# After a death in sheltered housing: the warden's job

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One of the most common aspects of the job of a warden of sheltered housing for the elderly is dealing with residents and their families following the death of a spouse, sibling, parent or child. The demands made upon a warden at the time of a bereavement can be enormous and very difficult to analyse. It almost feels as if there is no 'role' for us, and yet we must be prepared to play any role required. I have often questioned my ability to cope with these situations.

## INITIAL RESPONSIBILITIES

From the studies I have made and my own experiences, I have found that involvement can follow immediately upon a sudden or unexpected death, when the warden is faced with informing the doctor, police and, possibly, next-of-kin. In some instances wardens are the first to be informed of a death, in a hospital or in residential care, and are left with the task of breaking the news. This alone can be very stressful, but it is just the beginning.

For many families, this is the first death of someone close they have had to face and they may have little idea what to expect or do and may be suffering from shock. The warden is often the link between the family and the services required, so information, details and a list of local undertakers at hand is always useful. A range of free and moderately-priced publications are available in the UK from organisations such as Cruse Bereavement Care, Age Concern, the Compassionate Friends, the Royal College of Psychiatrists and Social Security

After any death, at home or in hospital, the warden's most important role is to be available, assisting when required and retreating when appropriate. This is an incredibly hard balance to keep, for the warden too has suffered a bereavement and at some stage will need space and time to grieve, although this may be very much later. It is extremely important not to offer more than is physically or emotionally practical, and to be careful not to intrude into a family's grief.

The feelings and reactions of the other residents have also to be considered, for they too have suffered the loss of a friend or neighbour and will, to some degree, need to mourn. Memories of their own past losses will be awakened and may cause some of the mourning processes to resurface, and this needs to be accepted and understood.

### EDITOR'S NOTE

This paper provides us with practical advice for dealing with the problems raised in the other two papers on bereavement in old age. Its implications extend far beyond the special circumstances in which the author works and point up the need for support felt by wardens and others who choose to care for the elderly

There can be no pattern to the help required or offered, for every situation is unique. Initially the bereaved is often cocooned by the family who take on many of the practical jobs, so that the warden only needs to continue with day to day practical matters as usual. Although bereaved residents need extra help and support at this time, it is important to be aware of the danger of increasing dependence in the long term. Encouragement will enable them to tackle new tasks, perhaps previously undertaken by the deceased, rather than letting others take over. Families, too, may need help and encouragement not to take on more than they can cope with, and reassurance that support and services are there if necessary.

## SUPPORT DURING GRIEVING

After the funeral, the initial shock and numbness begin to retreat and this is often when the warden is very important. Families return to their own lives, a new pattern emerges and the resident is left with an overwhelming mixture of emotions (grief) to cope with. The death of the partner will have created a great emptiness in their home and a realisation that many practical problems have to be faced for life to continue in the new pattern. A warden can often feel helpless:

'The loss of a loved person is one of the most intensely painful experiences any human can suffer, and not only is it painful to experience but also painful to witness, if only because we're so impotent to help.'[1]

### The counselling role

The most important thing to remember is that loss and change are always painful in some way, even if the relationship was poor or the death has been a relief after, for example, a long illness. Although there are other jobs which must be carried out, what is most frequently required is someone to listen, to accept the emotions and tears, and to be patient with repetition. The resident will usually want to talk repeatedly about the person who has died, and time and space for this is essential. Wardens are perhaps fortunate that they often knew the dead person and can prompt memories and facilitate some of the grief work necessary.

With this support, bereaved residents can begin to build a new life without their partner, to accept their changed role in society, and to find comfort and support from their family and friends. Professional help is also available from doctors, health visitors, clergy and social workers. Organisations which deal with the elderly and bereaved, such as Age

Concern and Cruse Bereavement Care in the UK, may be able to advise on practical problems as well as offer bereavement counselling and social events. Wardens should be aware of the available resources catering for the physical and emotional needs of the elderly.

## THE WARDEN'S NEEDS

The results of a questionnaire completed by nine wardens from several different agencies showed that despite the very great demands made upon them at the time of a death, there was a disturbing lack of support. The wardens had all experienced deaths among the residents of their housing schemes during the previous 12 months, and six had been present either at the time of death or immediately afterwards.

