

GriefMatters

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Natalie Coish BA (Double Hons) (English & Cin St),
DipProfWrtg&Edit, CertIVTAE
Australian Centre for Grief and Bereavement, VIC

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Australian Centre for Grief and Bereavement
253 Wellington Road
Mulgrave VIC 3170
Freecall 1800 642 066
Telephone: +61 3 9265 2100
Facsimile: +61 3 9265 2150
Email: griefmatters@grief.org.au
Website: www.grief.org.au
ABN 22 038 903 478
ACN 159 297 444

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EYE TO EYE GRAPHIC DESIGN

Phone: +61 3 9753 3010
Email: design@eyetoeye.com.au
Website: www.eyetoeye.com.au

Editorial



Neil Thompson

PhD, DLitt

Independent writer and
online tutor
Wrexham, Wales,
United Kingdom.

Email
neil@avenuediasolutions.
com

In this important special issue, three papers reflecting the value of social work in a hospital setting are featured. Each one brings useful insights into the complex issues associated with death, grief and bereavement that helping professionals face.

Helen Stewart and Robyn Clark make the important point that social workers can provide a degree of safety and containment not only for patients and their families, but also for colleagues. This reflects the holistic basis of social work, trying to look at situations in their entirety, rather than focusing on just one aspect.

They also highlight the social worker's role in "bearing witness" at the time of a death. This connects well with the "fellow traveller" model discussed by Holloway and Moss (2010) in their work on spirituality in social work. There are times when social workers are called upon to do things, to fix what is not working, to make things happen. But there are also times when the social worker just needs to be there, to listen to be "present" and to care.

This paper is intelligent, well written, well informed and highly sensitive, providing a glimpse of what social work can achieve at its best.

Vivienne Bateman's paper is also an important contribution. She discusses the role of the social worker in ethical decision making in end-of-life care situations. This illustrates nicely some of the tensions involved and rightly highlights the importance of family members being listened to. Bateman goes on to deftly explain how social work theory and values are well suited to wrestling with the complex issues involved. Where psychological and sociological issues combine to create pressures for individuals, families and groups, that is where social work has much to offer – hence the common characterisation of social work as a "psychosocial" enterprise.

Bateman also provides a helpful discussion of how social work fits into a broader interdisciplinary picture – an important consideration for patients and their families who need to be working with a unified team and not a set of disparate individuals. While at times the activities of other professionals may overlap with the social work role, it is the distinctive training, knowledge base, values and approach that enable social workers to offer valuable input in their own right. When we add the advocacy and championing role into the mix we can begin to understand the empowering role that social workers are able to play.

The third paper, by Marnie Sather, offers a theoretical perspective on suicide rooted in narrative therapy. We live our lives through stories, and so a narrative approach has the potential to cast a lot of light on important issues. Suicide understandably leaves people searching for meaning, asking the big question of "why?". The aim of narrative practice is to help to co-author more empowering narratives and empowerment is, of course, at the heart of social work.

Put together, these three papers and you have a clear and helpful picture of how social work can make a positive contribution to the challenges associated with death, dying and bereavement. They make interesting and insightful reading and should be of value to not only social work professionals, but to all of us involved in rising to those challenges.

Note

Neil Thompson is a writer and online tutor who has been involved in social work in the UK for almost 40 years. His books include *Grief and its Challenges* (Palgrave Macmillan, 2012) and *People Skills* (4th ed., Palgrave Macmillan, 2015). He runs the Avenue Professional Development Programme, an online learning community for human services professionals. His website and blog are at www.neilthompson.info

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Vivienne L. Bateman

BSW

Social Worker
Kew, Victoria
Australia

Email
viv.bateman@bigpond.com

Ethical Decision Maker or “Champion” of the Dying and Bereaved? The Contribution of the Hospital Social Worker to End-of-Life and Bereavement Care

Abstract

This article explores end-of-life and bereavement care from the unique perspective of hospital social workers.¹ It identifies key theoretical and ethical concepts that underpin social work and describes how these foundational concepts have influenced the core values, skills and knowledge base of the profession. Attention is given to the impact of patients' deaths on families, the ethical complexities relating to end-of-life decision-making, and the importance of best practice bereavement care within the hospital setting. The influence of the social worker on ethical decision making is explored, together with the constraints and challenges associated with hospitals' organisational hierarchies and interdisciplinary treating teams. Consideration is given to the affects this work may have on social workers including the stress related to conflict around ethical end-of-life decision-making. Emphasis is given to the need for hospitals to adopt a structural and systemic approach to staff support following the death of a patient, and strategies aimed at enhancing a supportive organisational culture are identified.

Ethical Decision Making and End-of-Life Care: What Contribution Does the Hospital Social Worker Make?

The ethics involved with end-of-life decision-making are the subject of much contemporary discourse. Discussions about the dilemmas associated with curative or “comfort” care at the end of life are regular media events, sometimes involving wide-ranging and volatile debate. Yet nowhere are these discussions more immediate, confronting and complex than in the hospital environment. It goes without saying that when a death is about to occur, the dying patient, their family members, and medical and allied health staff are all affected by the circumstances confronting them – the patient and family most of all. Medical social workers, depending on the ward or department in which they work, can find themselves having to deal with complex ethical dilemmas involving dying patients, their families and the views of other hospital staff on a regular basis. What influence does the social worker have in ensuring the patient and their family's “voice” is heard in this context? What challenges does the social worker face? What effect might this work have on the hospital social worker? And what can the social worker do to enhance bereavement care? This article seeks, albeit briefly, to answer these questions and to contribute to ongoing discussion.

“It Can Be Hard to Be Heard”: Death in the Hospital Setting and Its Impact on Families Should end-of-life care be focused on cure or comfort?

In a feature article in Melbourne's *The Age* newspaper, Orford (2015) wrote about the difficulties he recently experienced “navigating the end-of-life landscape” as

his elderly, frail father was dying in an unnamed, presumably Victorian, acute hospital. Orford writes about how he and his family had to “fight” what he describes as being “the ‘passive resistance’ to providing care focused on a comfortable death, rather than care focused on cure.” Orford describes how, over a period of a week, he had tried, on a number of occasions, to explain to his father's doctors that he and the rest of the family did not want their father to be resuscitated or to receive care that would prolong his life. Orford states:

It is not easy to say these things about someone you love, and when we did, we were told he would get full resuscitation, that the doctors involved in his care were not available to talk to us about treatment limitations until the next day, or the day after that. We were not heard. (p. 18) Throughout the article, Orford continually repeats or alludes to the fact that he and his family were not listened to by the medical staff. He describes the family's increasing levels of distress associated with this inattentive and dismissive response. He writes:

I have learnt that good end-of-life care is worth fighting for. After a week of anxiety, we flashed briefly into anger and frustration, and then, in desperation, we pushed back. I ... identified myself in my professional role. (p. 18)

Readers are then surprised to read that the author is Associate Professor Neil Orford, Clinician and Director of Intensive Care at University Hospital Geelong and Director of Critical Care Services at St John of God Hospital Geelong. Orford continues:

By the end of the day, the doctors involved in his care had spoken to me, understood our concerns, and agreed to our requests for care that concentrated on comfort. (p. 18)

It is worth pondering this circumstance for a moment. What does this brief account tell us about whose views are listened to when it comes to end-of-life care?

Turning off life support

As we all know, hospital patients, in their dying moments, are usually helpless. Their families too, feel helpless and are often very vulnerable. Not only is the family facing the impending death of someone close, they are confronted with a hospital environment that is unfamiliar, even foreign; controlled; composed of strange noises, smells, sights, equipment and people; and the ubiquitous sense of illness, injury, suffering and death. Confronted with these realities, it is understandable that family members experience rising levels of stress, anxiety, fear and confusion. If a patient is on life support in the Intensive Care Unit (ICU),

more often than not, family members are required to make decisions about how their loved one's life will end in this highly charged environment – decisions that are among the hardest any person can make.

Indeed, when they retrospectively reflect on the period leading up to and making the decision to turn off life support, bereaved family members invariably say: *"I felt like I was playing God"* and *"It was the hardest decision I have ever had to make"*. They are left with feelings of guilt, and wondering if they made the right decision. As these two parents testify:

We rode the roller coaster where they would say [our son] was going to make it and then no, he wasn't going to make it. I watched my child die. I gave the nod to turn off his life support. That is a trauma in itself.

My head told me that giving permission to withdraw treatment was the best thing for [my daughter] but my heart tells me it wasn't the right thing for me. I wanted my daughter in any condition. Understanding and accepting this selfishness has been very hard. (Bateman, 2000, p. 26)

The Social Work Profession

Ethical and theoretical base

Deaths that occur in hospitals may be the result of chronic, life-limiting or terminal illness and are expected and inevitable. Other deaths may be the result of a sudden, catastrophic illness or traumatic injury and are therefore sudden and unexpected. Regardless of the circumstances, the provision of quality end-of-life care – for patient *and* family – is a crucial aspect of responsive and humane healthcare systems. Yet ethical dilemmas regarding end-of-life decisions often "muddy the waters". How do hospital social workers make sense out of these dilemmas? What does the social work profession bring to the discussions that take place in these situations? And what is unique about the social work perspective?

Social work's code of ethics and theoretical base are the two foundational elements upon which the core concepts of the profession are based. These two elements (i.e. ethics and theory) inform what Scott (2011) terms "the social work 'trinity' – values, knowledge and skills" (p. 3). The Australian Association of Social Workers' (AASW) code of ethics:

proposes a systemic and reflective decision making process to resolve dilemmas when ethical values conflict ... ethics is the core business in social work, as are the values that underpin them. (Woolard, 2011, p. 3)

According to Swain (2009), "Ethical decision-making requires critical thinking, drawing upon knowledge theories, practice experiences and values" (p. 57).

