These kind of thoughts will often be expressed by the newly bereaved in sentences which begin: 'If only . . .'. 'If only I had called the doctor earlier . . . made him give up smoking . . . been with her when she died . . .' and so on.

Guilt about the manner and occasion of the death make up the first group of guilt feelings, which may lead back to guilt about the past relationship. Many people are faced with all kinds of recriminations about the past, arguments unresolved, disloyalties never shared, failures and shortcomings. Initially, it will be the client's task to share these and the counsellor's to listen. The healing process will begin in the voicing of such thoughts.

Then, the counsellor will need to help the client see that all human relationships are limited in their quality by virtue of the fact that they are subject to human weakness. To be spared all conflict and all negative feelings, one would have to withdraw from life altogether or else live with an unreal and dishonest partnership. When two adults live closely, if they are to be equal partners rather than acting out a parent-child role, conflicts will arise. It is a prime task for the counsellor to enable the client to remember her lost one, warts and all, to accept his (and her) shortcomings with love and honesty. If she is able to do this, she will be able to come to terms with any last angry exchanges or unfinished business. This can be especially important after a sudden death where there has been no time to prepare.

More serious problems occur when the feelings of guilt are not recognised and the bereft widow, for example, tries to submerge them by making obvious compensatory gestures—having an expensive funeral or lavish meal, or by constantly trying to convince herself of her husband's exaggerated talents and virtues. Alternatively, grief may become prolonged and painful as though, by making herself suffer, she might make reparation for the things she feels she has done in the past.

There is also another mode called 'survivor guilt' when death occurs out of its natural sequence or when there is a disaster which seems to strike some down at random leaving others alive and well. Piper Alpha, Zeebrugge and the German Air Show inferno will all have left this guilt in their wakes. Some may be full of guilt because they have survived, and others because they are so happy and pleased to be alive.

For counsellors, one important fact is not to be shocked by any emotion the client expresses, however strange or negative it may be or however unlike the counsellor's own feelings it seems to be. There is really nothing new under the sun, and to talk about difficult feelings will facilitate rehabilitation.

Thus we have three main but overlapping categories—guilt about the manner of death, guilt about the past, and survivor guilt*. Some people, naturally, will escape any guilty feelings whatsoever, or will deal with them quite successfully themselves. The acknowledgement of them is the first step but for those with religious beliefs, the act of confession can be helpful and may help with feeling forgiven for crimes, real or imaginary. For example the widowed client needs to feel that her husband can forgive her and that she can forgive herself. The problem will be aggravated where the relationship was known to have been unhappy, with little exchange of love. If it has been a stable marriage, then she will begin to realise that he would, given the chance, forgive her and that in a normal partnership there will be misunderstandings and things regretted.

Some bereaved people have found it helpful to keep a diary or write down their progress along the grief track. Provided that this is not just a way of avoiding the reality of the death it may be a legitimate thing to do. Care will need to be taken that the client does not get stuck in a denial phase or refuse to move forward, but it may be that this writing down, this time for 'getting it off one's chest' will facilitate recovery. Gradually, perhaps the widow in my example will be able to forgive herself her shortcomings. Although in some cases this takes time, failure to forgive oneself can become a kind of negative self-indulgence. As her self-confidence increases this will become easier and unless there is real cause for guilt—perhaps she *did* neglect him—will be a normal phase of grief. Abnormal or prolonged obsession with guilt will demand more than the average counsellor can cope with and further help should be sought. In most cases, though, the fetters of past mistakes and hypothetical situations will not hold the normal bereaved person captive and new life will begin to be experienced in due course.

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Footnote

* For a discussion of survivor guilt, see for example Lifton RJ, Responses of survivors to man-made catastrophes, *Bereavement Care* 1983; 2, No. 3. Available in 'Best of Bereavement Care No. 3: Bereavement Through Violence, Suicide or Disaster', £3.70 plus 80p p&p from Cruse, 126 Sheen Road, Richmond, Surrey TW9 1UR, England; overseas orders please send double postage and pay by Sterling Draft payable in London.

REVIEW

BEREAVEMENT AND COUNSELLING: A HANDBOOK FOR TRAINEES

Lyn Franchino. Counselling Services, 19a Weybridge Park Road, Weybridge, Surrey. 1989. £9.95 inc. p&p.

This is a handbook that has been prepared to accompany bereavement courses. The first half is about dying and bereavement and includes bereaved children, bereaved families, suicide and unresolved grief. The second half is on basic counselling skills. The emphasis in this handbook is on the practical skills which a counsellor needs in order to work with a bereaved adult. Each section is clear, coherent and is replete with exercises which help to illuminate and expand the text. It is designed for trainee counsellors, and needs to be used in conjunction with Lyn Franchino's manual on basic counselling skills for trainers of bereavement counsellors, published by Cruse 1986[1]. On the whole, I found it a very helpful adition to the literature and would commend it for use on basic courses on bereavement counselling.

Although some information about bereaved children and families is included, it is not made clear that counselling children, and family counselling, require a different and somewhat complementary set of skills from those skills outlined in the second part of this handbook. Although it is implicit throughout that the author is talking about the individual counselling of adults, by including in the first part of the book information on bereaved children, there is an implicit suggestion that her techniques will be useful also for children. This needs to be corrected in future editions. Specific references to counselling children and families would be helpful. Some of the author's statements about the development of the child's concept of death are inaccurate. Recent research has shown that children develop a quite sophisticated understanding of death at a much younger age than has hitherto been believed.

