Teaching Bereavement Care

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Few of those who teach bereavement care have been taught how to teach. In this paper Jenny Penson, who is a Senior Lecturer in Higher Education and also a nurse, offers some guidelines on the teaching of counselling to the bereaved.

Editor

The experience of being bereaved is as old as life—and death—itself. Whether it is discussed in terms of attachment and separation (Bowlby[1]), a process (Parkes[2]) or as a series of tasks (Worden[3]) or as a life transition (Hopson and Scally[4]), it is a natural phenomenon. Therefore the first question to be asked is: how much education, if any, is needed?

It was the philosopher Illich who first alerted us to the possible dangers of what he called the medicalisation of life events[5]. By this he meant that events such as birth and death are often taken over by the medical and health care professions, with power and control being taken away from the individual. Is there a danger that we may over-stress the significance of bereavement in terms of mortality and morbidity and, by providing various kinds of bereavement support services, begin to treat it as an illness?

It is surely part of the philosophy of our times that our health and well-being are our own responsibility. If we are bereaved then shouldn't we be able to deal effectively with our predicament, drawing on coping skills we have used in the past? Should there be any need for outside interventions of any kind?

If there is, then is not bereavement support simply commonsense? Does it require only a 'tender loving care' approach? If helpers have themselves been bereaved, does this constitute sufficient preparation for helping others? If the helper means well will all be well?

Not necessarily, I suggest. A lack of knowledge and skills can make the helpers feel inadequate and helpless. A lack of self-awareness may cause them to be overprotective or oversentimental in their approach. It is unlikely that someone can be taught to care, but it is possible to teach them to be more effective in that caring.

So what is there to teach? The answer to this question must be based on the objectives which have been agreed for the particular bereavement support service. Although there are likely to be some variations, it would appear that the helper has two main functions, those of assessment and of counselling. Both of these require appropriate knowledge, attitudes and skills.

What knowledge is needed by someone who has already experienced bereavement? What level of information might be necessary for someone who has not done so?

All of us have experienced some kind of loss in our lives. An obvious starting point is therefore to assess the existing knowledge of loss and bereavement present in any group and to begin by building on that. In this way, the acquisition of knowledge proceeds from the known to the unknown. Most people, in my experience, know more than they think they do! It is also valuable to adopt this approach in order to build confidence. The knowledge gained should not be prescriptive but enhance the helper's assessment of those potentially at risk of complications during mourning.

When planning such teaching I find it useful to consider the intended results in terms of the first three of Bloom's categories of the cognitive domain[6]. This is the area of learning concerned with intellectual outcomes.

1. *Knowledge:* simple knowledge of facts, of terms and of theories. This would be likely to include different perspectives on loss and bereavement, a consideration of 'At Risk' groups, and current research.
2. *Comprehension:* an understanding of the meaning of this knowledge. This can be tested out by questioning and discussion.
3. *Application:* the ability to apply this knowledge and comprehension in new and concrete situations. Information can be illustrated with examples from practice and the helpers asked to make links with their own experience.

Attitudes

Attitudes are the next component for consideration. They are not, of course, totally separate from knowledge, and indeed the values and expectations that the individuals hold will colour that knowledge and may affect what they choose to remember. Kalish suggests that the behaviours which surround death and bereavement are among the cultural features which are the 'most conservative and most resistant to change'[7].

Ideas of what is usual or unusual behaviour before, at the time of, or after a death, and how this is interpreted, is knowledge involving beliefs. These ideas are derived from the earliest socialisation and are reinforced or altered by the social group in which the individual now belongs. They are both description and explanation.

Therefore the attitudes of the helpers also need to be explored early on. Here my planning would take account of the affective domain (of Krathwohl *et al*[8]).

1. *Receiving.* This refers to the willingness to attend or listen; the motivation of the individual is also involved. However, the helpers may be motivated to help but may not think they have anything to learn.
2. *Responding.* This is the willingness to participate. It is not only about active involvement but includes the quiet, thoughtful helper who is involved in what is going on but lacks the confidence to participate directly.
3. *Valuing.* This involves the exploration of individuals' personal belief system on which their decisions may be based.
4. *Organising.* This level may also be applicable where the helpers,

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through increased self-knowledge and openness to different ideas and viewpoints, may actually modify some of the attitudes and opinions with which they started out.

The acquisition of skills comes from relating knowledge to practice and by learning and using a wide range of interpersonal skills. This is in preparation for the role of counsellor, a very over-worked word which is often used loosely. I sometimes feel it is impossible to have any communication on a one-to-one basis without labelling it as 'counselling'! However, its main features are that any interaction is always a two-way process, its approach is non-judgemental and its focus is on client-centred problems. This last point is particularly important. It means practice in putting one's own perceptions on one side and to be actively involved with the bereaved person's concerns, which may well be different from the helper's expectations. A starting point here is the widening of personal experience through increased self-awareness and self-knowledge.