Furthermore, as Gray & Webb (2009) maintain, social work is much more than a pragmatic endeavour; it is an intellectual activity, based on theoretical conceptualisations that attempt "to make sense of

human situations" (p. 3). Social work is endowed with a rich history and an ever-increasing body of sociological, psychological and philosophical theoretical perspectives, which underpin all aspects of the profession's knowledge base and practice. Yet most social work practitioners would agree that the overarching theoretical framework that best informs social work practice is that which is derived from "ecological systems theory" (e.g. Compton & Galaway, 1989, p. 123), which emphasises the person-in-situation/environment approach. Indeed, as Scott (2011) states: "the recognition of the dynamic interaction of factors within both the person and their social environment remains the conceptual hallmark of social work" (p. 6). In addition, social work's ethics-based approach addresses ethical dilemmas according to the principles of social justice, social inclusion, respect for human dignity, the individual and their right to self-determination, self-efficacy and autonomy.

As stated in the AASW Code of Ethics (AASW, 2010), "In all contexts, social workers maintain a dual focus on both assisting human functioning and identifying the system issues that create inequity and injustice" (p. 9). These fundamentals are the cornerstone of the profession's ethical frameworks, and encapsulate the context in which social workers practice. Moreover, because of their utilisation of knowledge derived from research findings, together with their familiarity with exploring the appropriateness of various theoretical perspectives, *and* linking both of them with practice, social workers who respond to dying, death and bereavement are well-equipped to reflect upon ethical dilemmas. They are also able to articulate and incorporate various grief and bereavement theoretical paradigms, including those articulated by authors such as Neimeyer, Rando, Klass, Bonanno, Raphael, Walter, Stroebe and Schut, and others. Furthermore, because of the various domains in which social work is practised, its practitioners are uniquely adept at dealing with the psychosocial consequences associated with the complexity, diversity, ambiguity, risk and uncertainty inherent in the hospital and community setting. Indeed, these are social work's "terrain" (Fook, Ryan, & Hawkins, 2000; Pockett, Walker, & Dave, 2010).

The Role of the Hospital Social Worker

Because of their work with injured, dying and deceased patients and their families, hospital-based social workers (particularly those who participate in an on-call roster and those who are attached to emergency departments, intensive care units and wards where patients have chronic, life-limiting illnesses) have the core skills and practice experience required to respond to patients and families facing end-of-life situations. These "front line" workers are usually embedded within well-established multidisciplinary teams with long-standing expertise in responding to crises, and being involved in end-of-life decision-making. As a result of their everyday practice, these social workers have developed the capacity to work within these intense environments and to deal with risk, ambiguity and change. As such, they have the skills and experience to support affected people's efforts to manage uncertainty and reduce anxiety.

Working with the dying and the bereaved

In relation to the dying patient and their family, the following elements have been identified as providing best-practice psychosocial support during the end-of-life process: a commitment to the development of a collaborative, trusting relationship between the patient, their family and the treating team; staff trained and skilled in the work; initiation of the family conference, and integrated family support through a full-time social work service providing 24-hour cover. Further, available evidence suggests that following the medical diagnosis that a close family member is close to death and unable to make known their own decisions, family members benefit most from being: encouraged to make autonomous, informed decisions based on what they believe the patient would want and the family's own understanding of the prognosis; prepared for the death through open, honest discussions; and provided with "consistent interpretations" (e.g. that the patient will never recover), which are shared by all involved doctors and consultants (e.g. Pockett et al., 2010, p. 262).

In the context of end-of-life care, the role of the social worker is to engage with the patient, their family and the treating team. Social workers understand that grief and trauma are not the only issues affecting the patient and family (and staff). Each individual influences the situation in one way or another, and the social worker's psychosocial assessments take into account views from the individual patient's perspective; family functioning, including strengths, resiliencies and vulnerabilities; together with the family's particular circumstances, which might include cultural differences, as well as various existential, spiritual and religious beliefs and practices. Medical social workers are used to working with well-functioning, articulate families, as well as with families with many pre-existing and/or concurrent stressors that impact upon their lives, including unemployment, family violence, family breakdown, substance abuse, poor housing, ill-health and so on. Hospital social workers are also used to interacting and collaborating with other health care workers who comprise the treatment team.

Social work, because of its person-in-situation and ethical conceptual base, is well positioned, as Pockett et al. (2010) propose, to "interpret the social and ethical context – in which decisions are made to ensure the rights and values of dying patients and their families are being respected" (p. 262). Hospital social workers have an important role to play throughout this decision-making process as "enablers" and "facilitators". Social work interventions may include mediation between family members in the event of misunderstandings and disagreements and advocacy on behalf of the patient or family unit with the treating team. These practices are "undertaken within a social justice framework in which social workers aim to ensure that inequalities are minimised through effective interventions" (Pockett et al., 2010, p. 262).

Working within an interdisciplinary setting – Some challenges

Over recent years, differing medical interventions related to end-of-life care mean that social workers,

like the families they serve, are now finding themselves facing increasingly complex treatment options and ethical dilemmas:

[Hospital] social workers working with those who are dying and those who are bereaved negotiate these complexities on a daily basis, drawing on their knowledge, ethical reasoning, critical reflection, skills, and professional judgment, often working as "context interpreters", differentiating the needs of patients and families to other members of the health care team. (Pockett et al., 2010, p. 254)

As noted above, social workers understand that they can play a critical advocacy role in ensuring the voices of the patient and family are listened to. But how difficult is it for social workers' views to be heard?

Hospitals are bureaucratic systems; medical social workers participate within multi- and interdisciplinary teams, which are often hierarchical in their structure, with doctors in a leadership position and social workers, like other allied health professionals, in a subordinate role. In hospitals, as elsewhere, there is also growing evidence to indicate a blurring of boundaries between other professions (such as nurses, psychologists, occupational therapists, counsellors and chaplains) and social work. While each of these professions have their own "discipline-specific approaches to clinical treatment based on their [own] disciplinary paradigms of care or 'operating philosophy' (Delaney, Spriggs, Fry, & Gillam, 2010, p. 473), they also "abut" social work, and sometimes breach the boundaries into the social work domain. However, while endeavouring to emulate its practices, they do so without its theoretical and ethical underpinnings and the profession's systemic approach to situations (e.g. Coyne & Ryan, 2007). In these circumstances, social work's ethical stance and value system can come into conflict with the values of these other disciplines and of doctors. For example, as long as the patient is capable of making decisions about their own health care, the social worker's role is to strive to preserve that right. In other situations, family members may wish to have palliative care initiated or to not have the patient resuscitated. Again, the social worker's ethical stance may lead him or her to advocate for the family. Doctors, on the other hand, may have other priorities, such as saving the patient's life at any cost, regardless of the outcome – doctors, too, are obliged to uphold the ethics of their profession.

Nevertheless, notwithstanding the importance and influence of medical ethics and the realities of unequal professional influence, hospital social workers owe the families with whom they work the opportunity to have their views heard. This is perhaps easier said than done. In some complex, problematic, and extraordinarily difficult situations where views are tightly held and disputed, social workers find themselves deciding between advocating for the patient and family and thereby facing criticism from other health professionals (including the doctor, specialist or consultant), or acquiescing to/with decisions that go against social work ethics and the social worker's personal integrity (Delaney et al., 2010). Whatever stance they take,

social workers probably have to accept the inevitability that doctors, not social workers, have overall authority and responsibility for making end-of-life decisions. (Delaney et al., 2010, p. 472).

Care of the bereaved

Prior to the death and in the immediate aftermath, social workers' skills and expertise in providing person-centred emotional and practical support within a trauma, grief and bereavement framework, as well as their readiness to work within interdisciplinary teams, means that they are uniquely placed to provide best-practice psychosocial care and assistance for the dying and the bereaved.

Although not termed as such, bereavement support often begins during the final "terminal" phase of the patient's life. It includes the support provided around the point of death (including that provided to extended family and friends who attend the hospital); allowing time to be spent with the body; and discussions about legal requirements, funeral arrangements, cultural considerations, spiritual beliefs and the like.

Social work is able to provide the kind of psychosocial "brace", which Gordon (1997) identifies as leading to better bereavement outcomes. As Gordon states, "what is needed is being there, comfort, support, information, advice, directions, assessing needs, practical help, listening, helping clarify experiences and sorting out emotions" (1997, p. 48). The social worker's use of a calm "self", which displays respect, empathy, compassion, warmth and genuineness has been found to assist affected people at this time. Social workers also need to be aware that certain families may present them with additional challenges, simply because of the trust that builds up between some family members and the social worker over the course of the patient's hospital admission. Some families may require more intensive and ongoing clinical work and it can be difficult for both parties to accept termination of hospital social work services and to engage with community-based bereavement support services.

Hospital-based bereavement care is crucial to the long-term adjustment of deceased patients' families. This includes those family members whose loved ones are dead on arrival at the hospital or die shortly after admission. Anecdotal and research evidence indicates that bereaved family members retrospectively emphasise the importance of best-practice psychosocial support following the death of a close family member. Regardless of the circumstances or the cause of death, memories of the hospital experience are enduring. Bereaved people, sometimes many years after, still remember aspects of the care provided, including that provided by social workers. As a neighbour of the author's recently said (some 15 years after the death of her husband):

I remember that the social worker's name was Barbara. She was very gentle and kind.

And a mother, 10 years after the death of her infant son:

The staff at the children's hospital had been very gentle and discreet. They let us spend as much time with [our son] as we wished. Yet the time came to leave him behind and to come home without him. (Bateman, 2000, p. 9)

The Impact of Dying, Death and Bereavement on Hospital Social Workers: Self-Care and Workplace Support

For any health care professional, the provision of medical and psychosocial interventions and support during the acute phase of a patient's illness and subsequent death is not easy. Witnessing the dying process of patients, together with the distress of family members, can be confronting and stressful – powerful emotional responses can be evoked. This is especially so in situations where a young child or adolescent dies (e.g. Dyregrov, Mitchell, & Hordvik, 1995); and where staff and patient and/or family have built up a relationship over weeks, months or even years.

