REVIEW

Seventh International Conference on Grief and Bereavement in Contemporary Society

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THIS CONFERENCE TOOK PLACE seven months after the tsunami of December 2004 killed over 283,00 people and a week after world leaders met in Edinburgh to try to reduce the massive number of untimely deaths from AIDS, poverty and armed conflicts. Four days before the start, terrorist bombs brought London to a standstill and 70 people were killed. This did not deter over 400 delegates from coming to London, from across the globe, to attend this international event.

Hosted by Cruse Bereavement Care, the conference was held at King's College, London. Thirty eight delegates came from Australia, 23 from the USA, 13 from Africa, 11 from Scandinavia, 7 from the Netherlands, and others from India, Israel, New Zealand, Germany, Belgium, China, Brazil, Spain, Canada, Malaysia, France, Japan and Taiwan, not to mention 334 delegates from Great Britain and Ireland. In addition to the seven plenary papers, there were 108 papers and workshops, five videos, three exhibitions of photographs and one poster.

So much for the statistics. What were the main themes? The two most popular concerned services for **bereaved children** and services for those suffering **traumatic bereavement,** particularly disasters. As was to be expected in an international conference, 18 papers focused on cross-cultural issues. Current methods of helping bereaved people were scrutinised and innovations evaluated. Several papers examined the ways in which continuing bonds to the dead are maintained, and others concerned complicated grief, its diagnosis and causes.

Rather than attempting a slavish report of this smörgåsbord, we will focus on some of the major issues that emerged. Since nobody was able to attend all the papers we apologise to any speakers whose work we missed. Further details of all the papers can be obtained from the *Book of Abstracts**.

Trauma and disasters

The London bombs, and the much more devastating Asian tsunami, had involved many of those attending the conference. Other disasters included the bombing of Bali, New York and Washington and the conflicts in Rwanda, Afghanistan, Eritrea and Nigeria.

A pre-conference study day on **Bereavement needs in emergency situations: a post-tsunami workshop** had been hosted by Help the Hospices and those taking part are providing support to bereaved people in the large area affected by the tsunami, or people who had been visiting the region when the tsunami struck. The highest death rate was among women and children. Participants reported that post-traumatic stress disorder had been less of a problem in India than the WHO's advisers had led us to expect. On the other hand, persisting depression and alcohol abuse had become a problem for many of the fishermen who had lost their central role in life as well as losing wives, children, boats and homes. Depression and/or complicated grief were also found among wives who had also lost children and whose husbands were unable to give them the support that they needed.

Care for survivors of the tsunami and other disasters was a recurring theme throughout the main conference. In the UK, bereavement volunteers are continuing to work alongside the police's Family Liaison Officers (FLOs). Andy Beckford (FLO), with Debbie Kerslake and Sue Stow from Cruse, showed how **Cruse Bereavement Care has developed a working partnership** with them in successive disasters since 9/11. This work is continuing after the London bombs.

Leila Gupta received a standing ovation for her moving paper on **'Violent death in the developing world'**. Drawing on her experience and systematic research in **Rwanda, Afghanistan and Sierra Leone,** she convincingly demonstrated the terrible cost to children (including high levels of intrusion and arousal on the Impact of Events scale). Much to the relief of her audience she also showed the improvement that results from a variety of culturally-sensitive interventions. Further support for this work came from Eugénie Mukanohélie and Celestina Omoso Isaramen, who described the continuing and horrific problems that result from needless deaths in **Rwanda and the Niger Delta.**

Other traumatic forms of bereavement

discussed at the conference were bereavements by **murder and manslaughter** (Dora Black and David Trickey), **suicide among students** (Jo Bell) and clients (Margharet Nelson Agee), the effects of war and civil conflict on **refugee children** (Guinevere Tufnell), the support of families faced with **mutilated bodies** (Jane Mowl) and death in an emergency ward (Christopher Hall), and the more chronic traumas **of families of death-row inmates** in the USA (Sandra Jones) and of **parents whose child is missing** (Geoffrey Glassock).

