Editorial

Marilyn Relf

Much is written in the literature about the importance of social networks and social support in sustaining resilience. Recent literature reviews and policy documents emphasise that the majority of people will cope with bereavement with the help of family and friends. This issue of *Bereavement Care* includes a number of thought-provoking papers that explore the relationship between social support and identity, how communities can be enabled to become more supportive, and the role of bereavement services when support is absent, or limited by stigma and cultural difference. These papers provide a timely reminder that we must beware of trite assumptions about the availability or quality of social support.

Ferrera-Pena, providing bereavement counselling in a prison, describes how family support and helpful social networks are generally absent in her clients' life experiences. Difficulties in forming relationships and trusting others, combined with a lack of privacy and the macho prison culture, makes counselling challenging and difficult to evaluate. Ferrera-Pena raises important questions about the potential friction between counselling practice and prison regimes, especially if the emphasis is on punishment and if prisoners are viewed as 'undeserving' of attention because they are 'criminals'.

In her work with bereaved asylum-seekers and refugees, Douglas meets many people who have come from countries with an 'interdependent' culture where family and the wider social group provide the main frame of reference. Many of the individuals Douglas supports have not only lost family members, often in traumatic circumstances; they have also lost a fundamental sense of themselves framed by their community, beliefs and rituals. She includes a particularly helpful section on how to work with interpreters, who may themselves become affected by the bereaved person's story.

Perreault, Fitton and McGovern have undertaken an important study examining the bereavement experiences of HIV-infected and HIV-affected people in an AIDS-impacted community in Ontario, Canada. For many people in the study, their sense of identity and belonging was strongly linked to being part of a community. The authors movingly describe the impact of multiple losses within these 'communities of meaning', where bereavements averaged at 174 per respondent, often spanning many years. Their loss of the 'life that was supposed to be' is echoed by Doka in his paper on the multiple losses and grief of people with dementia and their carers. The profound loss of the person while they are still alive is

difficult to express and the surviving person's grief may be 'disenfranchised' or not supported by social mechanisms. Doka includes helpful tips on how to support bereaved people who have dementia themselves, as well as how to support caregivers so that they do not feel so alone.

Bereaved people in the UK often describe how they are expected to grieve in private rather than express their grief in public. Over the last decade, however, roadside memorials have become increasingly common. These 'shrines' serve to make private grief very visible, while also warning others of the dangers of the road. Two articles in this issue address the topic. MacConville, reporting on her own and others' researches, describes the importance of these memorials to bereaved people and the responses of officialdom, in the form of local authorities and police. Sanders further explores this theme in this issue's Webwatch column.

Both articles emphasise how roadside memorials are felt by the bereaved to provide a continuing connection with the dead – a place where they feel much closer to the deceased than they do in a more conventional memorial setting. We must recognise the importance of this need to return to, create and maintain reflective spaces and offer them for people to use in their own way to remember and communicate with their loved ones.

Kellehear and Fook's paper challenges us to look beyond an approach that is focused purely on service provision. They argue that the field of public health offers models that we can use to develop the capacity of our communities to engage with dying, death and grief. They work from the premise that grief enters most facets of life – we all know what it is to lose – and challenge us to examine our assumptions that there are differences between bereaved and non-bereaved people.

They suggest that we adopt techniques, such as critical reflection, to improve awareness of bereavement and grief reactions, but we must not forget the powerful impact of grief on the individual and those who wish to help. Shear, in her paper, reminds us of the depth of some people's distress, and the great difficulty they can experience in progressing through the natural healing process. She outlines a valuable, and well-explained attachment theory perspective on complicated grief and describes a treatment combining a number of different therapeutic approaches. Some 10–20% of bereaved people will experience protracted and complex grief and research-validated descriptions of helpful interventions, such as that described by Shear, are much needed. We need more! ◼