Where ethics-focused conflict occurs, additional stresses result. As Delaney et al. (2010) point out:

... stress related to conflict in ethical decisions has been characterised as the effects of being unsure of what principles or values to apply in a given situation (moral uncertainty), of being aware of a conflict between values or principles (moral dilemma), and of believing in a right course of action but being prevented from doing this (moral distress). Reactions to these types of stresses include feeling demoralized, powerless, hopeless, frustrated, guilty and angry. (p. 477)

In the face of these and other psychological reactions, it is becoming increasingly well accepted among social work practitioners that following the death of a patient, the worker needs to undertake "self-care". "Personal" coping strategies which have been found to be useful include: maintaining one's own emotional, mental and physical wellbeing; becoming educated about the impacts of this work on professionals; and, engaging in holistic self-care that can reduce the negative impacts of stress (e.g. ensuring work-life balance; maintaining healthy nutrition, exercise and sleeping patterns; having a supportive family, social and professional network; gaining spiritual sustenance; and engaging in creative pursuits).

In contrast to this focus upon the individual's personal responsibility to reduce the impact of work-related stressors, a number of authors have pointed out that stress is a psychosocial phenomenon and not simply a psychological one, and that we need to move beyond the traditional, narrow, individualistic and psychological focus on stress, which unduly individualises (and in some instances, pathologises) the problem (e.g. Ashby, 2005; Renzenbrink, 2005; Thompson, 2005; Hunter, 2005). We need to also look at the systemic, structural and organisational factors that contribute to the stress inherent in, and resulting

from, this work. In terms of the needs of hospital staff following the death of a patient, the following factors appear to be related to positive outcomes: an organisational culture that is supportive; a management style that indicates an understanding of the impact of trauma and death on staff; accessible, skilled, supportive and trusted supervision that allows for the expression of thoughts, feelings and reactions within a confidential setting; monitoring of any grief, vicarious trauma or compassion fatigue experienced by workers; regular peer support meetings; a program of peer mentorship; clear communication within the team; clear policies, procedures, role descriptions and assignment of tasks; adequate resources; and opportunities for education and professional development relating to ethics, trauma, grief and bereavement and, in some instances, involvement in memorial services and other “ad hoc” rituals for staff. All of these interventions help to focus on rejuvenation, build trust within the team, and strengthen the resilience of the individual worker and the team (e.g. Ashby, 2005; Renzenbrink, 2005; Thompson 2005; Hunter, 2005; Pockett, 2006).

Being a Champion of the Bereaved

To this point, this article has focused on the challenges faced by hospital social workers who work with dying patients and their families. The question now needs to be asked – does this work offer any opportunities for the hospital social worker?

To answer this question, the words of esteemed social work academic Emeritus Professor Dorothy Scott may give us some direction. Scott maintains that the social worker’s core direct practice skills, which include “the use of self” and “the capacity for self-reflection”, mean that “we are and will always be, the instruments of our practice” (2011, p. 7). She notes:

The pioneers of social work were exemplars of the values and virtues of vocation, for social work was a vocation before it was a profession ... for many social workers work is still first and foremost a vocation [and] many of those drawn to social work still bring a deep vocational commitment ... (2011, p. 3).

Although the word “vocation” seems to no longer “fit” in this secular world, social workers need not be averse to speaking about and “personifying” vocation (Scott, 2011). Nowhere is this sense and practice of vocation more important and valued than in the context of care of the dying and the bereaved.

It is this author’s view that there is room, in every hospital, for a “champion” of dying and deceased patients and their families. There is no reason why a social worker cannot take on this role. Indeed, this writer knows of a small number of “bereavement champions”, who have been trained in social work and who have made, as their vocation, the championing of the causes of dying and bereaved people. Regardless of whether they have been heads of department or recent graduates, these workers have, “with great ‘invisible-like’ skills and often little recognition” (Joyce, 2011,

p. 24), actively advocated on behalf of the dying and the bereaved and have, as a result, helped to make meaningful and progressive changes to hospitals’ organisational climates and cultures.

Reflecting on the modus operandi of some of these “champions”, it is easy to see how they have incorporated some core social work activities into their bereavement-related repertoire. Upheld by social work’s ethical and theoretical foundations, they have provided positive role models for other staff and have all exuded a “well-developed sense of moral agency and professional identity” (Delaney et al., 2010, p. 477). Depending on their level of seniority, they have initiated, facilitated and maintained collaborative cross-disciplinary dialogue with other professional disciplines and hospital administration. This cross-fertilisation of ideas has helped to create, reinforce and raise awareness and understanding of the needs of dying patients and their families. They have attempted to articulate clear messages about best practice end-of-life and bereavement care within the hospital setting. They have built a “bereavement platform” within their hospital – a platform that utilises and straddles all areas of expertise within the organisation. They have used opportunities to have bereaved people’s voices heard (e.g. in memorial services and in hospital-auspiced literature). And, they have been aware of, and responded to, the impact of the death of patients on all hospital staff – from CEOs to cleaners.

Concluding Thoughts

Towards the beginning of this article, mention was made of *The Age* feature story in which Orford makes the statement: “I have learnt that good end-of-life care is worth fighting for”. As Orford says in his piece, it was not until he disclosed to medical staff that he was an associate professor and the Director of Intensive Care and of Critical Care Services at two large Victorian regional hospitals that his family’s repeated requests to allow their father to die “comfortably” were eventually heard by the treating doctors. Orford finishes his expose in the following way:

To provide better end-of-life care to patients and families, we need to identify them, offer support, listen, and give advice and treatment tailored to their needs. If we don’t, only those lucky enough to know the system, know someone, or stumble across a hospital that is really good at this, will we be given the choices we all deserve. (Orford, 2015, p. 18)

Hospital social workers can take up Orford’s challenge by becoming champions of the dying and of the bereaved. If this occurs, social work can continue to make a meaningful contribution to ensuring that the voices of dying patients and their families are listened to – and more importantly – heard.

Notes

¹ Also known as “medical social work”.

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The Active Witness: Social Work Care of Children and Families at the Time of Child Death



Helen Stewart

BSW, GradDipLoss&Grief
Counselling

**Acting Manager Social Work,
Aboriginal Health and Pastoral
Care Services**

Royal Children's Hospital,
Melbourne

Address

Royal Children's Hospital
50 Flemington Road
Parkville VIC 3052
Australia.

Phone

(03) 9345 6111

Fax

(03) 9345 6459

Email

Helen.Stewart@rch.org.au



Robyn Clark

BA, BSW, AMFSM

**Social Worker in Clinical
Practice Development**

Royal Children's Hospital,
Melbourne

Address

Royal Children's Hospital
50 Flemington Road
Parkville VIC 3052
Australia.

Phone

(03) 9345 6111

Fax

(03) 9345 6459

Email

Robyn.Clark@rch.org.au

Abstract

The Royal Children's Hospital, Melbourne, is a large tertiary paediatric hospital and primary paediatric trauma centre. One of the more difficult realities of this setting is that not all children survive. End-of-life and immediate bereavement care of families at the time of the death of their child is an integral part of hospital social work. The work draws on a variety of theoretical frameworks and skills, and requires nuanced, responsive reading of family cues as well as carefully crafted systemic work. The clinician listens and bears witness in the immediate aftermath of the death, intervening on multiple levels to foster connections and to facilitate the honouring and leave-taking of the child in the singular way that each family desires. This article describes the knowledge that informs acute bereavement care, and the principles that guide social work clinicians in enacting this knowledge with respect for the particularity of each family.

Unanticipated Child Deaths: Contexts and Impact

Despite the best endeavours of skilled and caring health professionals, in an acute paediatric hospital, some children die. It has been widely noted that the death of a child is one of the most significant losses that can happen in a family (Janzen, Cadell, & Westhues, 2004). A significant number of deaths are anticipated and children, families and staff have some opportunity to prepare for the inevitable. Other deaths are not anticipated and may result from a traumatic accident, nonaccidental injury, unexpected outcome of a known illness, or unexplained events such as an apparently well child collapsing and subsequently dying. When death is unexpected and traumatic the risk of prolonged grief, complicated grief, or posttraumatic stress disorder (PTSD) is increased (Janzen et al., 2004; Kaul, 2001). While all child deaths cause significant distress not only to family and friends but also to staff, the unanticipated deaths have a particular impact, and the work done to support children and families in these situations in the immediate period leading up to the death, the death itself and the time immediately postdeath is rarely described. This article explores the unique role of the hospital social worker in these highly distressing child deaths.

The Social Work Response

Hospital social work department clinicians at the Royal Children's Hospital, Melbourne (RCH), provide a 24-hour on-call service in addition to their usual work hours. This service responds to a number of crisis situations including end-of-life discussions and child deaths. All social work clinicians take part in the on-call roster. They receive training before participating and have a senior social worker available for phone back-up whenever they are on call.

Social workers are a valued and integral part of the health care team in most child death situations at the hospital. The presence of a skilled social worker brings a dimension of care not provided by any other multidisciplinary team member. Bereavement care is nuanced and sophisticated work that draws on a variety of theoretical frameworks as well as core social work skills and values. It can lay the groundwork for grieving families to make meaning from a tragic situation and, if done well, can assist in mitigating trauma (Janzen et al., 2004). The social work clinician can also provide a sense of safety and containment for the healthcare team who work initially to save the child but then, when this is not possible, to facilitate a "good death". While all health care professionals working in these situations endeavour to provide a compassionate and caring response to the child and family, it is the social worker who keeps the whole system in mind throughout the process, bearing witness to the tragedy of unfolding events and intervening on multiple levels to build and maintain connections for, and with, the child and family. The theoretical underpinning of systemic thinking so central to the social work knowledge base assists social workers in navigating this complexity.

Social work bereavement care also utilises many elements of psychological first aid and crisis intervention. However, the work cannot be easily prescribed, as it needs to be crafted according to the very specific needs of each bereaved family, reflecting that, as Silverman has observed: "There are no universal patterns for grieving or for dying and there is no fixed schedule" (2013, p. 223). Social workers are guided in their bereavement work by several principles, in particular, those of fostering connection, active witnessing and listening, following, and guiding.

