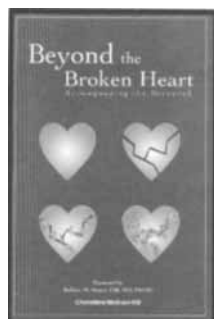


## B O O K

## A B S T R A C T S

**Beyond the Broken Heart**

Gillian McConnell  
(compiler)  
Montreal, Canada:  
Cheneliere/  
McGraw-Hill  
2003, 96p  
CAN \$20.95 pb  
ISBN 2 89461 938 3

Case vignettes are used extensively in *Beyond the Broken Heart* to provide a real, and at times moving, illustration of the many facets of grief and the challenge to volunteers working with impending death and bereavement. In its seven chapters the book covers issues of beginning and ending work with grieving clients, fostering normal grief and preventing pathology, and the difficult issue of suicide.

The content is a condensation of the experience of the volunteers of the Bereavement Support Program, first opened in 1975 as part of the palliative care service at McGill University's Royal Victoria Hospital in Montreal, Canada. It might have been helpful to have the description of the programme at the beginning of the book, rather than as the penultimate chapter, to give the reader a context for understanding the process of care giving and the support structures provided for volunteers, who are central to this Canadian service.

This book does not focus on an analysis of therapeutic skills but is an account of how volunteers engage with their client's losses using classic notions of grief. As seen from the largely dated references, contemporary grief theories, eg the dual process model\*, are not addressed in this text.

However, for many practitioners this book will feel refreshingly readable and jargon free, and a complement to more theoretical literature. I am sure it will be especially helpful to those new to the field of grief and bereavement. The case studies, particularly those dealing with difficult issues like suicide and disenfranchised grief, might usefully be used as material within training and supervision groups as lively sources for discussion on practical and ethical topics. ●

**Linda Machin**

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\* Stroebe M, Schut H. (1999) The dual process model of coping with bereavement: rationale and description. *Death Studies*; 1999; 23: 197-224.

**Assessment of guidelines for good practice in psycho-social care of mothers after stillbirth**

Hughes P, Turton P, Hopper E, Slyter H, Evans CDH. *Lancet* 2002; 360(9327): 114-118

It is well-recognised that mothers of stillborn infants are at greater risk than other mothers of subsequent depression and post-traumatic stress disorder. This important paper calls in question the widespread assumption that this risk can be reduced if mothers whose babies are stillborn are urged to see and hold them. Rather it suggests that '...there is no justification for telling parents that not seeing their dead baby could make mourning more difficult, and those who are reluctant to see or hold their dead baby should not be encouraged to do so'.

Seventeen mothers who had not seen or held their stillborn child were compared with 14 who had seen but not held and 34 who had both seen and held their dead baby. During the course of their next pregnancy the mothers who had not seen or held their former baby were significantly less depressed, less anxious and had fewer symptoms of post-traumatic stress disorder than the other mothers, with a tendency for the mothers who had both seen and held their dead baby to do least well. A year after the birth of the baby most of these differences had dropped below statistical significance, but the infants of those mothers who had seen/held their dead first baby showed evidence of a pattern of disorganised attachment which Main has attributed to unresolved mourning in the mother.

**To see or not to see, that is the question. Challenging good-practice bereavement care after a baby is stillborn: the case in Australia**

Brabin P. *Grief Matters* 2004; 7(2); 28-33

This issue of *Grief Matters* is devoted to three articles that examine the reactions of parents who experience the death of a child, particularly if it is stillborn or if the death is perinatal, and the care and help that are given at this time.

In the first article, referring to the *Lancet* paper reviewed above, Peggy Brabin reports the results of a similar study that she carried out in Australia. In keeping with Hughes *et al*, she found that when their first baby was born dead, mothers who opted to see the dead baby, go to the funeral, keep mementoes and talk about the baby, obtained elevated scores on the GHQ, a measure of psychological dysfunction, at four years after bereavement. Mothers who decided not to view the

baby and those for whom the stillbirth was preceded by a live birth (regardless of their decision to view or not to view) had less psychological dysfunction.

When all four groups were followed up for six and eight years the differences had disappeared. Indeed the group who had avoided looking at their dead first baby were now more disturbed than they had been and the other three groups rather less disturbed.

Brabin concludes that the increased GHQ scores at four years after bereavement result from 'facilitated grief' which, in accordance with traditional grief theory, subsequently resolves. The mothers who opted not to view their dead baby she sees as adopting a 'grief avoidance that can result in delayed mourning'. This tenuous argument is then used to support current 'good practice' guidelines, which encourage mothers to view dead babies.

Attachment theory suggests an alternative explanation for these findings, which is not considered by Brabin. Commenting on the *Lancet* paper, Reynolds (Reynolds JI. *Omega* 2000; 48: 85-88) points out that the explanation for these unexpected findings may lie in Bowlby's observation that seeing and touching ones baby are part of the process of attachment, which cements the relationship between mother and child. Mothers who do not see or touch a dead baby, go to the funeral or talk about it, may be less attached to the baby and, therefore, have less need to grieve and cope better with subsequent babies. On the other hand the emotional disturbance caused by losing a baby to whom the mother is firmly attached will last for five or more years and, particularly if the mother 'keeps alive' the memory of the baby by treasuring mementoes, her grief may then become chronic. Other studies indicate that witnessing horrific events increases the risk of post-traumatic stress in all its forms.

