best be treated. The official emphasis on the deceased's brave sacrifice may provide some useful short-term consolation for the bereaved, but it appears that a more beneficial long-term approach should seek to facilitate mourning rather than divert or postpone it. If bodies cannot be brought home for funeral ceremonies at which families participate, then it would help if photographs of the corpse could be made available. As Cathcart has emphasised, it is better to see a loved one's wounds than to spend the rest of one's life with fantasies, which are likely to be worse than the reality.

There are encouraging signs from the news bulletins: stories of counselling for servicemen, the release of filmed interviews with airmen talking of their feelings, including the tears they shed. We may seem to lack progress on preventing war but perhaps, if the notion is not too paradoxical, we may be becoming a little more humane in how we look after the participants.

References

1. Scowen P. Viewing the body after death. *Bereavement Care* 1990; **9**: 3.
2. Cathcart F. Seeing the body after death. *British Medical Journal* 1988; **1**: 297.

CONFERENCE REPORT

Third International Conference on Grief and Bereavement in Contemporary Society

This was held at the University of Sydney, New South Wales, from 30 June to 4 July 1991, under the auspices of the Australian National Association for Loss and Grief (NALAG).

It was attended by over 500 delegates from many different countries and fully lived up to the expectations engendered by previous conferences.

In addition to keynote addresses by Professor Robert Pynoos, Dr William Worden, Professor Selby Jacobs, Mrs Pat Sutton and the Hon Justice M D Kirley, 116 papers and workshops were presented. The Shamai Davidson Lecture was given by Professor Beverley Raphael.

It is impossible to give a comprehensive report since no one delegate could attend all papers. Highlights for me include:

Efficacy of counselling

Probably the most important contribution to our knowledge was made by a team from the University of Utrecht, Netherlands (reported by HAW Schut) on the efficacy of short-term counselling for widows. One hundred and thirty-two widows and widowers were studied and half (66) were assigned to either client-centred counselling (33) or behaviour therapy (33) (which involved structured and focused attempts at 'tackling behaviour or cognition that complicated the grieving process'). The General Health Questionnaire (GHQ), which measures psychosocial adjustment, was administered before therapy, at the end of therapy, and at follow-up 25 months after bereavement. As expected, there was a decline in GHQ scores in all three groups. The two treated groups improved more than the control (untreated) group. Of the two methods of treatment, those assigned to behaviour therapy had declined slightly more than those who received client-centred counselling.

When the sexes were examined separately it transpired that client-centred therapy was more efficacious for men (widowers), whereas behaviour therapy was more successful for women (widows). Those who were most 'emotional', depressed or lacking in self-esteem were said to have benefited more from behaviour therapy; on the other hand, people who felt 'very wronged' were said to have benefited more from client-centred therapy.

The author concluded that men cope less well with emotional issues and 'are inclined to follow a problem-focused trail of solution-seeking and apparently not being able to cope with the problems that can best be changed by emotion-focused intervention. Women, who are more inclined to make use of emotion-focused strategies, may be best helped by interventions not primarily aimed at the emotional impact of the event'.

Effects of bereavement on health

The incidence of symptoms of post-traumatic stress disorder (PTSD) following bereavement has also been studied by the Utrecht team. In another important study, Schut looked for the three criteria for PTSD as defined in the influential Diagnostic Statistical Manual (DSM III-R). In a self-selected group of 105 widows and 23 widowers a questionnaire was used to assess the prevalence of 'intrusive thoughts', 'avoidance' and 'arousal' (reflected in anger, panic, difficulty in concentration and insomnia) at four, 11, 18 and 25 months after bereavement. Of the sample, 20-31% met all three of these criteria on at least one of these occasions, with nine per cent reporting them at all four.

Although PTSD symptoms occurred with equal frequency following both anticipated and unanticipated deaths, they were more likely to persist for 25 months if the death had not been anticipated and those people who reported having said 'goodbye' to the deceased before death were less likely to complain of 'intrusive thoughts' thereafter.

This study suggests that it is not the duration of terminal illness *per se* that predisposes to lasting PTSD after bereavement. Rather it is the lack of opportunities to anticipate the loss. and the opportunities which anticipation brings of allowing leave-taking and the restructuring of assumptions about the world.

Bartrop's Australian research group have demonstrated an increased risk of cardiovascular, respiratory, musculo-skeletal and psychiatric illness in bereaved people followed up after an 11-year period.

Byrne and Raphael have dispelled the myth that bereaved elderly people are unlikely to develop psychiatric illness. In their sample of 57 bereaved and 57 non-bereaved Australian men, the bereaved were more likely to reach 'psychiatric' levels of emotional disturbance six weeks after bereavement, with 19 per cent satisfying DSM III-R criteria for a current Axis I psychiatric disorder, two-thirds of these being a 'Major Depressive Disorder'.