Witnessing and Fostering Connection at the Time of Death

The on-call social worker is asked to come to assist with, for example, the family of a previously well 14-month-old boy who has apparently had a cardiac arrest at home. The social worker arrives to find the infant being given CPR by a fully involved resuscitation team of doctors and nurses in the Emergency Department resuscitation bay. Shocked parents and grandparents stand back, waiting for a response. After several minutes of concerted effort and no response from the monitors, the resuscitation is called off and the child pronounced dead.

How does the social worker enact the principle of fostering connection in such a tragic and alienating situation? For a time, the child seemed to belong to the medical team and his life was in their hands, now the parents have to find a way to reclaim their relationship with their precious and now deceased child. To see

the lifeless body makes the death real. To see the exhausted and now silent medical team brings home the reality even more. To hear the words confirming death is almost unbearable. For the social worker, to bear witness to this grief, to listen but not intervene in the wailing of the mother and sobbing of the grandparents, to watch and not interfere with their desperate clinging to the child, to allow the staff the humanness of their own grief at their perceived failure to revive this child, is skilled and active work. It may appear that the social worker is merely a presence in this tableau but in fact the worker is consciously listening, observing and responding to all that is going on, gently encouraging the grandmother to comfort her daughter and reconnect as her mother, facilitating staff to say their own goodbye to the child, acknowledging their efforts and reinforcing their connection to each other. The social worker supports the devastated young doctor in his explanations to the parents, assisting with reading family cues and knowing when to speak and when to simply remain present but silent. This is not passive work; it is skilled, dynamic and crucial intervention.

Active Listening, Following and Guiding Postdeath

The roles of the other members of the team change as the focus shifts once the child has died, but for the social worker, the focus was always the family. The worker has had no active part to play in the efforts to save the life of the child. The worker is there to help the family navigate this minefield of emotion and guide them towards the long journey of grief ahead, always acknowledging the particularity of their grieving.

Families have no road map for this journey. Parents and other relatives do not know how to behave, what happens next or what their choices may be. To simply ask a parent “What would you like to do now?” is meaningless in this context. Parents cannot be expected to act in a rational and thoughtful manner at this time but need guidance, a sense of holding and the opportunity to speak of their child and strengthen the connection they fear they have lost. Some parents may want to talk about the events surrounding the child’s death and the social worker needs to be able to listen to this. As the initial shock, disbelief and outpouring of grief dissipates, the social worker may quietly assist the parent to decide what to do next – move to a more intimate and private space, call other relatives or friends, or seek spiritual guidance. The social worker also pays attention to the physical needs of the parent and may organise food and drinks, blankets for the parent, somewhere comfortable to sit down – basic principles of psychological first aid. The worker follows the family’s cues and gauges their readiness for further information not only about what the doctors understand of the causes of the child’s death but also about procedures to come – coroner’s processes, police involvement, etc. In a study of suddenly bereaved parents (Harrington & Sprowl, 2012), parents spoke of their need for “timely and concrete information”. In acute paediatric social work, it is the role of the social worker to ensure this information is given in a way and at a time that the parents can hear and make sense of.

Saying Goodbye

Families have reported that they felt they were not allowed to spend enough time with their child after death (Dent, Condon, Blair, & Fleming, 1996; Smeesters, 2013). The hospital social worker aims to facilitate families spending as much or as little time as they need with their child in an appropriate environment with the people they most want to be present. This time allows parents to carry out the final rituals of parenting for their child – to wash and dress the child, hold and speak words of love and farewell, aloud or silently, to gaze at the face and body of their child for the last time, and try to make sense of the fact that their child is now dead. The social worker plays a crucial role in facilitating these rituals and helping the family to find what is meaningful for them. Worden (2009) identifies accepting the reality of the death as an important task of mourning. The process starts here – recognising the death is real and beginning to find a new way to remain connected to the child. The importance of this ongoing connection has been extensively articulated through the concept of continuing bonds (Klass, Silverman, & Nickman, 1996).

Not all families wish or are able to spend time with their deceased child. Cultural beliefs and rituals, individual family differences, responses to the trauma of the death and simple practicalities may guide these family decisions. Such wishes need to be respected and the family given permission to leave or to stay, as is fitting for them.

If the death is reportable, another layer of grief may be added as families are unable to have all tubes and medical equipment removed from their child’s body, or to wash or dress their child. The child remains entangled in the medical process that failed to save his or her life, and is not yet able to be fully reclaimed by the family. It often falls to the social worker to explain to families in clear and honest language why their child will need to go to the coroner and what the process will involve. Knowing what will happen in the immediate future and why it will happen assists families who feel no sense of control to find some connection and grounding in a world that has been upended. The social worker in this situation also works to help the family look beyond the tubes and lines, to see their child, speak their farewells and their love and reaffirm their significant role in the child’s life.

Staff take great pride in their ability to create mementoes for families when their child dies – hand and foot prints, a lock of hair, a finger or hand print for jewellery. While it is generally nursing staff who create these mementoes, it often falls to the social worker to decide when and how to talk with the family about this and gain their consent or otherwise. When families do not wish to have mementoes created it is the social worker who may explore the meaning behind the family’s wishes and then pass this on to staff to ensure these are understood and respected. When families wish to be involved in memento making, the social worker must work sensitively with staff members and the family to enable parents to be included in a respectful manner.

The time a family can spend with their deceased child is precious and lays the foundation for future memories that do not include only the horror of the death. The social worker observes what is happening and what they can see of the relationship with the child and reflects this back to the family in a powerful therapeutic intervention: "What a beautiful, strong-looking boy he is". This statement triggers a conversation about the child as a living, vibrant person. Maybe his dad is a wrestler and the child was going to follow in his father's footsteps; maybe the child loved the food his grandma prepared for him; maybe the family were proud of his size and robust appearance. In this way the relationship between the child and his family is recognised and he is brought to life for those who never knew him. The love the family felt for him is acknowledged and validated by the observations the social worker makes. The family may share photos and stories with the social worker, inviting the worker into their world. When the child is a very young infant these observations are particularly important, as the family do not have a wealth of memories to draw on and have not had time to discover their child's emerging personality. In these instances comments such as "Look at that little nose – do you think he has his dad's nose?", "You have dressed her so beautifully", or "The nurse told me how she always settled much more easily when you were in the room" reinforce the significance of the parents' relationship with this tiny baby.

This is hard and purposeful work. When it is enacted well, the family feel they have time to begin to integrate their loss, to say farewell to their child and to reconnect to the memories of their living child.

Leave Taking

Although families need time to be with their child it is also important for staff to understand that parents may need assistance with the process of leave taking. Leaving the child in the hospital for the final time is perhaps the hardest thing a parent has to do. To facilitate this leave taking the social worker may ask the family if they would like to know more about what comes next – funeral arrangements, coroner's processes, what will happen to the child's body and so forth. If they have not done so already they may start to talk about likely reactions of other children, and about how grief may feel and be expressed by those closest to the child. The social worker may explore who else needs to be told and who could tell them. They may offer information on support services and common grief and trauma responses, and discuss the immediate practicalities of how the various family members are going to get home. Often the social worker becomes an advocate for the parents with well-meaning others who wish to protect them from the overwhelming pain of returning to a house empty of the vitality of the now dead child. In short, the worker starts to prepare them for the coming hours, days and months outside the relatively safe walls of the hospital. The worker may also identify particular individuals who are most able to receive this information and may play key roles in supporting the family in coming days.

The social worker attempts to understand how the family wish to say goodbye to the child. Do some relatives need to be told gently that the couple need to have the opportunity to spend time alone with their child? Does the mother need to relinquish the child into the arms of the father for a time? Has anyone not had the opportunity to express their grief and to say their farewell? Have any children present been included, had the opportunity to ask questions and have them answered, to be present or absent as they need, to be hugged, included, played with, or fed? All family members need to be given recognition of their singular relationship to their child and the particularity of their loss.

Many families cannot bear the thought of their child being left alone and may request that someone stay with the child until the undertaker comes. Some families wish to wait until the undertaker arrives and want to see their child placed in the undertaker's vehicle. Some want to see their child placed in the mortuary. It is the social worker who attempts to understand the meaning of these requests from the family and does their best to facilitate them. At times this requires advocacy with other members of the care team. Whatever the family needs to be able to leave their child should be, if at all possible, accommodated. It is important, however, to ascertain what the parents understand of what they will see before, for instance, going to the mortuary. Social workers are not always comfortable to hold a dead body if the parents have asked for this, but words and actions can be found to make this better, for example, "Why don't you wrap your baby up snugly and put her in the cot and I will stay with her until the undertaker comes"? Alternatively, perhaps a nurse is able to hold the child while the social worker walks the family out of the hospital. However it is done, this is a crucial and incredibly painful time for the family, and the role of the social worker in making this as good as it can be is significant.

Conclusion

The role of the hospital social worker in the care of a family experiencing the unexpected death of a child is unique in the health care team and requires specialised training and skilled use of self. The social worker supports the family from the beginning through to the time they leave the hospital and beyond. The social worker is not involved in the endeavours to save the child's life and the role does not change when these efforts eventually fail. While nurses may change shifts and doctors move in and out, also tending to living patients, the social worker remains present with the family. Not only must the social worker be present with the family to guide them through this most unexpected and unwelcome of experiences, they must be constantly assessing risk. The worker must be cognisant of the tasks that families are faced with if they are to be able to go on and form a new relationship with their child, must understand trauma responses, grief reactions, cultural needs, support systems, the complexity of a hospital system, and the legal requirements around unexpected deaths. Most of all, the social worker must know how to be an active witness, fostering connections between the family and their child, different family members, parents and surviving children, family and their community, and

members of the health care team. If all this is well attended to, the family are likely to begin on their path of grieving feeling that their child's death was managed by a caring and compassionate team. Nothing can ease the immense and long lasting pain of the death of a child, but good intervention at the time of death may allow the possibility of an investment in living, while carrying the loss.

