# Abstracts

**Denise Brady**
Librarian
St Christopher's Hospice, London

## Therapists' views of the relative benefits and pitfalls of group work and one-to-one counselling for bereavement

Vlasto C (2010). *Counselling and Psychotherapy Research* 10(1) 60–66

This paper was written by a counsellor working in primary care in Scotland. Much of his work involves bereavement counselling and he decided to conduct this study as he noticed that some people responded well to a group whereas others detested the very idea of attending one.

The study asked nine counsellors with extensive experience of working with bereaved people for their views on the merits and drawbacks of group work versus one-to-one counselling. This was done in a single interview, either face-to-face or on the phone. The results were analysed using a grounded theory approach.

The results provide an interesting array of opinions. The advantages of group work were thought to be social support, social skills practice, challenge of witnessing difference, generating a culture of honest sharing, and normalisation of grief. The disadvantages were considered to be non-disclosure of feelings and information, 'competition' and over-exposure.

The overall conclusion seemed to be that people need a one-to-one session before joining a group and that one-to-one sessions are more appropriate when someone is in deep grief. As one interviewee commented: 'In extreme grief you just feel ... that you can't reach out, but equally people are afraid to reach in.' Group sessions were felt to be more useful when people are beginning to re-engage with the outside world, perhaps some time after bereavement.

This article offers some helpful insights on the appropriate configuration of bereavement services. However, the author acknowledges that its findings cannot be safely generalised: the counsellors had all trained in different therapeutic approaches (although they shared a person-centred component) and were not providing the same levels of service.

## A meta-analysis of interventions for bereaved children and adolescents

Rosner R, Kruse J, Hagl M (2010). *Death Studies* 34(2) 99–136

At first glance, you might think that a detailed study such as this would yield more precise results than the one by Vlasto (also on this page). It involved a detailed literature search as well as a quantitative analysis of the findings of 27 carefully selected controlled and uncontrolled studies of interventions for bereaved children.

However, even given the complex statistical analysis performed by the authors and the fact it is a meta-analysis, the findings cannot be generalised, although they can suggest some directions for bereavement practice.

It is a robust piece of work and makes a constructive attempt to gather together similar research in one article. The authors also provide an extensive discussion of their findings and compare them with contrasting results from other, seemingly similar, meta-analyses. Nevertheless it also illustrates how extraordinarily difficult it is to compare findings from different trials. Although meta-analyses are regarded as the gold standard for evidence-based research, they can still leave many questions about effectiveness unanswered. How can you compare studies of bereaved young people in which the participants range in number from 230 down to five; where they are of different ages, have different relationships to the deceased person, and use different types of interventions and in different settings? The authors also acknowledge that the quality of the research in these 27 studies varies, and that they have had to estimate effect sizes in some cases.

Nevertheless the authors do come up with some positive findings. In general, the results of these 27 studies point to a small to moderate positive treatment effect from the various interventions. The two most successful studies are both music therapy interventions. A study of trauma/grief-focused school-based brief psychotherapy also showed a large positive effect. However, many of the interventions were not clearly described.

The authors conclude with an interesting comment that they only begin to explore: that you need different outcome measures if your aim is to offer specifically support and comfort, rather than psychotherapy (the latter being for young people with significant stress that could lead to developing clinical symptoms).

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rBER Issue 29_3 TEXT.indd 44 02/12/2010 08:22:00

## Viewing the body after bereavement due to a traumatic death: qualitative study in the UK

Chapple A, Ziebland S (2010). *British Medical Journal* 340 c2032. http://www.bmj.com/cgi/reprint/340/apr30_2/c2032 (accessed 8 August 2010)

The purpose of this qualitative research was to explore bereaved relatives' views about seeing the body of their loved one after death. A total of 80 people were interviewed who had lost a loved one to suicide or other violent death (eg. murder or traffic accident).

The interviewers recruited people via GP surgeries, support groups, a coroner's office and other means. Almost half had been bereaved in the previous four months and almost a quarter had been bereaved more than 19 years ago. Most participants were interviewed in their own homes.

Half (49) had chosen to identify or view the body. Of these, 35 felt they were right to have done this, nine had mixed feelings, two regretted it and three did not comment. Eleven people had not been given an opportunity to view the body.

Many people wanted to see the body to check that there had been no mistake, to care for their loved one's body and to say goodbye. People felt that viewing the body made them accept the reality of the death. A few people had regrets about seeing the body, but this was the exception rather than the norm. Many had to look at very maimed bodies or parts of bodies, and coped with this. Indeed, people seemed to find it more upsetting that the undertakers had (say) given the dead person a different hairstyle.

The findings have implications for anyone involved in helping people to decide whether to view a body or not. Professionals can help bereaved people to make this decision by explaining to them what they can expect to see and giving them time to think about it.

This study is also relevant to those involved in mortuary work or the funeral industry who have responsibility for looking after dead bodies and for dealing with bereaved relatives.

## Hospice disease types which indicate a greater need for bereavement counselling

Jones BW (2010). *American Journal of Hospice and Palliative Medicine* 27(3) 187–190

This article reports findings of a two-year study of the bereavement support needs of people whose loved one died in a hospice. Its aim was to see if the levels of support needed varied depending on the cause of death.

Aside from the research findings, the article is interesting because it describes the minimum bereavement service required of a hospice by the US social insurance company Medicare. Medicare will pay for a 13-month bereavement support package. It includes a letter from a bereavement co-ordinator within two weeks of the death; a phone call from the hospice bereavement department between one and six weeks after the death; a home visit or a grief manual by post; a further follow-up call after three months; a grief support mailing six to nine months post-bereavement, and an invitation to a memorial service a year after the bereavement.

The research is about the people who took up additional services to the above – extra phone calls or visits, referral to another provider (the purpose of this is not explained) or participation in a monthly grief support group facilitated by the hospice bereavement co-ordinator. Of those in the study who requested these additional services, some received many phone calls and others had one-to-one counselling with the hospice bereavement department.

Frustratingly, the numbers who used this enhanced service are not reported. Nor is it clear whether all hospices provide this extended service.

The deaths with the highest requests for bereavement services were those where the person died of lung cancer, Alzheimer's disease or renal failure. The authors go on to offer a number of possible explanations for the high level of requests for additional bereavement services in relation to these deaths.

This is an interesting way to examine the needs of bereaved people, but this study does not provide enough sufficiently robust data from which to draw conclusions. If it had been conducted over three, rather than two years, a more consistent pattern might have emerged, and the authors acknowledge this. More detailed research into this topic is essential before acting on these findings. ■

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