Psychiatric Bulletin (1993), **17**, 25–26

Training matters

A bereavement counselling course: training for a multidisciplinary group of mental health professionals

GIANETTA RANDS, Senior Registrar; and FIONNUALA MCKIERNAN, Chartered Clinical Psychologist, The Maudsley Hospital, Denmark Hill, London SE5 8AZ

For some time it has been recognised that death and non-death loss events are commonly associated with the onset of psychiatric illnesses, especially affective conditions (e.g. Murphy, 1982). Studies have shown that counselling targeted at high risk grievers can significantly reduce their psychological and psychosomatic manifestations of grief, with an associated reduction in the use of statutory services (Raphael, 1977; Parkes, 1980). Bereavement counselling thus offers one of the few opportunities to implement preventive psychiatry.

The elderly in particular are subject to a wide range of loss experiences such as loss of the spouse, friends, job, home, mental and/or physical health, family, status, and so on. Many witness their loved ones becoming ill. Dementia, for instance, has been described as a living death – the sufferer is alive but the previous personality lost; carers often need to grieve this loss. A 'loss model' has many applications and can be helpful in providing a framework for understanding overwhelming emotions, cognitions, and behaviours which may otherwise seem irrational.

Given the impact of loss events, and the possibility of effective treatment, it is perhaps surprising that there are so few opportunities within the National Health Service for training staff in bereavement counselling skills. Instead, training in this country is left mainly to voluntary organisations such as Cruse – Bereavement Care, The Stillbirth and Neonatal Death Society (SANDS), and The Compassionate Friends, who encourage both professional and lay people to join their training courses.

As a psychiatrist also trained as a CRUSE bereavement counsellor, and a Chartered Clinical Psychologist with a research interest in grief processes, we surmised that we had a sufficient range of skills and experiences to draw on when approached by colleagues from our multidisciplinary team to organise a bereavement counselling course. This is an account of our course structure, its development, and our reflections on the course.

The course structure

The course consisted of eight sessions, each lasting two hours, with a five to ten minute tea-break approximately mid-session. It was initially open to staff from all disciplines, but closed after three sessions. The course was attended by one doctor, three social workers, one occupational therapist, two psychologists, and one nurse.

The first half of each session covered a range of theoretical topics including descriptions of grief models and processes of grief, losses through the life cycle, atypical grief reactions, risk factors and determinants of outcome, and therapeutic interventions. Topics not covered included spiritual aspects of grief, and the variety of cultural mourning rituals. The teaching materials were mainly handouts, although videos were used for two sessions and key reference papers given for 'homework'. Group discussion was encouraged. We aimed to draw on reference material from a wide range of sources including multidisciplinary papers and textbooks, novels, and even magazine articles and films, many of which were included in our reference list. (Available on request from authors.)

The emphasis in the second half of each session was on experiential learning. Individual reflections on attitudes to death, work in pairs on personal loss experiences, role play (least popular!), and small and large group discussions were used. Key features of assessment and counselling processes were highlighted, as were concerns about being a bereavement counsellor.

The course development and feedback

In the first session we used a 'Gives and Gets' format; individual participants were asked what they had to offer the course and what they hoped to get from it. This, together with the weekly feedbacks instituted after the second session, helped us integrate our agenda with those of our participants. In the final

session a 'Gots and Gaves' task enabled us and the participants to review and reflect on the course.

The mean weekly attendance was 7 out of 8 participants (range 5 to 8), and the mean return rate of feedback forms 80% (range 50–100%). Generally, feedback was positive; at first handouts and academic information were valued more than group discussions and experiential exercises, but as the course progressed this pattern was reversed. A consistent comment was the need for more time, particularly for experiential tasks.

An overall feedback form, circulated two months after the end of the course, revealed that course attenders valued the academic information and reference material, and that most of them felt that their clinical confidence, knowledge, and understanding of grief processes had improved. Sixty per cent felt that they had benefited personally from the course. The limited time available remained a memorable feature. Advice was offered about re-structuring the course on a regular half-day or full-day basis, and the possibility of future supervision.

Reviewing emergent agendas

From the confidential feedback and the group discussions it became evident as the course developed that several agendas were entwined.

(a) *Theoretical knowledge of bereavement and counselling*

We started with the assumption that our course participants were experienced professionals with a wide variety of psychiatric, psychological, and counselling skills. We also assumed that they would all have some personal experience of loss. Our agenda was to highlight relevant previously learned skills, to impart the basic theoretical knowledge about bereavement and counselling, and to provide a "bag of tools" to facilitate work with grieving people.

(b) *Personal development*

Several participants had recent death and non-death losses. Rather than denying these, the opportunity to integrate theoretical knowledge of loss reactions with personal experiences was valued. We were concerned about the possibility of precipitating psychological pain, but the feedback indicated that this opportunity for reflection was helpful.

(c) *Space to share work experiences*

Many participants had grievances about the ways that stressful work experiences, particularly violent incidents and suicides, were usually managed. Space to share, compare, and understand these grievances was valued. The opportunity was taken to review alternative ways of dealing with work crises, including debriefing procedures (Wright, 1991; Raphael *et al*, 1991). Although this is not straightforward bereavement, there are similarities between staff stress reactions and grief processes, and theoretical knowledge can be helpful.

Conclusion

This course became a greater entity than either of us had envisaged. This seemed to underline the importance of understanding human reactions to loss and the need for developing relevant counselling skills. We would suggest that courses such as this should become commonplace in the training of all health care professionals.

Acknowledgement

We are grateful to Christine Kalus, Chartered Clinical Psychologist, for advice, information, and supervision with this course.

References

MURPHY, E. (1982) Social origins of depression in old age. *British Journal of Psychiatry*, **141**, 135–142.

PARKES, C. M. (1980) Bereavement counselling: does it work? *British Medical Journal*, **281**, 3–6.

RAPHAEL, B. (1977) Preventative intervention with the recently bereaved. *Archives of General Psychiatry*, **34**, 1450–1454.

—, MELDRUM, L. & O'TOOLE B. (1991) Rescuers' psychological response to disasters. *British Medical Journal*, **303**, 1346–1347.

WRIGHT, B. (1991) *Sudden Death: Intervention Skills for the Caring Professions*. Edinburgh: Churchill Livingstone.