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Marnie Sather

MA (MarriageFamTherapy),
MA (NarrativeTherapy &
ComWork), MACA (Level 4)

Narrative Therapist
Ngwala Willumbong
Co-operative
St Kilda, Victoria
Australia

PhD candidate
Melbourne University

Email
marnie3@mac.com

Stories Matter: A Narrative Practice Approach to Bereavement Through Suicide

Abstract

The bereaved by suicide are rapidly catapulted into not only making sense of the death of their loved one but also dealing with the multiple social prescriptions about what can and cannot be discussed. This presents those bereaved by suicide with special problems unique to the method of death. This paper discusses a narrative practice approach to therapy that has been specifically developed to counter the effects of marginalisation and stigma attached to certain forms of life experience. The founders of narrative therapy were both social workers, committed to challenging operations of power and privilege in mental health services and psychiatry. Four modes of narrative practice are reviewed – re-membering practices, multi-storied tellings, collective narrative practices and reclaiming histories – and how they assist people who are bereaved by suicide is described.

Narrative Approach to Suicide Bereavement

Suicide is a significant public health concern. According to the World Health Organization (WHO), nearly one million people worldwide die by suicide each year (WHO, 2013). For each person who dies by suicide, many are affected. As with any death, those bereaved by suicide can be defined as any person greatly saddened¹ by the suicide death of a loved one. It is important that all people who feel the loss of a loved one have a voice and are not excluded by traditional kinship definitions.

Suicide is not a “typical” death. The bereaved must contend with the centuries-old social stigmas, taboos and fears that surround suicide. Creating contexts for the bereaved to speak free from cultural taboos is an important contribution that therapy can make. Therapy can help a person find the specific meanings the death had for them, as independent as possible from received meanings. Marsh (2010) makes clear: “Descriptive variety becomes possible when a number of terms are available within a language, and these terms can allow for apparently similar acts to be given different meanings” (p. 79).

There is an abundance of research and resources devoted to prevention of suicide. Less attention has been paid to those bereaved by suicide. The field of suicide postvention remains relatively immature in terms of the current knowledge base. The focus on research is often on the family searching for reasons behind the suicide. (Maple, Cerel, Jordan, & McKay, 2014).

Many people have written about clinical practice with people bereaved by suicide (Chapple, Zeitland, & Hawton, 2015; Neimeyer, 2000; SUGRUE, McGILLIOWAY, & Keegan, 2014). Narrative practice arose specifically

to counter discourses that marginalise and stigmatise people, thus being particularly suited to assist those who have been negatively affected by bereavement by suicide. White and Epston, the founders of narrative therapy, were both social workers and were committed to challenging operations of power and privilege in mental health services and psychiatry. White and Epston are most associated with the early writings and clinical practices related to narrative therapy. Epston brought a narrative metaphor to the field of therapy (Epston, 1986; White, 1988b). White’s interest in Foucault drew attention to the clinical importance of addressing the client’s particular sociopolitical/historical location (Foucault & Gordon, 1980).

Another feature of narrative practice that makes it particularly appropriate for people who are bereaved by suicide is that therapists include clients in identifying what they know about their problems and ways to ease them. This is called “co-research” (Epston 2014; Epston & White, 1990). In this method, narrative practitioners and their clients discover together what is and is not helpful at every step of the therapeutic process.

This paper explores the rationale and ethics of “elevating” the lived experience of people bereaved by suicide. Elevating the knowledge of those bereaved by suicide promotes a greater sense of agency and a reduction in shame. It is these very effects that seem most appropriate to grief counselling with those bereaved by suicide.

Historical Perspectives on the Meanings of Suicide Taboos and the Implications for the Bereaved

Responses to suicide and suicidal behaviours are deeply embedded in particular social, political, ethical, and historical contexts (White, 2016). The bereaved are rapidly catapulted into having to make sense of suicide while also experiencing socially prescribed censorship in the conversations available to them. The bereaved inherit a variety of degrading assumptions (e.g. suicide is “selfish”, a “violent” act, or an “easy option”) applied to their loved ones’ actions by the “cultural community”. Hjelmeland (as cited in Marsh, 2016) writes:

Suicidal behaviour always occurs and is embedded within a cultural context and no suicidal act is conducted without reference to the prevailing normative standards and attitudes of a cultural community. (p. 34)

There are diverse interpretations of suicide throughout history, from the chillingly harsh to the quite pragmatic and even honouring:

... people who attempt to end their lives, people who do end their lives, and those who are bereaved as a result, are in relationship with ideas from earlier centuries. When we consider this relationship in a western context, we are aware that very often there have been some very harsh ideas. Although some have changed over time, the past still haunts us today. (Sather & Newman, 2016, p. 117).

In past times suicide was considered to be a moral, theological and criminal issue. In more recent times, suicide is more often understood and explained by reference to psychopathology and mental illness (Marsh, 2010). Attitudes towards suicide bereaved have also changed over time. They were once punished harshly, their goods were confiscated, and their loved ones were denied a Christian burial (Marsh, 2010). In contemporary times, the bereaved are scrutinised by authorities. Alexander (1991) described, after her mother's suicide:

I was angry at my exposure, at having my open wounds and those of my family available for inspection by police, by the medical examiner, neighbours and passers-by. Their spectacle was my nightmare. (p. 41)

An honourable or noble meaning of suicide is possible when the suicide is seen as a form of resistance to power, for example, if someone is forced to live in a way that doesn't fit with their values.

In working with those affected by suicide, it is important not to homogenise all experiences into one kind; instead, inviting people to create a variety of descriptions for "apparently similar acts". In narrative practice, this is linked to the principle of drawing out the client's specific experience, rather than assuming that it fits with the normative meanings usually attributed to the act of suicide.

Suicide forces friends, family, therapists and communities to "think about the unthinkable". Suicide attracts attention as it violates many taken-for-granted truths, the most sacred being that the role of human existence is to protect, value and treasure life.

Taboos and Stigma: The Way Bereavement by Suicide is Different

The bereavement process after suicide is different from other bereavements; one of the distinguishing factors is stigma (Cvinar, 2005, p. 14):

Stigma is an attribute that is discrediting of the person. Those stigmatized are often seen as less of a person than others are, usually those doing the labelling. Stigma can act as a form of social control. (Goffman, 1963)

The bereaved are left to make sense of the loss, often in isolation, given the stigma surrounding suicide. The discovery of the death is often traumatic. Family members sometimes find their loved one dead in the house, receive the bad news over the phone from authorities or wait while their loved one is missing.

Families often endure an investigation into what happened. These features of bereavement are intimately related to taboos and stigma.

Taboos represent persons, things, qualities and activities deemed so sacred or privileged as to be beyond discussion. They can also reflect entities considered so dangerous, unfit and unclean that they cannot be discussed. The result is that those entities deemed taboo are removed from the circulation of meaning that language – and conversation – provides, silencing the past, the present and the future.

Chapple et al. (2015) documented the stigmatising of the suicide bereaved. Taboos operate at a societal level, while stigma and shame are experienced both individually and collectively. One of the bereaved interviewed described the effects of the societal taboo as follows:

People don't know what to say, I mean we're not good at dealing with death in our modern day society, ... people will walk across the other side of the street sometimes to avoid talking to you. (p. 617)

Narrative Practice

A narrative approach to counselling and community work takes into account power relations and the societal/historical context of hardship. Narrative therapy was pioneered during a time of radical social change. As White (C., 2011) describes: "Along with many others, Michael [White] became determined to challenge and put forward alternatives to the taken-for-granted authorities within mental health services and psychiatry" (p. 158).

In the 1980s, White and Epston began to challenge established ways of working with individuals and families. Epston brought his experience of anthropology and co-research to narrative practice. By consulting with those who consulted him, he created a two-way working relationship, allowing more opportunities to identify culturally based "blind spots" (particularly in relation to language and culture) that would otherwise marginalise those involved in therapy, and preventing a "one-size-fits-all" understanding of suicide-bereavement experiences. White and Epston were clear about not wanting to talk "on behalf" of others but, rather, wanted to create the most felicitous conditions for people to speak for themselves.

At the same time they resisted the idea of "individualism". Madigan (2012) has described the central role of "individualism" in modernist psychological culture: "Individualism is the dominant hegemonic philosophical position that influences how we come to know ourselves as persons. ... Individualist assumptions rest at the very centre of psychology's project" (p. 29). Marsh (2016) outlines three particular assumptions that dominate research and practice in contemporary suicidology; all three derive from the paradigm of individualism and have particular implications for clinical practice in general:

- Suicide is pathological (People who kill themselves are mentally ill)
- Suicide is science (We will come to the best understanding of suicide through studying it objectively, using the tools of Western medical science)
- Suicide is individual (Suicidality arises from, and is located within, the ‘interiority’ of a separate singular, individual subject). (pp. 16–17)

Narrative practice is adept at circumventing these assumptions, as it emanates from a different paradigm than the one on which they are based.

Individualist assumptions invite the bereaved into having to formulate one singular “truth” about the self-accomplished death, a headline to explain events to the wider community. The bereaved have to explain why their loved one suicided and why they did not see it coming. Marsh (2010) argues that an “individualised, internalised, pathologised, depoliticised and ultimately tragic form of suicide has come to be produced, with alternate interpretations of acts of self-accomplished death marginalised or foreclosed” (p. 219).

These particular unitary and individualistic accounts can affect how the bereaved come to know themselves and their loved one after the loss. Narrative frameworks give practitioners ways of supporting people affected by suicide in ways that do not locate the problem in the individual.

Insider Knowledge

“Insider knowledge” is another key concept of narrative practice that can assist those bereaved by suicide. Epston has recently drawn on the writings of the philosopher Polanyi to refer to insider knowledge as “tacit knowledges” that demonstrate that we “all know more than we can tell” (M. Polanyi, 1958, in D. Epston, personal communication, October 2009). Two major social developments that have influenced the understandings of insider knowledge are the political actions taken by mental health consumers and those taken by indigenous communities worldwide (Chilisa, 2012; Hornstein, 2009; Smith, 2012; Wingard & Lester, 2001).