Bereaved children

William Worden's plenary drew from the Harvard Child Bereavement Study and looked at how 125 school children in 70 families reacted to the **death of a parent**. He found more than a third of the children to be at risk, with **teenage girls who had lost a mother the most vulnerable**. It is important that young people feel involved (eg in the funeral) and that the home routine and connection with the dead parent are maintained as far as possible

The relationship between resilience and memory processes was explored by Julie Stokes of the UK children's bereavement service, Winston's Wish. That maintaining or creating memories of a dead parent is important is well testified, but many children find these memories unwelcome at times, particularly at school (35%), and when they are having fun (20%). **Memory work must be carefully handled** so that children can both hold on to and push away their mental image of their dead parent.

Problems and solutions

Considerable research has been carried out in recent years into the existence of a type of complicated grief that causes lasting suffering and disability. Holly Prigerson reported on the work of her group at Yale (and now Harvard) universities. They have established clear diagnostic criteria for a form of **complicated grief** that is distinct from depression and other mental disorders and is associated with increased risk to both physical and mental health. Other workers have demonstrated successful ways of treating complicated grief and three of them, Birgit Wagner, Andreas Maercker and Christine Knaevelsrud, reported favourable results of a random-allocation study comparing treated groups with waiting list controls. In this instance the treatment was an innovative form of **internet-based cognitive behaviour therapy**. (See also the review, on p64 of this journal, of another successful treatment in a random-allocation study by Jordan *et al.*)

Other speakers were more concerned with the prevention of psychiatric problems, including complicated grief, by intervention before and after bereavement. One such is David Kissane who has developed a **'family-focussed grief therapy'** (FFGT) in his palliative care work in Australia. He reported results of a comparison of 233 individuals from 53 families who received FFGT with 130 individuals from 28 control families. The research demonstrated that well-functioning families with high levels of cohesion are more resilient than those that were dysfunctional (categorised as either 'hostile' and chaotic with conflict; 'sullen' with muted anger and depression; or 'intermediate'). **Avoidant families, especially the 'sullen' group, benefited most from the intervention.** This work will be of particular interest to people working in palliative care settings

Promising results are also being obtained by Jesus Angel Garcia-Garcia from an ongoing random-allocation study comparing bereaved patients of **Spanish family doctors who have received training in bereavement care** with a control group of the bereaved patients of untrained family doctors.

The work of **Cruse Bereavement Care**, a British **national organisation** for bereaved people that provides a wide range of **support by volunteers** backed by professional staff, was examined by several speakers including Debbie Kerslake, Sue Stow, Peter Bowie and Anne Townsend. A new service based on the Cruse model is being pioneered in Goa by Gracey Andrew, Sue Stow and Phillipa Weitz.

Reviewing research into the effectiveness of bereavement interventions, Henk Schut demonstrated that there is **no one method of counselling or therapy that has proved effective for all types of bereavement.** On the other hand several interventions aimed at particular problems have proved their worth. He instanced his own work in Utrecht which showed that, contrary to intuitive expectations, men seeking help from a bereavement support service benefited more from an intervention aimed at helping them to express grief, whereas women benefited more from a more cognitive, problem-solving approach.

Analysis by Marilyn Relf and Cathy Lines of a 13-year database monitoring assessment decisions and the work of Sobell House hospice bereavement service, Oxford, found that **nursing staff** using a formal process of risk assessment consistently identified some 40% of bereaved relations as likely to need ongoing support. Though there were more female patients and carers in the hospice population, in contrast to expectations there was no difference in the proportions of men and women taking up offers of support or in their use of the service.

Particular interventions for particular problems reported at the conference included work **with bereaved people with intellectual disabilities.** This was reported by both Sue Read from Staffordshire and Jane Hubert and Sandra Dowling from Sheila Hollins' research team at St George's Hospital, London (details of the positive results of a random-allocation study of intervention by Cruse-trained bereavement volunteers, were reported in *Bereavement Care* 2003; **22**(2): 19-21*)*. Other special solutions for special problems included Peter Hammersely and Dorothy Ayling's work with **bereaved men in prisons**, and two papers reporting support after the **loss of a pet** (one by Kenneth and Nathaniel Kaufman and the other by Sue Dawson and Bill Campbell).