Four wardens had had no previous experience of death, while the others did have some experience from other jobs, eg nursing. None of the employing agencies provided any training for bereavement care, but three wardens had themselves undertaken some form of training. Not one had received any support from their agency in this area and seven felt they would appreciate more back up.

In my experience as a warden for over 10 years, I have had 38 deaths, of which seven were sudden and the deceased was found by me, and two were deaths at which I was present. They were all my friends; I visited them in their own homes almost every day, and each one holds a special place in my heart.

After discussions with other wardens, the most noticeable common experience was that other people generally assumed that, because of the nature of the job, wardens would 'be used to death'. However, we all felt that we too needed to mourn, to be understood, supported and listened to, so that we in our turn could give our support, comfort and ears to our residents.

'They don't need advice or comfort – there is none. They need to talk endlessly. They need to hear anecdotes and stories about their loved one, and most of all they need to cry whenever and wherever it comes over them. Don't be embarrassed and don't block it – it might be your turn next.' [2]

## References


1. Bowlby J. Processes of Mourning. *International Journal of Psycho-Analysis*, 1961; **42**: 317-40.
2. Guild J. Death duties. *She* magazine, June 1987: p52.


# Releasing the past to help the present


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Faced with an operation for cancer at 75 years of age, a mother shared this memory of the death of her young son, Jimmy, offering an opportunity for understanding her own fears. She had not talked about her own condition but had literally taken to her bed.

'I walked with Jimmy to the hospital early in the morning. He needed his tonsils done, you know. Frank blamed me. I don't think it was my fault.

He had to get straight into bed – not with my help but the nurse's. I heard him laughing as I hovered outside the door, before going home. They let me see Jimmy briefly before that.

He said, "Dad would laugh at these socks I got on." He had to put socks and a gown on for his operation. Broke my heart to leave him. But I don't suppose I could have stayed, could I?

I was home when the police came... told me there had been some difficulties during the operation. I tried to tell Frank; he looked at me and closed the door. He wouldn't come so I went on my own, in the police car.

As I walked towards the ward I heard Jimmy calling, "Mummy, Mummy".

"Can I go in to him?" I said. "No, not yet", they said. He was wheeled past me in the ward and had to go down to the operating theatre again.

I think a lot about that (pause). Joan – who used to work on the ward as an orderly – told me that Jimmy had spoken to her. He told her about his socks.

I remember walking to the hospital. Jimmy in his blue cap, blue overcoat with its buckle belt. Said his dad was going to drive him, but didn't. He said he didn't like the hospital as we got near. He died during the operation. I said to Joan she was the last person to speak to him, you know ... that knew him.

Frank came to the mortuary where we could see Jimmy. He was on the second shelf up and Frank kept telling me it was my fault while I climbed the ladder. Jimmy had his eyes open and I closed them.

No-one knows how I felt. When I told the consultant who is seeing me now about Jimmy he said, "But that was 45 years ago!". I had hidden all Jimmy's pictures away. My GP told me to get them out. He said it wasn't Jimmy's fault that he died. So they've been up on the wall ever since.

He was a good boy, "never any trouble", the neighbours would say. But he put up with a lot, covering his baby sister when Frank was hitting me, just like his older brother covered him. He bled to death you know; that's why they didn't want me to see him, I expect.'

### EDITOR'S NOTE

**Memories of traumatic events do not seem to decay as other memories do and may be recalled, with great vividness, many years later. Malcolm Williams' report from an elderly woman ill with cancer illustrates this.**

After telling this story and reliving its detail, she said, 'People can bleed to death in operations, can't they?' The fear for her own life and the vivid revisiting of her young son's death had combined to freeze her in her own decision making. The metaphor of her story gave permission not only to discuss her fears for her own future and treatment, but also to release a deeply felt grief and to disclose ways in which people could support her now.

Two weeks later she was admitted to hospital for major surgery which involved the removal of a tumour, leaving a deep and extensive wound. She told me she had felt very disorientated a few days after the operation and in her delirium had worried about her potential for healing. She needed consistent reassurance that she was doing well, and on the occasions when her wound did bleed, felt some panic and asked repeatedly for medical and nursing attention.

Following four weeks of in-patient care, she was able to return home to the care of her family and make slow but steady progress as the wound healed. We talked again of her young son and she concluded our discussions by saying:

'I still vividly remember him, but I can talk about him now.' ■