Narrative practice values people gaining access to expertise in their own lives and believes this is where expert knowledge lies. Thus the person who has lived experience holds a wealth of knowledge. Insider knowledge is not simply a story or account of things as they happened. Rather, it is a deliberate rescuing of the skills and knowledge of living that we assume everyone holds, but that can so often be difficult to recognise (Sather & Newman, 2015). Narrative practitioners use particular interviewing methods that manifest the belief that the bereaved holds the keys to the undoing of their suffering. With this belief in place, questions enable the “rescuing” of knowledge.

The concept of insider knowledge is commonly used in narrative practice. It is similar to Webb’s “first-person knowledge”. Webb (2003) suggests there is no accidental oversight but a very deliberate and systematic exclusion of this critically important first-person knowledge for people who commit suicide:

There is a fundamental flaw at the at the core of contemporary thinking about suicide; which is the failure to understand suicidality as it is lived by those who experience it. (p. 25)

Webb (2003) describes suicidology as the “science of self-destructive behaviours”, and it is precisely this inherent judgement that limits understanding the lived experience of suicidality. He writes: “Constrained by a conceptual framework and empirical methods that *demand* observable objects, it is blind to the subjective reality of the suicidal dilemma” (p. 25). He calls for innovative methods that capture the more subjective, “soulful” meaning of lived experience, empathising first-person accounts, and capturing and honouring the original voice of the person who commits suicide.

Innovations in Narrative Practice for the Bereaved by Suicide

Re-membering conversations

Narrative practice with the bereaved has been influenced by Myerhoff’s (1982) concepts of “re-membering” and membership. She describes a particular type of recollection:

... the term re-membering may be used, calling attention to the reaggregation of members, the figures who belong to one’s life story, one’s prior selves, as well as significant others who are part of the story. Re-membering, then, is a purposive, significant unification, quite different from the passive, continuous, fragmentary flickerings of images and feelings that accompany other activities in the normal flow of consciousness. (p. 111)

White (1988a) introduced the “saying hullo again” metaphor as a concrete representation of Myerhoff’s re-membering notions, a shift away from the presumption that successful grieving requires saying goodbye and passing through linear, prescribed stages of grief. “Saying hullo again” enables the reincorporation of the deceased person into the client’s life.

In working with people bereaved by suicide, Sather and Newman (2015) compiled a resource, *Holding Our Heads Up: Sharing Stories Not Stigma After Losing a Loved One to Suicide*. In keeping with the practices of narrative therapy and community work, questions were developed to help generate responses and stories from the bereaved. Some of the re-membering questions and responses are shown in Table 1.

Table 1.
Re-membering questions and responses (Sather & Newman, 2015).

Ongoing Relationship	
Questions	Responses
<ul style="list-style-type: none"> Does the person live on with you in some way? If your loved one was still here, what would stand out to them most in how you have carried on? 	<ul style="list-style-type: none"> "I wear my Dad's watch, this helps him be close to me every day. Sometimes I think about the places he may have gone wearing the watch." "My mom would notice that I held onto hope after she died, and that I am in my first meaningful relationship with a man. She would be proud that I didn't let despair get the better of me day-to-day."
<ul style="list-style-type: none"> What would you imagine the person would want to say to you when speaking about these things? 	<ul style="list-style-type: none"> "I'm proud of you, Dad." "I miss you." "I'm sorry times a million."
Legacy	
Questions	Responses
<ul style="list-style-type: none"> What would you say has shaped your life? 	<ul style="list-style-type: none"> "We started an Asperger's awareness campaign and resource website with donations that came in honour of my brother." "He lives on when I can feel my own gentleness and kindness because that's the man he was."

Multi-storied tellings

A basic assumption in narrative work is that people's lives are multi-storied. This means that as we listen to any story, we believe that many other stories are possible (Freedman & Combs, 2009). This is different from listening for symptoms or "gathering information". We listen and ask questions in order to generate meaningful stories, which will create alternate, and more helpful, experience (Freedman & Combs, 1996). White and Epston called these "re-authoring conversations" (1989). When people have been subjected to trauma, they often speak of a single-storied account, one that predominantly features a sense of hopelessness, futility, emptiness, shame, despair and depression. Alternate stories represent other "territories of living" where people are able to speak of their particular knowledge, wisdom and that could help heal them from the trauma they have been subject to.

A narrative, multi-storied approach allows the bereaved to speak about all their lived experiences – more so than less – without the limiting lens of gender, culture, or political context. For instance, multi-storied, re-membering practices have been used to assist women in the transition after a male partner's suicide; the women were able to speak of the complexity of the meanings to them of losing their partners. Here, one woman sums up the experience of many women in the group:

Together we acknowledged horrific events and their vast effects. We also acknowledged that we women are more than these events, not merely passive recipients, and that we had responded in particular meaningful ways. Acknowledging multiple stories provided a chance for us to revise our relationships with our histories, and in doing so created a space for new possibilities in our current day-to-day lives. (Sather, 2015, p. 45)

Guntarik, van de Pol and Berry (2015) observe: "Some stories are hard to swallow. They contain material that is taboo and some would say that the taboo is forbidden territory. Most of us want the fairy tale ending". In working with the bereaved by suicide we can explore transdisciplinary and imaginative works that have historically given voice to the marginalised. These works can help narrative practitioners find ways to engage "hard-to-swallow stories". Narrative practitioners can provide ways to have conversations that acknowledge the effects of guilt, shame, secrecy and blame but also "excavate" and archive skills and knowledge. Capturing responses that elude guilt and shame and that express, for example, caring and compassion, helps people take back things that are important to them and create identities that are more robust.

Collective narrative practice: Responses to stigma and taboo

Collective narrative practice is an emerging field. Building on the conceptual and practice foundations of narrative therapy, it seeks to respond to groups and communities who have experienced significant social suffering. Collective practices can include narrative documentation, definitional ceremonies (the telling and retelling of the stories of people's lives) and performance that can contribute to social-historical healing. (Denborough, 2008, 2011; Denborough, Freedman, & White, 2008; Myerhoff, 1982).

Sather (2015) used collective narrative practices to reveal and challenge shaming discourses, exploring the complex experiences of women who had lost a male partner to suicide after experiencing violence from that partner. These circumstances often resulted in women trying to rise from the "double stigma" of violence and suicide. Multi-story re-membering practices created space for women to speak of a whole range of

experiences, which were then documented and shared among the women. By listening with understanding and compassion to the experiences of others, they were able more easily to free themselves from the double taboo affecting them. One woman wrote:

As women we are finding ways to untangle ourselves from some of the taboos of suicide. Society has ideas about how we should grieve. We are judged for staying in abusive relationships and for leaving. Family, strangers, teachers, and the church, all tell us how we should bury the father of our children. (Sather, 2015, p. 48)

In the above example, the excavation of knowledge requires legitimation through various forms of witnessing, documentation and subsequent circulation (Denborough, 2008; Lobovits, Maisel, & Freeman, 1995). It is not just the documenting of insider knowledge that is important in narrative practice; it is the art of “double listening”. Wingard and Lester (2001) explain:

Not only are we telling our stories differently, but we are listening differently too. We are listening for our people’s abilities and knowledges and skills. We’ve been knocked down so many times that we often don’t think very well of ourselves. But we are finding ways to acknowledge one another and to see the abilities that people have but may not know they have. (p. 11)

When women who are bereaved by suicide come together and are helped to do double listening, to respect what they know and to respect what others tell them, then they are much more able to overcome the perilous times the suicide places them in. Together, in community, with the help of collective narrative practices, they are more able to forge a preferred identity.

Truth and Fact: Story and Family Histories

So far, this paper has addressed ways of working with an individual who faces the social stigma, taboo and subsequent marginalisation that accompany the death of a loved one by suicide. However, there are also challenges faced by the family as a whole. The particular stigma that these families face can lead to distortions in how the family creates its history: facts may be altered; the stigma may lead to secrecy about the circumstances of the death; and sometimes the death is renamed an accident or covered up. The burden of shame can cut off families from their own histories. Minh-Ha (1989) writes, “when history separated itself from story, it started indulging in accumulation and facts” (p. 119). A family’s ability to engage in storytelling and to endorse its own history is compromised by stigma and taboo.

Narrative practice endeavours to interrupt families’ loss of their history by helping them to resurrect the actual story of what happened and the many other stories that comprise the family’s life together. The stories that are gathered weave the contributions their loved ones made to their lives before the suicide occurred. Often

the therapist must help families notice what is absent. It requires imagination to do so. Denning (2009) describes the relationship between imagination and history: “Imagination is seeing what is absent; hearing the silence as well as the noise” (p. 64).

Alexander (1991) chose to write memoirs as a way of rescuing their family history after the suicide of her mother:

I was searching for some way to make sense of the incomprehensible thing that she had done, and I wanted to know whether I would ever again have a life that felt whole, whether other people had survived this kind of loss and been able to put their lives back together again. (p. 1)

Alexander found little written except for a few clinical articles on the “pathological” effects of parental loss in early childhood. She notes: “The silence on the subject was unsettling” (p. 1).

Alexander discusses the connection between language and taboo; obituary notices “tip toe” around the subject and loved ones end up using evasive phrases such as “died suddenly”. In one anecdote, she shows the positive effect a clergy person at a funeral had on the bereaved when he suggested retrieving an important memory unclouded by the pain of suicide. A woman at the funeral was then helped to recall a fond memory. Alexander provides narrative practitioners with “insider knowledge” stories based on valuable lived experience that would otherwise be hidden. She re-authored her family’s history.

Conclusion: There is No End

While suicide is never going to be seen as a “typical” death and negative discourses are likely always to be present for those bereaved by suicide, narrative practice offers clinical options that can help people resist stigmatisation and marginalisation by critically engaging with the dominant ways of constructing taken-for-granted truths about bereavement.