* The *Book of Abstracts* is available in printed version and as a PDF from Cruse Bereavement Care: tel +44 [0] 20 8939 9532; info@crusebereavementcare.org.uk

REVIEW

The nature of human attachments

It comes as no surprise that love and grief are related yet it is only in recent years that systematic attempts are being made to examine the relationship between problems in loving and problems in grieving. At this conference several papers from the University of Utrecht focused on these issues. Thus, Margaret Stroebe's research demonstrated **an association between insecure attachments and complicated grief** (this confirms other work reported during this conference by Prigerson, Parkes and Kissane). After the loss of a child, **parents who reported being anxiously attached to their partner or avoiding attachment experienced high levels of grief and depression.** Reviewing recent work Karolijne van der Houwen widened the influence of insecure attachments to include measures of depression and general health. Wolfgang Stroebe found support for attachment theory in his studies of **social support** for bereaved persons. While generally beneficial such support **does not mitigate grief itself**; attachments are not transferable.

Parkes, in his opening plenary paper, summarised some of the findings to be reported in his forthcoming book, *Love and Loss.* Systematic retrospective assessments showed that **people who** reported having **had insensitive or over-protective parents in childhood** were more likely to cling later in life and to **suffer lasting grief/loneliness after bereavement.** Those whose parents were **intolerant of closeness** themselves became similarly intolerant; as adults they had difficulty in expressing both affection and grief and, after bereavement, expressed much guilt and self-reproach. Those from families affected by **violence/rejection, danger or depression** had been unhappy children with little trust in themselves or others. As adults they turned in on themselves at times of stress and, after bereavement, became **anxious, depressed,** and/or inclined to use alcohol as an escape.

Attachment does not end with bereavement and several papers focused on the **continuing bond** to the dead person. These included a fascinating account by Cecilia Chan of the rituals and beliefs associated, **in China,** with the ghosts of the dead These return to earth for one week each year in order to receive gifts of paper money, paper television sets, computers and other items that are ritually burned in the street.

Laura Lewis described how, in the West, **physical possessions** of the deceased assist the mourner to maintain their attachment to the lost person. Other types of **creative memorial** were described by Karen Sorensen, Wasim and Claire Barratt. It is particularly difficult to maintain a continuous bond when a child has **died in the womb.** Anne Lastman described how the **pregnancy** itself and the humanity of the child can be memorialised and any unresolved guilt assuaged. Jan Oyebode and Andy Dunn warned us that there are many kinds of **continuing bond** and they **may inhibit or facilitate** the work of grieving.

On a different tack, Mara Lashchuk from Adelaide University looked at **bereavement reactions as a function of personality** among 200 people classified by personality type rather than loss. Past bereavement experiences in the group were subsequently identified by interview, and grief reactions were measured retrospectively. Those whose personality was over-emotional or who had high depression and emotion levels suffered the most, with easy-going optimists and those who hid their emotions having the lowest distress response.

Meaning making

Continuing bonds are intimately linked with attempts to find meaning in the death of a loved person. This was the theme of a moving paper by Robert Neimeyer. He uses the concept of **narratives** to explain how bereaved people **reconstruct their assumptions** about the world ('**constructivism**'). This is a highly creative activity and sometimes results in increased maturity and in works of literature, art or music. These **gifts of grief** were the focus of a compilation of videotaped interviews with talented bereaved people, produced by Nancy Sobonya. In similar vein, June Allen argued that **anger,** which is often a problem after bereavement, can also be a force for good, particularly when **social action** is needed to right a wrong.

Lisa Dinhofer stressed that organ donation is motivated by the need of bereaved people to give meaning to the life, and death, of those they loved, rather than by altruism. In her USA study of organ and tissue donors, 30% doubted the information given by the hospital staff and **44% of organ donors wondered if their relative had really been dead.** This area is an important one for further study, as there may be serious implications for national policies that assume consent.

Conclusions

Research and services for bereaved people are burgeoning across the world. Three conclusions emerged from the evidence reported at this lively and important conference:

- While there is no reason to believe that most bereaved people need specialised bereavement services, there is a minority who suffer greatly, whose physical and mental health is at risk, and who will benefit from the right kind of help. These include bereaved children and those adults who suffer unusually traumatic losses.
- In view of the great number and character of unnecessary, untimely and traumatic deaths across the world, particularly in developing countries, there is a great need for people working in the field to reach out across cultures. We all have much to learn from each other.
- There is no single therapy for the problems of bereavement. This said there is now a growing body of evidence that the right help, given to the right people, at the right time, can substantially reduce needless suffering and may even foster increased maturity and creativity. It is a extremely unhelpful that trauma counsellors and bereavement counsellors are often unaware of and uninterested in each other's work. Successful help for traumatic forms of grief can best be achieved by those who take the trouble to combine both fields. Likewise those trained in the overlapping fields of psychology, sociology, psychiatry,

philosophy and ethics have much to learn from each other as have those from different ethnic backgrounds and religions.

