Counselling bereaved people – help or harm?

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At present much of the counselling in the UK is provided by carefully selected and trained volunteers. However, the perception of what 'counselling' means is changing and the tightening up of criteria for training makes it likely that, before long, only those with professional levels of training will qualify and volunteers may be squeezed out. Yet selected volunteers with proper training have been shown to be capable of providing services which meet the needs of most bereaved people[1]. Whatever the service, it is important to provide criteria for accreditation.

It is sometimes said that a drug which cannot do harm is unlikely to do much good. The more powerful the drug, the more effective it is likely to be, but also the most poisonous if used in the wrong dose at the wrong time. The same could be said to be true of counselling services to bereaved people. It is possible to counsel in a bland way which is unlikely to do any harm, but we run the risk that it will not do much good either.

People frequently seek help at times when they have come to the end, or think that they have come to the end, of their own resources. They are, perhaps, more willing than at other times to change their ways of thinking and acting in the world. This provides them and us with an opportunity which is not to be missed, but it also makes them more than usually vulnerable to harmful influence.

How then, can we ensure that services do good rather than harm? In this paper I shall draw upon research findings and clinical experience to attempt an answer to three questions, using the term 'counselling' for both voluntary and professional service:

- Who is most likely to be helped by bereavement counselling?
- What types of counselling service are likely to help which types of problem or client?
- Are there some service providers that are more likely to do harm than good?

Finally, I shall consider some of the implications of these answers.

WHO IS MOST LIKELY TO BE HELPED BY BEREAVEMENT COUNSELLING?

The study of risk indicators enables us to identify before, or at the time of a bereavement, people who are likely to have lasting problems. These include people who have suffered unusually traumatic and unexpected types of bereavement and people who have a particular vulnerability to loss. Other research has shown that people at such risk are likely to benefit to a statistically significant degree from counselling[1, 2].

The same cannot be said for counselling offered to unselected bereaved people who, in several studies, showed no differences between those who received counselling and comparison groups who did not (see Parkes[3] for a review of this work). In other words, the experience of bereavement is not sufficient grounds, on its own, to justify people in seeking counselling although certain types of bereavement and certain types of client are likely to benefit.

In one of Raphael's studies[3] she showed that people who perceive their own families as unsupportive are at special risk after bereavement. She also found that it is this group who obtain the most benefit from counselling. By the same token, people whose bereavement has been timely and anticipated, who have no personal vulnerability and whose families are supportive, seldom need bereavement counselling. It is even possible that they may be harmed by it, for instance, their family may feel de-skilled by the counsellor and back off just when they are most needed.

Self-selection is the most frequent route to counselling and common sense suggests that people who request help are more likely to need and benefit from it than those who do not. Yet there is no research known to me that confirms this and clinical experience suggests that there are some people whose mood is so low after a bereavement that they cannot believe that anything or anybody could possibly help them. In this instance it may well be the case that the people who need help most are the least likely to request it.

It would seem that, while self-selection will remain the principal route to counselling, systematic risk assessment and referral should, wherever possible, supplement it. Members of health care systems, particularly general practitioners in primary medical care and members of

EDITOR'S NOTE

Parkes here reviews some of the research literature on bereavement counselling to give us pointers on who can most benefit and who may be harmed by such interventions. One of the groups at increased risk of developing short- and long-term adverse sequels following a death is young children bereaved of a parent. For that reason they should be considered, like other high-risk groups, for a preventative intervention. Harris and her colleagues* found that the increased risk for children was related to the quality of care they received following the death of a mother. Consequently any support and help given to widowed parents is likely to play an important part in improving not only their functioning but also that of their children.

* Harris T, Brown GW, Bifulco A. Loss of a parent in childhood and adult psychiatric disorder: the role of lack of parental care. *Psychological Medicine* 1986; 16: 641-659.

palliative care teams, are in a position to do this and should be properly trained for that purpose.

WHAT TYPES OF COUNSELLING ARE MOST LIKELY TO HELP WHICH TYPES OF CLIENT?

In an ideal world counsellors would be trained to meet the full range of needs of their clients by whatever means have been shown to be effective. This said, there are a variety of schools of thought and training programmes which emphasise different approaches. These include 'emotion-focused' approaches derived from Lindemann's classic study[4] and the more 'cognitive' or 'problem-focused' methods pioneered by Beck[5]. If choice is available how should we decide between them, or should we leave it to the client to decide?

