prepared to address loss issues because loss, as she put it, is a universal concept. 'Enhancing the shared knowledge of loss within the general population may aid the improvement of social support offered within the social networks of those confronted with adverse life events[14].'

However, as with the separation between bereaved people and their communities, divisions between bereavement workers themselves are increasingly being fostered by focussed services such as the Compassionate Friends, Victim Support, Widow and Widower Groups and the many organisations dedicated to supporting children after a death. While acknowledging the deep yearning of bereaved people to find others who can relate to their loss and offer shared support, bereavement care programmes must address the consequences of such divisions. Care providers should guard against keeping themselves apart from one other by speciality, or from bereaved people by being a specialist. Since specialisation and training can separate bereavement workers even further from those who are grieving, what safeguards should be put in place to avoid setting the bereavement workers apart from those they serve? Are there potential dangers in specialised groupings of bereavement? How can the informal resources of kith and kin be integrated into programmes that use volunteer or professional carers?

DO WE PATHOLOLGISE NORMAL GRIEF?

Therese Rando's perspectives on complicated mourning are harshly criticised by Catherine Foote and Arthur Frank.

> *Normal* is defined in terms of *progress*, and abnormal is its opposite, the failure to 'accommodate' to the loss. Thus abnormal is described variously as absent grief, delayed grief, inhibited grief, distorted or exaggerated grief, conflicted grief, unanticipated grief, chronic or prolonged grief, and abbreviated grief. In sum, complicated mourning either lasts too long (prolonged or chronic) or not long enough (abbreviated). It is either expressed too demonstrably (exaggerated,

distorted, conflicted) or not demonstrably enough (absent, inhibited, delayed). What is left over – as normal or 'uncomplicated' mourning – becomes difficult to imagine.

As a strategy of power, the normalisation of grieving works in two stages. First, the abnormal is defined in contrast to a supposed category of the normal. Second, the clinical criteria for candidacy in the abnormal are expanded until the normal is defined out of existence or at least relegated to the margins[15].

Whether you agree with these writers or not, their critique is provocative! Is it possible, as research and knowledge about bereavement grow and the levels of sophisticated information increase, for practitioners to avoid what Frank and Foote have described? If wisdom and knowledge are indeed different, how do bereavement carers become wiser about their use of knowledge?

After his wife's suicide, Edward Rynearson wrote: 'Don't let anyone persuade you that avoidance is unhealthy. Resilience first allowed me a temporary avoidance from the chaos of Julie's dying...Avoidance was my only option[16].' In his recent book, *Retelling Violent Death*, he advocates a combination of personal support and clinical structure. Still, his approach can be summarised by this sentence: 'Without a caring connection, a violent death is an item for the news instead of a story that we need to restore ourselves around[16].'

The challenge for bereavement care workers is careful use of information about all the nuances of bereavement, without allowing that same information to become a barrier to personal connection and support. Diagnostic categories can become self-fulfilling prophecies, thereby robbing the grieving person of dignity and support for their unique efforts to deal with death. Provocative statements like these from Foote, Frank, and Rynearson will not stop me from buying the next book about grief and bereavement. But such perspectives have caused me to wonder about the tendency to see problems and dangers more clearly than resources, resilience and normality.

Some lines from a poem by Mary Sheepshanks, a widow, serve to remind me of what is important to us as bereavement workers.

> ...all we can do
> is share your north-face
> route with you.
> No one can take
> your pain away
> or cut bereavement's
> journey short.
> ...But let us share
> that cold road too
> – to walk a little
> way with you[17]

SUMMARY

It is important to emphasise that this article has been written with keen appreciation of bereavement support. This is a lover's quarrel. At this crossroads for bereavement care, challenging questions are being raised from outside the field, especially since public tragedies like 11 September. It is crucial that those within it also address issues that may undermine the potential of quality care. Use this article to continue that discussion. BC

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*Available from Cruse Bereavement Care, 126 Sheen Road, Richmond TW9 1UK, UK.

BOOK REVIEW

NOBODY'S CHILD

Diane Sher Lutovich

Amityville, New York: Baywood Publishing Company, 2002, 148pp. $28.95 pb. 0 895 032533 8



Nobody's Child offers us a new perspective on older women confused by their feelings after the death of their mother. Diana Sher Lutovich explores what she views as a fairly recent change in the role and relationship daughters have with their mothers, caused by longevity. Mature women, she suggests, are now forging closer links with their mothers and this is giving rise to new patterns of grieving.

Whilst the book includes Lutovich's personal experiences, she has also collected and analysed a range of effects and feelings from other grieving daughters and collated them under headings exploring the new relationships. She found that women had difficulty in dealing with the loss of the new closeness and the feelings of guilt or relief that followed having given support in the latter stages of life.

Lutovich looks at how bereaved daughters can break free from the past and move into a new phase of their own life. In her summary, she analyses the range of responses, the gamut of feelings expressed by the women interviewed, pulling together what she has understood of the new relationship between mothers and their daughters during this special time and how that has affected the bereavement.

Lutovich writes of North American women, but I have noticed similar bereavement difficulties here in the UK resulting from a 're-bonding' between daughters and ageing mothers. *Nobody's Child* is a reference tool, detached and analytical in style and not easy to read straight through. Nonetheless, it is a useful aid with an important message for those of us involved in helping women in this situation understand what has happened and gain from their feelings and experiences. BC

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