Types of bereavement

A study by Professor E Keijser examined the circumstances attending the deaths of 1,635 patients in the University Hospitals of Louvain (Belgium). This showed that relatives were only present at the time of deaths in 35 per cent of cases when the death was expected, and this proportion fell to 16 per cent when the death was unexpected. Only five per cent of babies died in the presence of a relative, although physicians and nurses were present at 90 per cent of these deaths and most parents subsequently received counselling from a social worker. Following other types of unexpected death, social workers and clergy were less likely to be involved than they were after more expected deaths! Fifteen per cent of hospital patients were on their own at the moment of death, but this proportion rose to 31 per cent of the deaths of patients of 80+ years.

In a comparative study of 173 widows and 156 divorcees in Cleveland, Ohio, Kitson showed higher initial levels of both pining and anger among widows three months after bereavement than among divorcees three months after divorce, but little difference between the groups at 13 months.

The bereaved child

Professor Pynoos had made a clear analysis of ways in which disasters affect children:

- Life threat and/or injury leading to post-traumatic stress disorder
- Loss leading to grief
- Worry about significant others leading to separation anxiety
- Stressful previous life experiences leading to renewal or exacerbation of previous symptoms.

He reported high rates of suicidal thinking, dysphoric and depressive reactions in children exposed to sniper attack in a school. Studies of children whose parents had died by violence were said to have felt reassured by seeing the body after it had been made presentable.

Contrary to popular belief, children over the age of six were found to cope remarkably well with the death of a parent, particularly if that parent was of the same sex as they were. Worden and Silverman's controlled study found no significant differences between bereaved and non-bereaved children on measures of anxiety, withdrawal or dependency. Overall, bereaved children were rather more angry and had more somatic symptoms than non-bereaved, but non-bereaved showed more attention-seeking behaviour.

The bereaved parent

Vance reported a prospective study by a team from South Brisbane (Queensland), who compared the responses of parents to stillbirths, neonatal, other sudden infant deaths and normal births. All bereaved groups showed significantly more symptoms than controls throughout the two-year period of the study, although there was some improvement in the bereaved. Parents losing a child by sudden infant death had more symptoms than those who lost a child by other neonatal death or by stillbirth. As might be expected, mothers had more symptoms than fathers.

Cultural influences

Cultures can be studied by comparing one with another, or in historical context, i.e. by comparing the situation now with that in the past. Systematic cross-cultural comparisons are rare (and none was reported at this conference), but at any international conference opportunities exist for informal discussion of cultural differences and these occupy a significant part of the interactions outside the programme. Australia proved a good place to meet Australians (both white and aboriginal), Polynesian, Chinese, Malaysian and other races who seldom reach the conferences of Western Europe and America. Their accounts of funeral and mourning customs in their native lands, and of the special problems and losses to which many of them are subjected, helped to broaden our understanding of the psychological and social aspects of bereavement.

A perceptive and convincing paper by Sforcina explained how contemporary attitudes to grief and mourning have developed in Australia. The privation of convicts and other early settlers gave rise to anti-authoritarian attitudes, gallows humour and disdain. Successive waves of immigrants found themselves at odds with the aboriginal inhabitants and with each other. Two thousand Europeans and 20,000 aborigines are estimated to have died in these conflicts. In a society in which there were six men to every woman convict, women became tough, harsh, unsentimental and unnurturant. Maternal mortality remained higher than that of the UK until 1940.

Churchmen were as tough as the rest. Many sat as magistrates, and the 'flogging parson' became a byword: 'Lord have mercy on us, for his Reverence has none'. Contempt for 'do gooders' and 'God-botherers' became widespread.

The high mortality among Australian troops in the first World War aggravated (as it did in Europe) a tendency to understate, repress and displace the expression of grief. Sforcina suggested that these attitudes continue to influence contemporary Australian society, creating problems in the expression of grief and in the organisation of a caring response.

An example of the consequences of such attitudes was movingly described by Lolu Edwards, an aboriginal woman who had been separated from her mother in early childhood. She was taken to a home for girls where she remembers being whipped for crawling into her sister's bed. Brought up to believe that her family did not want her, she suffered continuing dislocation from her parental culture, and nightmares which only stopped when she met her family for the first time in 1983. Her restrained account of her life brought tears to my eyes, and earned her two standing ovations from the conference.

Further insights into the special griefs of Australian aborigines came from Pat Swain's account of the numerous cultural losses which they have suffered, from Rhonda Holland's account of eight years' work as a 'womba' (silly) nurse providing mental health care for aborigines, and from John Dawes's chilling report of the statistics of aboriginal deaths in police and prison custody. As a social worker and prison governor, he is endeavouring to teach prison staff the interpersonal skills and psychological understanding needed to combat racial prejudice and its effects on prisoners (some of whom are prone to suicide, and others to murder each other, in prison).

Another innovative service which makes use of current work in bereavement is the city morgue service described by Rosenblatt and Merrick. They are social workers attached to the Coroner's Court in Sydney, who provide support to people attending the morgue and Coroner's Court, and support police and victims of disasters, crimes or violent incidents.