The chapters on suicide risk and unresolved grief do not, in my opinion, state clearly enough how a counsellor should evaluate or when she should seek professional help for the client, or how she should go about it, and these sections need revision in future editions.

With these reservations, I am delighted to recommend an extremely useful handbook.

Dr. Dora Black
Consultant Child Psychiatrist and formerly Chairman of Training Committee, Cruse.

FORTHCOMING COURSES

Bereavement Counselling Skills for those working with the bereaved. London W9. Friday mornings starting 28 September, 1990. Westminster Bereavement Service. Enquiries: Jill Dunbar, 31 Llanvanor Road, London NW2 2AR (Tel. 081-455 9612).

Bereavement — Implications for People with Learning Difficulties. 2 October, 1990, repeated 22 March, 1991. One-day programme open to all. £39. Details: Castle Priory College, Wallingford, Oxon OX10 0HE (Tel. 0491 37551/26350).

Cruse—Bereavement Counselling Courses. For details of Cruse courses in the U.K. in Autumn 1990 and Spring 1991, contact Cruse, 126 Sheen Road, Richmond, Surrey TW9 1UR (Tel. 081-940 4818).

4. How do we know that these experiences have been useful? (evaluation)

Number 4 is, of course, the crunch question. Is this kind of learning measurable? We cannot objectively measure it but I suggest that by developing intuition—which is, after all, knowledge borne of experience—the helpers may be able to evaluate the process that went on between them and the bereaved person. What may, or may not, have been prevented in terms of morbidity or mortality, let alone straightforward human unhappiness, is inevitably hard to quantify.

In all this it can be seen that the teacher's role is as group leader, manager and facilitator, rather than as a purveyor of knowledge who may appear to be remote from the individual's own experience.

During this brief look at what the field of education may have to offer helpers involved in bereavement support, I am not suggesting that it can equip them to meet every need, to relieve every situation. On the contrary, one of the myths that has to be dispelled early on is that the helper can actually help everyone. Common sense about human nature and humility about ourselves are needed

Neither is bereavement support all sweetness and light. Relatives may hate the person who died (and feel very guilty about this). There may be complex family problems. Worse still, the bereaved person may not always appear grateful for the time and effort given by the helper; they may even, occasionally, hate the helper too!

We are all, of course, both teachers and learners. Much of our learning, for good and for ill, is 'caught' as we go through life. I suggest that what we are 'taught' is of equal value when attempting to support bereaved people. Bereavement is about death and, therefore, also about life, and many helpers are drawn to this work because they are sorting out their own personal philosophy. This is not new. Plato wrote: 'What matters most is not the knowledge imparted to a man but what the man himself becomes in the course of acquiring that knowledge.'[10] I suspect that this is what education for bereavemnet support is really about.

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Jenny Penson was formerly a Macmillan Home Care Sister.

REVIEW

MATTERS OF LIFE AND DEATH: A STUDY OF BEREAVEMENT SUPPORT IN NHS HOSPITALS IN ENGLAND. A KING'S FUND PROJECT PAPER

A. Wright, J. Cousins, J. Upward. London: King's Fund. 1988. £2.75.

The starting point of this project was an unhappy personal experience; one of the authors (Wright) was distressed by the poor quality of care and communication in hospital following the death of his son.

The need of relatives to 'talk through' the death of their loved ones with the doctors and nurses involved in their care was not recognised, nor was there any follow-up at a later date, despite the fact that the doctors and nurses were involved in care over an extensive period. As a consequence the author felt 'abandoned, isolated and dissatisfied'. The question raised by this was: is this experience merely a reflection of the service in that particular hospital, or does it reflect a more pervasive problem, characterising the handling of bereaved relatives in general hospitals across the country?

In seeking to answer this question the authors referred to a variety of sources, including relevant published literature: a survey of District Health Authorities (DHAs) in England requesting information on their provision of services for dying patients and their relatives; and finally, and perhaps most significantly, the views of a sample of bereaved relatives. The information taken from these sources provided a surprising degree of congruence and, considered together, indicated that Wright's experiences were by no mean exceptional. Particularly worrying was the grim picture portrayed by most of the bereaved relatives who contacted the project by letter or telephone, following a request in newspapers and on the radio for their views.

There are, of course, problems with this approach to research; for example, one cannot assume that those who chose to write or telephone were representative. There are all sort of reasons why those who wish to complain might be more compelled to write or telephone than those who were happy with the service they received. However, the fact that so many people appeared distressed by the quality of care they received, producing a catalogue of distressing episodes, is in itself worrying. In addition, different approaches to obtaining a sample of bereaved relatives have produced remarkably similar findings (e.g. Silvey 1988[1]).

The literature review and survey of District Health Authorities produced not only evidence of poor practice but an increasing realisation of the extent of the problem and, in response to this, the development of a range of approaches to ameliorate the situation. These efforts are directed at all levels within hospitals, including the provision of guidelines for good practice for staff, information leaflets for bereaved relatives, the appointment of Bereavement Officers, increased attention to the educational and training needs of hospital personnel, and support for staff in recognition of the stressful nature of this aspect of their work.

As someone involved in the education of nurses I found this paper immensely helpful, and I have no doubt that it should be read by all those involved in planning resources and providing care for the dying and their families. In addition to the research findings it provided useful information on relevant books, helpful addresses, two hospital Working Party Reports on Care of the Dying in Hospitals, advice on following up vulnerable relatives, and a really helpful checkist of actions to guide doctors and nurses caring for the dying and bereaved.

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