Societal taboos that make it necessary for those who are bereaved by suicide to keep private about the death of their loved ones make it difficult for the bereaved to hold on to rich stories of their lives with the deceased. It also makes it more complex to find the most fitting meanings to the way they ended their lives. Narrative practice does not encourage the bereaved to gloss over the hurtful actions of those who committed suicide; rather, it assists in creating full accounts. Even memories of hurtful moments can be treasured. To constantly be told that your loved one purposely tried to hurt you forecloses possible healing conversations. People have found it helpful to reconnect with the values, hopes and dreams that shaped the life purposes of their loved ones before these were eclipsed by the suffering that produced the suicide.

Stewart (as cited in Pipyrrou, 2014) speaks to the power of the “alternate plot being publically circulated”: “Suicide stories allocated alternative plots and publicly circulated are eventually adopted as memory, a

pool of inspiration from where people create novel historicisations” (p. 189). Sather and Newman (2015) collected stories about the ways people coped with the suicide of a loved one. The bereaved spoke of their own “novel historicisations”. One woman described how important it was that she was given a simple cup of tea and a plant:

My mother’s friends checked in with me after she died. One day unexpectedly, her best friend turned up to my flat. I had been hibernating and she brought me a plant. This was symbolic. I held onto the plant and we had tender conversations over a cup of tea, My mum did a lot in the community and was well – respected. Hearing stories of how she has helped so many people gave me the strength on difficult days to keep going. (Sather & Newman, 2015, p. 29)

My own son has connected to his father’s love of writing and works hard at keeping an ongoing relationship despite his father’s suicide. He thinks his father would be proud of him and this gets him through hard times.² As my son has remained proud of his father, I am proud of my son for taking this stance. As a family we have been silenced by an array of societal attitudes but we are committed to escaping shaming discourses and writing our own history.

Notes

¹ Saddened is only one part of the complex experience people bereaved by suicide may feel. After the loss of my husband by suicide, I felt many things, from deep despair to relief that my children and I were safe.

² My son wanted me to include these observations in my paper as a way of helping other children know they can stay proud of their parents.

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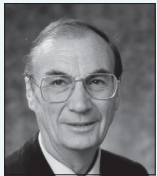
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University of Memphis, USA
*Intervening in Meaning: New Directions
in Grief Therapy*



Dr Edward K. Rynearson

Violent Death Bereavement Society, USA
Traumatic Grief After Violent Dying



Dr Mary L. S. Vachon

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*Empathy and Compassion in the Care
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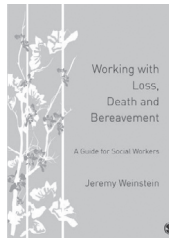
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Book Reviews



Working with Loss, Death and Bereavement: A Guide for Social Workers

Jeremy Weinstein (2007)
200pp. ISBN: 9781412923910
London: Sage
RRP: \$84.00

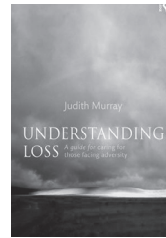
This book outlines the professional values, methods and theories drawn upon by social workers for working with individuals, families, support groups and communities when a service user experiences a loss related to the death of someone important, as well as other losses relating to disability, illness, mental health and ageing.

The case scenarios link the experiences of the social worker and the service user with professional values and practical skills that can be drawn upon. Examples are also taken from films and novels. Self-tests, points for practice and advice for further reading are included in each chapter.

The book presents the psychological theories relating to grief and loss, as well as social work theory. The case scenarios highlight how social discrimination and oppression cause and heighten the experience of disenfranchised grief. There is valuable discussion about the tensions between surveillance and support as well as the need to identify and work towards outcomes while also attending to process to ensure that the stories of service users can emerge. The author highlights the ethical importance for the social worker to be a critical and reflective practitioner, one who is conversant with the research, the need for “relentless self care”, and to be aware of their values and how these may influence being present to the experience of those facing loss.

As this book provides a valuable insight into the committed work of social workers who support service users, their families and communities in times of loss, it is highly relevant for counsellors. I commend it as a valuable practical resource for counsellors working with death, loss and bereavement in order to reflect upon, and develop, their own practice in attending to both the intrapersonal and interpersonal experience of those facing loss as they find meaning and rebuild their lives in relationship with others.

Denise Howes
Counsellor and Creative Arts Therapist
Practitioner Associate
Australian Centre for Grief and Bereavement
Trentham, Victoria, Australia.



Understanding Loss: A Guide for Caring for Those Facing Adversity

Judith Murray
238pp. ISBN: 9781138829466
Abingdon, Oxon: Routledge
RRP: \$49.95

Murray’s book sets out a discussion about developing a comprehensive psychology of loss as it applies across the life span and in a variety of situations. She argues that since the major theories of grief and loss, each of which she introduces in some detail, have emerged from a bereavement model, many other areas of knowledge need to be considered to build a more universal picture of loss.

A strong focus in the book is the importance of taking a person-centred approach to the psychology of loss and its application. This is mapped out using three mutually dependent concepts: respect, understanding and enablement, each of which has its own chapter as well as being woven throughout the text.

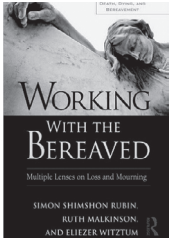
Murray’s psychology of loss is also organised around nine “Themes of Loss”, which become the basis for the practical aspects of providing care for people facing loss. These themes become the focus of the second half of the book. She provides new frameworks for listening to a person’s story and for structuring assessments and interventions so that they enable a person to “come to terms with the world ‘that was’ and to live within the world ‘that is’ in a way that is meaningful to them” (p. 161).

This book has something to offer anyone who is interested in an informed and evidence-based understanding of loss, as well as professional caregivers working directly with people who are experiencing loss.

The highlight of the book for me is that it brings together the myriad current models, theories and strategies about loss, and presents them in a unified and thoroughly referenced context that I imagine I will dip back into often.

Murray has provided a great platform from which to continue the discussion about exactly what is a psychology of loss and how that is best applied.

Jacqueline Taylor
Coordinator, Cabrini Vale
Community Bereavement Support Program
Malvern, Victoria, Australia.



Working With the Bereaved: Multiple Lenses on Loss and Mourning

Simon Shimshon Rubin,
Ruth Malkinson, and
Eliezer Witztum (2012)
266pp. ISBN: 9780415881661
New York: Routledge
RRP: \$79.99

In recent years, the loss and grief field has re-examined how the bereaved adapt and maintain their relationship with the person who has died. Working with the Bereaved makes a valuable contribution to this discussion.

The book centers on the Two-Track Model of Bereavement (TTMoB), first described by Rubin in 1981. The model strongly argues for attention to how the bereaved are coping with their changed world and particularly how they are renegotiating their relationship to the deceased. “(T)here are two basic questions any clinician can and probably should ask: (1) What is the current status of the impact of the loss upon the bereaved’s day-to-day living? (2) What is the current status of the ongoing relationship to the person who has died?” (p. 25).

The model’s structure is clearly described and used as the foundation for exploring various themes throughout the book. Track I relates to biopsychosocial functioning after bereavement, while Track II focuses on the relationship to the deceased. Each track consists of 10 components that can be rated by the clinician; a scoring key is included, as are several examples of how the tracks were scored with clients discussed in the book. Also included is a copy of the 70-question Two-Track Bereavement Questionnaire (TTBQ2-70), accompanied by a guide to scoring and permission for the questionnaire to be used for clinical and research purposes.

The book addresses many areas of interest to bereavement clinicians, such as trauma-bereavement interface, therapeutic work with the relationship to the bereaved (Track II), cultural elements of bereavement, and dealing with emergencies in complicated grief. Particularly interesting is the examination of “relational traumas of bereavement”, when a death includes a major attack on the bereaved’s experience of the deceased and leads to traumatic reactions where, for example, the bereaved discovers postdeath that their partner was having an affair or had perpetrated sexual abuse. The authors provide very useful information about using the TTMoB as a basis for therapeutic

approaches including psychodynamic therapy, cognitive therapy and strategic interventions, such as letter writing and leaving-taking rituals.

The authors have effectively communicated their extensive clinical and research experience and included several helpful practice tools. Numerous engaging case studies illustrate how the TTMoB can usefully guide assessment and intervention. For those interested in developments related to continuing bonds, attachment and traumatic grief, this book extends practice knowledge. It is well worth consideration by anyone working with the bereaved.

Michael Bull
Senior Lecturer in Social Work (retired)
Flinders University
Adelaide, South Australia, Australia.

Abstracts

Quinn-Lee, L. (2014).

School social work with grieving children.

Children & Schools, 36(2), 93–103.

doi:10.1093/cs/cdu005

This article describes the outcomes of a US study that aimed to advance understanding of the work of school-based social workers. Outside a child's home, the most significant environment is the school. Clinically trained school-based social workers are able to differentiate between normal and problematic grief, depression and anxiety. However, the subject of children and grief appears very minimally in social work literature. A literature review identified that student responses to grief and loss affects academic performance and progress, which can further exacerbate their coping. Age and developmental stage affects emotional response, understanding of death and ability to cope.

The study used open-ended, inductive approach using qualitative methods in two stages: a preliminary email survey followed by a 45–60 minute face-to-face interview. A sample of 105 school social workers was invited to participate, all of whom were: licensed in Minnesota as a school social worker, employed as a school social worker in the Minneapolis–Saint Paul area, and a member of the Minnesota School Social Workers Association. Fifty-nine school social workers participated in the email survey, with 22 participating in follow-up interviews.

Data analysis identified four key themes: (a) barriers to helping grieving students; (b) variations on how grief is defined; (c) social workers' preparation for dealing with grief and loss issues; and (d) referral of grieving students to outside resources. The greatest barrier to support was parents, who may mistrust school social workers, may believe grief counselling interferes with their rights, and may believe it is an invasion of the family's privacy. Support from other school staff was also a barrier. Social workers' preparation for dealing with grief and loss issues focused on issues in standard social work training courses; for most it comes from on-the-job experience and requires specialist further training.