At this time, few systematic comparisons of different types of counselling have been carried out. One exception is the comparison by Schut *et al*[6] of emotion-focused and problem-focused counselling, both of which were found beneficial by comparison with a control group. But the most interesting finding of this research was that men in the study benefited best from emotion-focused help while women benefited more from problem-focused. Given a free choice one suspects that the men would have chosen the problem-focused help while the women would have chosen the emotion-focused help.

Clinical experience suggests that the provision of cathartic, emotion-focused counselling to people who are already highly emotional is not only a waste of time but may even increase feelings of insecurity and foster a dependent attachment to the counsellor. We should not allow our feelings of empathy for our clients' feelings of weakness and helplessness to cause us to treat them or think of them as weak and helpless. It is our respect for their worth and potential that is likely to benefit them rather than our pity for their weakness.

On the other hand, if counsellors collude with people who have difficulty in expressing emotions by encouraging them to find intellectual solutions to emotional problems they may reinforce the client's secret fear that emotions are too dangerous to be expressed. Emotions are often expressed by non-verbal means by both clients and counsellors. Counsellors may need to be encouraged to pay attention to the non-verbal messages which they give and receive.

In another important study Schut *et al*[7] found that a combination of psychotherapy with art therapy was more helpful in the treatment of pathological grief than traditional methods of psychotherapy. It is not unreasonable to suspect that the art therapy, by using non-verbal means of communication, facilitated focusing on emotion-laden issues.

A related problem is the avoidance of painful memories that is characteristic of people suffering from post-traumatic stress disorder (PTSD). This condition tends to follow losses that have been unusually horrific in their nature, particularly if the bereaved person witnessed terrifying or violent happenings. They then find themselves haunted by the memories of the event which are easily triggered by any reminder of the loss. They may go to great lengths to avoid such reminders. Since it is not possible to grieve without thinking about a person who has died it is not surprising that PTSD regularly interferes with the course of grieving.

Several good treatments are now available from psychologists for this condition but most of them are not suitable for use by bereavement counsellors. For this reason it is important to diagnose and obtain treatment for the PTSD before undertaking bereavement counselling. The successful treatment of PTSD does not, however, mean that counselling may not then be needed.

ARE SOME COUNSELLORS MORE LIKELY TO DO HARM THAN GOOD?

Counsellors, as we have seen, are influential people and it is important to use that influence for the benefit of the client rather than the counsellor. It is all too easy for counsellors to feed their own needs for power and status by talking down to their clients, expressing pity and suggesting clever solutions to their problems. While clients are sometimes glad to hand over responsibility for their lives to a 'superior' person, the long-term consequence is likely to be emotional dependence and diminution of the client's self-esteem.

At the other extreme we have caregivers who have chosen to counsel others in order to compensate for the lack of support in their own lives. Their own needs for nurture make it easy for them to sympathise and 'understand' their clients but the client soon begins to feel that the counsellor is more frail than they are. While it is often helpful for counsellors to share grief, it is most important that it is their shoulder that is being cried on rather than the client's.

Other clients become aware that, while their counsellor is generous with offers of help, when the crunch comes they back away, just when they are most needed. Counsellors need to be trained to hang in with their clients, especially when the client becomes distressed. One way of training counsellors to become more comfortable with their feelings is by role-playing counselling situations. Although one might think that role-play techniques would teach counsellors to act a part, in fact they usually evoke real feelings and help counsellors to cope with them.

Another way in which counsellors deal with their own internal feelings of chaos is to attempt to take control of the client. Thus they may cling to a theory, philosophy, methodology or faith that appears to provide a simple answer to complex problems. The client's problems are then forced to fit their particular views and any deviation is criticised as resistance, sickness or just plain bloody-mindedness.

Theories have their uses and may help us to understand a problem, but they should be drawn on because they fit the client rather than the client be pressured to fit the theory. Thus, some counsellors and clients have found the phase model of bereavement helpful in providing them with a rough template for 'normal' grief; but it is very unhelpful to label people who deviate from that 'norm' as failures, sick or in need of treatment. In the same way, some clients who have a strong religious faith will be helped by a discussion of divine forgiveness, but this does not justify us in forcing our own particular beliefs on people who have no religious orientation.

It is most important for counsellors to be aware of their own limitations and to refer on those clients who need other forms of help. Conditions for which medical or psychiatric referral is likely to be needed include clinical depression and anxiety/panic disorders. Recent advances in pharmacology now provide effective treatments for these conditions and may indeed save a life if a client is tempted to suicide.

