Abstracts

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Death acceptance through ritual

Reeves NC (2011). *Death Studies* 35(5) 408–419

This paper reports the author's research into the use of ritual as a psychotherapeutic tool in work with bereaved people.

The meaning of ritual in this context is clearly defined, and its use within the overall therapeutic relationship. Reeves describes three phases of a ritual that involve a metaphoric 'journey across the threshold', and provides some interesting case studies. The longest is that of a woman who suffered a brain injury as well as bereavement following a car accident, in which the interlacing of the physical and emotional effects of the accident is described.

Reeves also discusses why ritual may not be helpful, and provides an example of a baby who died of a congenital disability. The parents had grieved from the birth of the baby and regarded the funeral as the time when they would have permission to 'move on'. They were confused and upset when the pastor declared they were just 'starting their grieving process'. This serves to illustrate the need to ensure the ritual is suited to the particular circumstances of the individuals concerned.

Key elements of psychotherapeutic ritual identified from the research are careful preparation, awareness of the importance of symbols, participation, inclusion of others and acknowledgement of the interplay between the past, present and future.

Ritual needs to be considered with great care but its effects, as described in this article, can be far-reaching and positive. ■

Parenting after the death of a spouse

Glazer HR, Clark MD, Thomas R, Haxton H (2010). *American Journal of Hospice and Palliative Care* 27(8) 532–536

The researchers in this US study considered the specific needs of bereaved spouses to help them in their parenting role following the death of a partner. The article explores the themes arising from interviews conducted with six bereaved parents after the death of their partner.

The interviewees comprised two men and four women and represent a very specific group: all described their faith as Catholic and all attended church regularly; all had either recently attended a grief support group or were currently doing so.

The paper identifies five themes emerging from the interviews: grief related to the loss of their partner; changes in their parenting style since bereavement (this mainly occurred after the death, even if they had been the main carer for some time before that); taking on the role of the other partner; support from family and friends, and involvement in support groups and their positive effect.

This is an article that could usefully be given to bereaved parents as it is written very clearly and simply, and contains many quotes from the interviewees on each theme. Any bereaved parent is bound to identify with some of them. ■

Development and implementation of a bereavement follow-up intervention for grieving fathers: an action research

Aho AL, Astedt-Kurki P, Tarkka MT, Kaunonen M (2011). *Journal of Clinical Nursing* 20(3–4) 408–419

This is an account of the planning of an intervention for grieving fathers – primarily those whose child died between the ages of 22 weeks gestation to three years old. The focus is on action research, the first author having considerable knowledge of this model.

These authors had already conducted research on grieving fathers and ascertained a need for more social support. This formed the rationale for the development of the intervention, and they followed this up with a literature review to identify material on the experiences of grieving fathers and interventions that have been tested with grieving fathers/families when a baby dies.

They also emphasise that evidence to inform the development of an intervention/service should draw not just on theory and research but on clinical experience and expert advice (in this case mainly peer support – that is, other parents who have lost a child).

The paper reports their work in three areas: a survey of existing support services for bereaved families in 25 hospital departments in nine hospitals that are likely to be involved with bereaved fathers/parents; a study of the views of grieving parents on their perceived needs for social support, and the views of health care professionals involved in their care; and their activities to ensure the managers of the relevant hospital units as well as individual staff in those departments are committed to supporting the intervention, and that they are making direct links with local peer support groups.

The final aspect of the intervention for fathers is the provision of an information pack tailored to their individual family situation, given to them before leaving the hospital after their child has

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died; the offer to be put in contact with a peer from a local support group who has also experienced child bereavement, and the opportunity to have a follow-up visit from a nurse on the ward where their child died. In particular, the intervention takes into account the fact that men may grieve differently, and grieving fathers may have particular issues that are best discussed with another bereaved father. The intervention also recognises that fathers are not always included by staff in follow-up work after the death of their child, as mothers are – and so need to be explicitly offered a time to do this.