Dr Colin Murray Parkes, Senior Lecturer in Psychiatry, London

Papers on services for bereaved children

First among these was a very interesting presentation by Dr Ben Wolfe, Director of St Mary's Grief Support Centre, Deluth, Minnesota. The Centre offers support groups for children aged five to eight years, nine to 13 years and 14-17 years. The optimum number in each group is eight. I was surprised to learn that 88 per cent of children beginning the programme completed it, and that the sexual breakdown of the groups was 58 per cent female and 42 per cent male. It would seem the male reluctance to seek help is a development of adult life.

Each participant is visited at home by a leader before coming to the group. This gives the leader an opportunity of seeing how the child relates at home. There are two leaders in each group, one male and one female.

The programme consists of seven sessions for the young person and a final session to which parents/guardians are invited. During the sessions children are encouraged to talk about the deceased, his or her likes or dislikes, make up a biography of the deceased and work on a 'memory book'. They discuss the funeral and draw pictures of it, or, if they did not attend, what they imagine it would have been like. A visit to a funeral home is included, during which children are encouraged to ask questions. One child asked what is done with a person's arms and legs, and when pressed about this, said: 'Well, you bury the body, but what happens to the arms and legs?'

Another stimulating paper was presented by Louise Rowling, Faculty of Education, University of Sydney, who argued for a wider approach in handling grief and bereavement in schools. There should be congruity between the formal curriculum, the hidden curriculum (or ethos of the school) and school/community relations.

The formal curriculum is proactive, it includes the acquisition of skills to express feeling, expand coping mechanisms and reach out to friends in need. It can convey the message to young people that it is okay to accept help and that this is not a sign of immaturity or lack of independence. The hidden curriculum involves a supportive social context, providing pastoral care for pupils and staff, and pointing up policies for dealing with issues.

Other related papers included one by Ruth Wraith of Balwyn, Victoria, who looked at trauma in children from a developmental and psychodynamic point of view, and a very interesting paper 'Children and Loss—A Proactive Model for Schools' by Rosslyn Heinecke and Rob Spence from Wollengong, New South Wales.

Patrick Shannon, National Officer for Northern Ireland Cruse—Bereavement Care

REVIEWS

HEALING PAIN: ATTACHMENT, LOSS AND GRIEF THERAPY* Nini Leick and Marianne Davidsen-Nielsen (Danish edition 1987, Trs. English 1991). London: Routledge. £35 hb, pb £10.99. (Available from Cruse, £10.99 + £1.50 p&p).

A psychologist and a psychotherapist describe their approach to group work with the bereaved in Denmark. Their approach owes much to the late Ronald Ramsay whose 'forced mourning' for people with pathological grief proved controversial. Leick and Davidsen-Neilson use a similar directive and confrontative approach to evoke intense grief in their clients but, unlike Ramsay, they work mainly in open groups, i.e. groups which patients are free to attend or not attend.

To judge from the numerous and interesting case histories which are described, clients find their approach daunting and often need to be persuaded to persist with the treatment. They are expected to make a bargain, not to commit suicide while the therapy is in train and, up to now, the authors know of no case in which the bargain has been broken. But they report no follow-up studies nor do they record the number of clients who 'drop out' in the course of treatment.

Although patients with psychosis are excluded from their groups, most of their clients are vulnerable people whose problems come closer to the pathological end of the spectrum than do the majority of bereaved people. The book contains a short section by a psychiatrist, which reads very strangely in what is otherwise an articulate volume. There is a flattering but inaccurate reference to the bereavement counselling services, such as Cruse—Bereavement Care, which exist in Britain, and which are assumed to be more suitable for people with lesser degrees of emotional disturbance.

In my opinion there is a place for psychologists and psychotherapists to treat people with pathological grief but the methods advocated in this book require evaluation before their widespread use can be endorsed. Evaluations of a directive approach which were conducted at the Maudsley Hospital (Mawson *et al* 1981[1]) suggest that this method does help some bereaved people but further research is needed to determine who responds best to directive and who benefits from gentler methods.

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1. Mawson D, Marks IM, Ramm L, Stern RS Guided mourning for morbid grief: a controlled study. *British Journal of Psychiatry* 1981; **138**: 185-193.

ST. CHRISTOPHER'S IN CELEBRATION
Cicely Saunders (ed). London: Hodder and Stoughton, 1988. £1.99 exc. p&p*.

In 1988 St. Christopher's Hospice in Sydenham celebrated the 21st anniversary of its opening.

The vision of care for the dying and their families which St. Christopher's pioneered in 1967 has been taken up, modified and extended by others. A new medical speciality, palliative medicine, has been recognised. But in this book Dame Cicely Saunders, founder of St. Christopher's, takes us back to the human stories which form the springboard for the professionals' skills by presenting the experience of 21 patients or relatives who used St. Christopher's services. In her introduction she sets out the principles of hospice care, discusses the search for meaning in which so many of the dying are engaged and makes clear her own Christian view.

Sixteen of the chapters are by staff, five by Dame Cicely herself. They record some very different approaches to death by individual patients and their families, and they put flesh on the principles set out in the introduction. Lynn MacKay shows the real problems that had to be grappled with in letting Sam maintain an independence that took no account of ward routines. Wendy Leatham's detailed record of George's last