This conference provided us with the opportunity and privilege of crossing these boundaries and was highly valued by its participants. Congratulations are due to the staff of Cruse Bereavement Care and, particularly to the conference organiser, Sarah Hill, who not only made the whole event possible but serenaded us all as we danced the night away on a delightful trip down the River Thames.

It is with great pleasure that we welcome the decision to hold the **8th International Conference** on Grief and Bereavement in Contemporary Society in **Melbourne, Australia in 2008** under the auspices of the Centre for Grief Education and the Australian National Association for Loss and Grief. Watch this space! ●

TRIBUTE

Cicely Saunders OM DBE FRCP FRCN 1918-2005

photo © St Christopher's Hospice

Although Cicely Saunders is best known as a pioneer of the hospice movement and concerned with improving the care of dying cancer patients, she also played a major part in supporting their families. Rather than yet another obituary, this tribute focuses on the influence she had on hospice bereavement services.

Cicely first wrote to me in 1965 in response to my paper, 'The pastoral care of the bereaved'[1]. She described a new type of hospice she was founding in London (later to be called St Christopher's after the patron saint of travellers). Meeting her in person with John Bowlby later that year, I was impressed by her single-minded devotion to her patients and her recognition of the need for family care.

Soon afterwards Cicely came to stay with my family in Boston, USA. She spoke of her regret that, as a doctor, she could do little for families after bereavement and asked me to help her to create a service for bereaved people at St Christopher's Hospice. At the time I was directing the Harvard Bereavement Project, a short longitudinal study of young widows and widowers looking at risk factors at the time of bereavement which would predict who would do well and who badly. Cicely's request coincided with my wish to find a 'test bed' for the results of my researches. She had a quality of directness and a lack of dissimulation; by the time she left our home I was hooked.

Within psychiatry, an idea was gathering momentum of replacing the staff-dominated mental hospitals with therapeutic communities of staff and patients working together to find a better quality of life for the patient. It seemed to me that what Cicely Saunders was describing was a kind of therapeutic community for families invaded by cancer. I wrote down my thoughts in the form of a letter to which she replied enthusiastically, expressing her interest in the 'non-hierarchical staff structure' I had described and also 'the work [with] families both while the patient is ill and afterwards'[2].

St Christopher's Hospice opened its doors in 1967 and it has been my privilege to act as psychiatrist to the hospice ever since. While there was never any doubt who had the final say, Cicely was very open to new ideas and listened with respect to all of her staff. As a result we all felt valued and gradually learned to respect and, in the end, to love her. She wrote, 'The long pain of the family's bereavement is a part of terminal pain. They will begin to grieve their imminent parting during the patient's illness but the real letting go and approach to the new situation will rarely happen before the patient dies'[3].

Although the idea of a family service had been approved by Cicely, and encouraged from the start, the details were worked out over several years. From the outset all members of staff were encouraged to get to know the families, but it took several years before the family tree got onto the front of the case notes and all nurses, doctors and social workers could draw one. Staff members were encouraged to provide ongoing support to any bereaved family member who asked for it and to make home visits when necessary, but few relations asked for help and busy staff seldom made home visits after bereavement.

It took the suicide of the widow of one of our patients to persuade us that self-referral was not the best method of choosing patients for follow-up. At this juncture, I was able to initiate the research project that subsequently demonstrated the value of proactive intervention for high-risk bereaved people using carefully selected and trained volunteer counsellors.

Looking back it seems amazing how quickly the model of palliative care that was initiated at St Christopher's has spread across the world. The focus on cancer has been widened to include HIV and other life-threatening illnesses; indeed, an entire science of palliative medicine has come into being with university chairs and huge tomes, such as the *Oxford Textbook of Palliative Medicine*[4], encapsulating a growing literature on every aspect of symptom control and other treatments.