The word 'education' is derived from the Latin *educare:* to bring out that which is already there. It is therefore important to recognise that individuals bring to the role of helper everything that they are. Many will be volunteers and their contribution in terms of maturity and life experience must never be underestimated.

How we teach is intimately linked with how we learn. Research supports the view that most learning takes place by active participation, that is by exploring, imitating and doing. One of the most effective methods, widely recognised in specialist medical education, is to work with an experienced person. After all, teaching is not confined to professional teachers and learners; wherever the inexperienced and those with expertise are together, some kind of learning is going on.

However, the needs of the learner have to be balanced against the needs of the bereaved person. Having an extra person present, no matter how discreet, inevitably alters the interaction between the helper and the bereaved person, whether it is in a negative or even a positive way. My own experience of taking learners with me on visits to bereaved people rarely caused problems, leading me to question my initial reservations. Were they perhaps based on my own insecurities rather than on evidence of interference with what I was hoping to do?

However, even when it is possible to provide experience 'on the job' it is still necessary, I suggest, to make provision for some learning to take place outside bereavement visits or groups.

Bearing in mind Tyler's guiding principle that no single learning experience has a very profound influence upon the learner[9], a variety of methods can and should be used. These are intended to provide opportunities for individuals to explore their experiences and feelings. Bruner alerts us to the potential problem inherent in these kind of approaches; that their adoption can become 'an excuse for vague and haphazard goings on'[10]. It is therefore important that sessions are planned beforehand and are structured.

Attention to the available environment is an important initial consideration. We all have ideas of what would constitute ideal surroundings, construction and size of the group, but reality may dictate something quite different! I have run various workshops for professional and volunteer helpers in such diverse situations as the local library, church and village halls, a hotel conference room, a hotel ballroom, classrooms in colleges and schools of nursing, in an individual's own home and in a church! The size of groups has ranged from 12 to more than 50. Flexibility is obviously essential, and making the best of what you have means creating as relaxed and informal an atmosphere as you can.

Formal lectures are rarely appropriate. I find that short talks to provide information, followed by questions and discussion, are useful ways of beginning to work, and encourage participation in a non-threatening way. It is important to value each contribution but, at the same time, to guide the group so that the main objectives of the session can be achieved.

Case studies, starting with straightforward situations and progressing to ones which illustrate typical problems, are invaluable ways of relating knowledge gained to what is likely to be encountered by the new helper. Working in pairs and/or small groups and then feeding back ideas to the main group invariably produces lively exchanges which need to be tactfully and unobtrusively managed.

Workshops are an effective way of practising skills. There needs to be plenty of time to build confidence and group cohesion, and one must allow for self-consciousness at the beginning. I find it helpful to ask the group, at the start, for their ideas of what is going to happen so that their expectations and anxieties can be expressed and shared. Burnard, describing a workshop exploring methods of coping with emotional release (obviously an essential topic area for those involved in bereavement work), points out that when other people become emotionally upset we often become distressed ourselves[11]. If even one participant appears to be in difficulty, embarrassment and confusion can quickly run through the others. Once again, careful and sensitive management is essential.

Role play

Role-play is a high-profile method for all kinds of work in the interpersonal skills area. However, I approach it with great caution. I would never use it where I did not know the group over a period of time or where the group members did not know each other well and were not very cohesive. In any group there may be members who have recently been bereaved or have 'hidden' bereavements (abortion or miscarriage for example, or simply a loss they have not acknowledged to the group). There may be unresolved losses in their past, such as loss through an earlier divorce, or a childhood bereavement which has never been worked through. In other words, role-play can be a minefield. However, when it is possible to use it appropriately with supportive small groups, it is a very effective way of exploring feelings and practising skills. Role-reversal can be particularly useful in providing insights into the experiences and perceptions of others. It is very important that adequate time is left at the end of such sessions for a full 'processing' of the experience.

Reinforcement is an important learning principle. It can be useful and illuminating to bring a group of helpers back together again after a period of providing bereavement support. This serves both as refreshment for them, being a chance to review past and present learning and to share new ideas, and as reinforcement of the knowledge and attitudes originally taught. It is also a way for them to support each other. It can be helpful to the teacher as it offers an opportunity to evaluate teaching in terms of both process and product.

Tyler's model of teaching and learning provides a summary of these points[9]. The four questions he asks are:

1. What is the purpose of the teaching situation? (aims)
2. What experiences can we provide? (content)
3. How can these be organised? (method and organisation)

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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