IMPLICATIONS

These issues are important in the selection, training and supervision of counsellors. We should do our best to choose for training those who are not driven to control others and are not so needy that their own needs for nurture or control will intrude into their work as counsellors. Previous experience of loss is not a bar to counselling but it is most important for selectors to be sure that past grief has been resolved. This means that

each applicant should be interviewed in depth and that the feelings evoked by past losses be explored. If people are in touch with their feelings about such matters, but no longer overwhelmed by them, they will probably make good counsellors. On the other hand, the applicant who is still very 'tender' or who has dealt with past losses by walling them off emotionally will make a poor counsellor.

We should be suspicious of people who tell us that they know the answer to bereavement, for bereavement is so complex a topic that there is no one answer that will suit everyone. On the other hand a person who shows willingness to hang in with people despite the absence of an answer to their problems will probably make a good counsellor.

No matter how rigorously applicants have been selected it is important to pay attention to these issues in the course of training. While books and didactic training have a place, it is only experience that enables us to test out and to develop our ability to cope with emotional issues. Role-play, self-awareness training and, in due course, supervised counselling experience are all valuable ways of doing this. They enable those who are capable of developing counselling skills to do so and they also make it clear that some people are not yet ready to take on the responsibilities of a counsellor. For this reason full accreditation should not be offered until training is complete and a final selection process undertaken.

In the present state of our knowledge there is no research which indicates that help given by full-time professional counsellors is superior to that provided by well-selected and trained volunteers, although common sense suggests that higher levels of training should be beneficial if only to a minority of clients with special difficulties.

In many countries there are organisations that provide accreditation for bereavement counsellors. These include **The Association of Death Education and Counselling** in the USA, **The National Association for Loss and Grief** in Australia and New Zealand and **Cruse Bereavement Care** in the UK. Although criteria for accreditation vary from country to country the above named organisations do seem to meet reasonable standards.

CONCLUSION

Counselling for bereaved people has proved its worth but, like all effective interventions, it is not universally beneficial and may even do harm. In order to maximise the benefit and minimise the harm, attention should be paid to the selection of clients; the selection, training and supervision of counsellors; and the provision of a spectrum of services to meet the varied needs which are encountered.

Members of health care teams have the opportunity and, indeed, the responsibility to assess bereavement risk in family members before or at the time of a death and should be trained to do this.

Those who offer service to bereaved people should be selected, trained and supervised by accredited organisations.

The need is so great and the potential benefit so well-founded that it is time for national standards to be agreed and for national plans to be drawn up and implemented.

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Picasso's *Science and Charity*

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Visiting the Picasso Museum in Barcelona recently, I came upon this picture (reproduced on the cover of this issue) for the first time. It was painted in 1897 when Picasso was 15 years old and is a good illustration of his enormous talent which was to dominate the whole of 20th century art. Picasso here paints a young mother at the point of death – her eyes are turning up. Her young child watches her from the nurse's arms. The mother is attended by the doctor who must, at the point at which the painting freezes time, have just realised that he has lost his patient. The nurse is proffering a drink that she will never taste.

Why should Picasso have chosen such a poignantly sad subject to paint? The previous year his beloved sister, Conchita, had died of diphtheria, at the age of seven. Picasso had made a vow when she fell ill that he would give up drawing and painting permanently if God would spare her, a measure of his devotion to her. He was already struggling with the agnosticism and anti-clerical feelings which were part and parcel of his rebellion against his father who, an indifferent painter and teacher himself, was rather overbearing and authoritarian in his direction of the young Picasso's talent. Father was, in fact, the model for the doctor. It may not be too fanciful to imagine that the loss of Conchita stimulated the adolescent Picasso to feel he had to use the talent he nearly vowed away to pay tribute to her – to thank her, so to speak, for not making him have to hold to his vow – by depicting a deathbed scene.

I marvelled at the perfection of technique that Picasso had attained by the age of 15 and it helped me to understand why he spent the rest of his long life at the cutting edge of experiment. But most of all I was moved by the insight this young person had into the plight of the child. The child looks down without emotion upon his mother, not yet comprehending the momentous event that will deprive him forever of her care. The nun is not looking at the child; she is holding him with one arm, rather casually and without emotion, almost ignoring him, even though she is aware of what he is about to lose. The doctor pays no attention to him at all and the mother cannot look at him as she is at the point of death. The source of light comes from in front of and above the child, lighting him and the nurse. Our eye is drawn to him by the light and the white of the nun's coif. He is alone. Neither science nor charity can restore his mother to the child and, of all the people in the room, he alone is bereaved.