While it would be wrong to ignore a woman's right to express her grief for a baby to whom she has become attached, we may need to think again about the wisdom of fostering a doomed attachment which will only result in great distress, and may give rise to psychological dysfunction in the mother and in future children. ●

**Colin Murray Parkes**

**Treasure Babies Programme – supporting 'best practice' in perinatal crisis bereavement care in hospitals**

Giljohann BA, Mulvey N. 34-38

**The past and the present: listening to parental experiences of autopsy practice**

Robb B, Sullivan J. 39-43

*Grief Matters* 2004; 7(2)

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The second *Grief Matters* article describes an organisation that was set up in Australia, called the Treasure Babies Programme, to help the parents of perinatal babies. As the authors comment, these parents often feel that their loss and grief are not recognised or acknowledged, and so they have little or no support to help them through their grieving process. The programme provides a very practical way in which such families can be supported. Volunteers make beautiful tiny clothes which are given to health professionals so that, if the parents wish, their babies can be dressed, cuddled, and perhaps dressed for burial. There are other gifts, such as memory boxes. The clothes in particular are much appreciated: as one mother wrote, 'It made him a person, gave him his dignity'.

The third article outlines the historical and contemporary contexts and processes of autopsy practices. These can be deeply upsetting to the bereaved parents, particularly the retention of organs when this has not been discussed or agreed upon. In many traditions such a violation of the body is particularly shocking. Apart from the autopsy issue, the authors also discuss the need of bereaved parents for other information concerning their child's death, which will support their recurring hope that they may find something that will help to validate the child's life.

Some of the material in these articles has especial relevance for Australia, where *Grief Matters* is published. They should, however, be of interest and help to anyone working, or coming in contact, with parents mourning the death of a baby.

## Report on bereavement and grief research

Center for the Advancement of Health. *Death Studies* 2004; 28(6): 491-575

In 2000 the Project on Death in America commissioned the Center for the Advancement of Health to

assess the state of research on grief. A scientific advisory committee was formed, and this issue of *Death Studies* is entirely devoted to the committee's report. It makes recommendations to strengthen grief research and to facilitate the use of evidence to guide the provision of high-quality, appropriate bereavement- and grief-related care. It examines the advances in understanding that have resulted from recent empirical research, the use of this research to improve care, and the relationship between bereavement and physical and mental health. It also identifies factors that limit the attention paid to bereaved persons by health care professionals and recommends that far more training in bereavement care should be given to physicians and healthcare providers. The implementation of the large number of intervention programmes for over the last 20 years is discussed. Among the conclusions reached, the report emphasises that there is tremendous variability in 'normal' responses to bereavement, and that positive emotions and experiences are possible following loss. There is evidence that a significant lack of connection exists between the information generated by researchers and the information that is used to guide the provision of services to the bereaved.

The tremendous changes in research on bereavement in recent years – with the appearance of new theories, research methods, clinical practices, and above all empirical research – which have begun to transform our understanding of bereavement as a human experience, give this report a particular relevance. Robert Neimeyer, the editor of *Death Studies*, describes it as a 'landmark document'.

## Daddy

Waisanen EM. 291-298

## Understanding the psychological sequelae of the murder of a grandparent/caregiver: cases of Jamaican school-age children

Mahoney AM, Clarke CP. 299-314

*Journal of Loss and Trauma* 2004; 9(4)

These two articles each discuss the effect on children who are faced with the death of a parent or grandparent.

In the first, a 16-year-old girl writes of her grief as she watches her father, whom she loves deeply, die of cancer. There is much in this essay that will immediately resonate for students of bereavement and caregivers of the bereaved. Depicted vividly are a bereaved youngster's crushing sense of loss, her identification with a beloved parent, sudden unwellcome surges of grief and tears, continuing attachment beyond death, and the potential power of a deeply caring friend contrasted with the frozen or obtuse responses of much of her peer 'support network'. Particularly telling is the portrayal of the

cost of watching a painful, long-drawn-out illness.

The second is based on case reports of five children of between six and 12 years who suffered the traumatic loss of a grandparent or caregiver murdered by someone other than a member of the family. The article describes the children's psychological, behavioural and academic response. Although focusing on these particular children, it also discusses the reactions of children generally who have experienced similar traumatic events, and stresses the important role of the school in such cases. The authors believe that the development of school-based intervention programmes is a necessary step in places such as Jamaica, where this type of help is limited and the level of violence is increasing.

## Sole survivor: a case study to evaluate the dual-process model of grief in multiple loss

Hunt J. *Illness, Crisis and Loss* 2004; 12(4); 284-298

The devastation which AIDS wreaks globally, and especially in Africa, makes this study of bereavement in Zimbabwe (which has one of the highest incidents of AIDS in the world) particularly relevant. It follows the attempt of a 40-year-old Zimbabwean woman to cope with multiple loss. She experienced the death of her two brothers and two sisters, three of which were AIDS-related, as a result of which she became responsible for the care of numerous nieces and nephews. Since in her culture to have AIDS is regarded as disgraceful, and the deaths of relatives tend to be attributed to other causes, individuals are forced to hide their grief rather than confront shame and rejection. Anna thus grieved for six years as best she could, but the sudden death of her mother brought her to breaking point, creating what has been called bereavement overload. As a result she sought counselling therapy, and the author of this article describes the stratagems which were devised to enable her to cope with a situation which had turned her world upside down. ●

*Sheila Hodges and John Bush*

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