This is a description of painstaking but rewarding work. The intervention described in this paper would make a good template for consideration by any health professional when developing a bereavement service for a specified group of bereaved people, especially in a hospital setting. ■

Meeting the demand for evidence-based practice

Cooper M (2011). *Therapy Today* 22(4) 10–16

This article can be regarded as controversial, and even tongue-in-cheek in places. The author begins by stating his preference for qualitative research. He goes on to argue that many counsellors and psychotherapists mistrust randomised controlled trials (RCTs), for both methodological and ethical reasons. Yet RCTs are regarded as the gold standard in health research because of their 'perceived ability to demonstrate, in an unbiased manner, the effectiveness of a treatment'. Guideline groups such as NICE (the National Institute for Health and Clinical Excellence) in the UK regard RCTs as best evidence; more RCTs have been conducted on cognitive behavioural therapy (CBT) interventions than on any other kind of psychotherapeutic approach. It is this, Cooper argues, that explains why they are recommended as a treatment of choice in the NHS.

However, the author points out that most counsellors and psychotherapists do not use CBT techniques – they use a person-centred approach, for which the evidence base is weak if the RCT is seen as the gold standard.

So Cooper's concern is how the counselling community can ensure person-centred counselling and psychotherapy is similarly valued in the NHS. If it is not, he argues, pragmatically from the point of view of counsellors, jobs could be at risk. He makes seven suggestions as to how to ensure this kind of work is valued. At one extreme, he suggests that practitioners could simply trust that policymakers will come to see the value of non-RCT research. At the other extreme, he suggests that it is essential to develop skills and knowledge in conducting RCTs. Somewhere in the middle is 'Hope that someone else will develop the RCT evidence base for counselling and other non-CBT therapies'. This is obviously not going to happen.

Cooper's other suggestions include encouraging counsellors to get involved in the debate and in research by, for example, challenging the value of RCT evidence, by drawing on the experiences of clients, and by developing equally rigorous non-RCT methods of research.

Whatever one thinks of his views, the real purpose of the article is both to encourage counsellors to engage in thinking about and critiquing research and to consider writing about and conducting it. Letters in the following issue of the journal confirm interest in the subject, which is also of relevance to those engaged in bereavement support and counselling. ■

Strengthening grief support for children with developmental disabilities

Sormanti M, Ballan Michelle S (2011). *School Psychology International* 32 179–193

There has been a growing recognition of the needs of adults with learning difficulties (or developmental disabilities, as they are termed in the US) following bereavement, and this is reflected in an emerging literature over the last 30 years.

However, these authors found very little published on the needs of bereaved children with learning difficulties. In this article they synthesise the literature on bereaved adults with learning difficulties with that on bereaved children generally.

From this literature and from their own clinical practice, they make a number of important points. They emphasise the range of losses experienced by many of these children – for example, they often have associated medical conditions that can cause change and disruption in their lives; their grief is often disenfranchised; complicated grief is not easily recognised and challenging behaviour may not be understood as a symptom of bereavement. These issues are discussed and examples are given of some of the debates, such as how best to deal with death in this population. For example, they cite two studies: one that identified increased anxiety in bereaved children attending funeral rituals, and another that suggests this does not mean it is inadvisable for children with learning disabilities to attend funerals and emphasises the importance of explaining to them what is happening.

The article lists the main difficulties experienced by bereaved children with learning difficulties. These are: understanding death and dying; understanding the cause of death; managing the emotional impact of grief; managing internalisation of grief, and maintaining social connections and support. For this last challenge one suggestion is to provide psycho-education about loss and grief to peers of the bereaved child, to help them understand the importance of their friendship, sensitivity and understanding at this time. This would be very relevant in mainstream schools where pupils with learning disabilities are integrated with children of all abilities.

This is an article that would be of interest to anyone who has contact with bereaved children with learning disabilities, whether family, friend, teacher or health professional. ■