Children only cope as effectively as the adults around them – school social workers need to work with adults that support them as well as the children themselves. Recommendations included: increase in services, facilitate communication between community and school social workers, collaborate with families, inform social work degree programs about preparedness of graduates, and to view parents and teachers as part of the service delivery system.

Cacciatore, J., Thieleman, K., Osborn, J., & Orlowski, K. (2014).

Of the soul and suffering: Mindfulness-based interventions and bereavement.

Clinical Social Work, 42(3), 269–281.

doi:10.1007/s10615-013-0465-y

This article examines the evidence for mindfulness-based interventions (MBIs) for use in bereavement care. The authors provide a review of the literature around MBIs and then present a case study of the use of the ATTEND model, an MBI designed for use with bereaved clients.

Working from Kabat-Zinn's (2003) definition, as well as that of Bishop et al., who broke mindfulness down into two components as an operational definition, the authors define mindfulness further as: "a mental practice that is cultivated in order to develop a particular stance toward experience, as well as a stance toward experience itself. It is both an action in which one chooses to engage ... as well as the fruit of such action in one's life" (p. 270).

Both academic and clinical interest in mindfulness and mindfulness-based interventions are increasing in fields of social work, psychology, medicine and neuroscience, as well as in the broader cultural sphere. While long associated with Buddhist practices, mindfulness is independent of spiritual traditions. First adapted to health contexts in the 1980s for treating stress and then chronic pain, Kabat-Zinn's mindfulness-based stress reduction (MBSR) program was the foundation for much research into the practice.

Several empirical studies have supported the application of MBIs for people experiencing: (a) some forms of chronic pain, (b) anxiety disorders, (c) depression, (d) irritable bowel syndrome, (e) fibromyalgia, (f) binge eating, (g) psychosis, and (h) substance abuse. Studies have also shown MBIs have been used beneficially with medical students, nurses, trainee therapists, child abuse survivors, cancer patients and carers of children with chronic conditions to reduce psychological distress.

Mindfulness practices complement social work practices; both seek to reduce suffering and increase overall wellbeing for the client. Importantly, mindfulness can also support the social worker in being present and in their own self-care, further enhancing the therapeutic relationship and ultimately providing better support for the client.

The authors describe a mindfulness-based model for bereavement care, the ATTEND model (attunement, trust, therapeutic touch, egalitarianism, nuance and death education). A tripartite model, ATTEND is designed to benefit the client, the clinician and the therapeutic relationship. A case study is presented of the beneficial use of the ATTEND model with a client who experienced the sudden and traumatic death of his son. More research is needed to further study this emergent field for use with bereaved clients.

Du Plooy, L., Harms, L., Muir, K., Martin, B., & Ingliss, S. (2014).

“Black Saturday” and its aftermath: Reflecting on postdisaster social work interventions in an Australian trauma hospital.

Australian Social Work, 67(2), 274–284.
doi:10.1080/0312407X.2013.862558

This article describes the experiences of social workers based at a major trauma hospital in Melbourne, Australia, and their work providing psychosocial support to patients and their families following the Black Saturday bushfires. This experience highlighted the limited literature on postdisaster social work interventions, leading the social work team to document their practice through a critical reflection process.

This was a challenging time; a catastrophic national disaster: 173 dead, 414 presented to emergency departments around Melbourne. Twenty of the most severely injured were admitted to The Alfred’s Victorian Adult Burns Service (VABS). This was the highest number of simultaneously admitted casualties in its history, and intense community and media interest also contributed to new practice challenges for the social work team. Unprecedented event meant no practice or procedures available to guide the response. Processes were decided by the team based on core practice principles of social work and wisdom.

All patients admitted for bushfire related burns and their families were allocated a social worker on admission, who conducted initial assessment and developed an intervention plan where appropriate. Four key interventions were offered in the immediate disaster aftermath: a 24-hour on-call response for the first two weeks; initial crisis management and containment; provision of psychological first aid; and discharge planning.

Compounding traumatic stressors at the time of admission included: immediate threat to life; prolonged periods of separation and fear of loss of family, neighbours and friends during emergency; actual loss of life; loss of property, possessions and pets; profound economic losses; loss of future livelihoods.

The critical reflection process comprised journaling and discussion over several meetings in the weeks following the disaster with a social work academic from the University of Melbourne, to identify assumptions and to improve professional practice. This involved deconstructing and reconstructing experiences in a whole-of-team thematic analysis, which: (a) described

practice and situational dilemmas; (b) reflected on actions, particularly how influence and power as social workers influenced those situations; and (c) to redevelop practice and theory.

Three key themes were identified in the social work team’s critical reflections: (1) managing privacy and publicity; (2) negotiating the boundaries of professional practice; and (3) managing the impact of the work. These practice challenges are discussed in light of the relevant trauma and disaster literature, which addresses promotion of self-efficacy, hope and connectedness; forming narratives of survivorship and resilience; negotiating the ethical questions of service intimacy and intensity; and implementing both active and avoidant self-care strategies.

One key challenge to patient support was protecting privacy in the face of huge media competition for access to patients. Some patients welcomed media coverage; others avoided it, and in some cases impeded patients’ recovery progress. Difficult to maintain the balance of protecting patients while honouring patients’ own choices; response ultimately guided by the social work principle of encouraging self-efficacy and promoting connectedness.

Recommendations for future disaster event responses are also provided, relating to the division of roles within the social work team, self-care of staff, planning and referral for longer-term care, and continuity of care for non-disaster patients.

Programs and Services

Australian Centre for Grief and Bereavement

The Australian Centre for Grief and Bereavement (ACGB) is an independent, not-for-profit organisation established in 1996 to provide a range of counselling and support services, education, training, research and consultancy for individuals and organisations working with, or affected by, grief and bereavement.

Bereavement Counselling and Support Service

ACGB operates a statewide Specialist Bereavement Counselling and Support Service for Victoria. This program is supported by the Victorian Government Department of Health and has counsellors located across metropolitan Melbourne, in regional areas (Grampians, Gippsland, Hume, Barwon South-West, and Loddon Mallee) and in areas affected by the 2009 Victorian Bushfires.

Practitioner Consultancy Service

This service provides free information, consultation and support for practitioners who are working with bereaved clients experiencing complex and prolonged bereavements. To access this service, call 1300 858 113 during business hours.

Education and Training Program

As the largest provider of grief and bereavement education in Australia, ACGB offers quality education and training opportunities for health professionals, students, volunteers and any other individual or agency looking to enhance grief and bereavement knowledge and practice. Education and training programs are offered as workshops, seminars, short and long courses, customised training, conferences, international educator events and webinars. For full details of all programs and services offered, visit www.grief.org.au/education

Bereavement courses

ACGB offers a range of research-informed courses that bridge research and practice, including the nationally accredited post-graduate training program, the Vocational Graduate Certificate in Bereavement Counselling and Intervention (conducted in Mulgrave, Victoria).

Customised training and consultancy

To cater to the unique needs of organisations and workplaces, ACGB develops and provides a range of customised training and consultancy services that provide research-informed professional development programs.

Resource Library

The ACGB reference collection contains over 1,000 books and journals and is one of the largest collections of grief and bereavement literature in Australia.

Membership

Members of ACGB can access a range of benefits through the membership program.

New membership structure

Following our 2014 membership survey, the Australian Centre for Grief and Bereavement has restructured our membership benefits and services for 2015. We are also pleased to announce that in 2015, memberships can be renewed online. In addition, a new range of member services will be accessible via our new online member section of our website (coming soon).

2015–2016 member benefits

Please note: Not all of the membership benefits listed below will be immediately available. These benefits will, however, be available to 2015 members upon the launch of our new online membership platform from 2015. Members will be notified via email when this platform is available.

- printed copies of *Grief Matters: The Australian Journal of Grief and Bereavement* (three times per year)
- access to the Member Only section of the ACGB website
- access to back copies of *Grief Matters* online in PDF format
- access to EBSCO, a repository of full-text academic articles, including the major grief and bereavement journals (e.g. *Death Studies*; *Journal of Loss & Trauma*; and *Omega: Journal of Death and Dying*)
- member discounts on books and resources
- member discounts to education and training events
- complimentary admission to the Grief Lecture
- a discount application fee for the Bereavement Practitioner Certification Program
- inclusion in the ACGB Membership directory
- the right to vote at the Annual General Meeting, in elections and to hold office.

2015–2016 Fees:

Membership type	One-year rate
Individual	\$195.00
Organisational	\$450.00
Concessional	\$95.00
Student	\$75.00

The above prices include GST – Australia only.

For International membership information (only available outside Australia and New Zealand) please visit our website at: www.grief.org.au

Submit an Article to *Grief Matters*

Grief Matters is a ranked journal with the Australian Research Council as part of the Excellence in Research for Australia initiative. Previous contributors have included George A. Bonanno, Cecilia L. W. Chan, Kenneth J. Doka, John R. Jordan, Ruth Malkinson, Robert A. Neimeyer, Colin Murray Parkes, Holly G. Prigerson, Simon Shimshon Rubin, Henk Schut, Margaret S. Stroebe, and J. William Worden.

The Editor welcomes submissions for publication in *Grief Matters: The Australian Journal of Grief and Bereavement* that are in keeping with the journal's aims and scope.

Scope

The journal publishes work that encompasses both academic and applied aspects of grief and bereavement.

Published three times a year, each edition focuses on a central theme relating to grief and bereavement. Three research articles appear in each edition and are not to exceed 3,000 words.

It is a condition of publication that papers have not previously been published, nor are currently under consideration for publication elsewhere. Publication is also subject to thematic suitability.

Preparation and submission of manuscripts

In preparing manuscripts, contributors should follow the rules set forth in the *Publication Manual of the American Psychological Association* (6th ed.).

For more detailed information on the submission of manuscripts, visit our website at: http://www.grief.org.au/resources/grief_matters/information_for_contributors, or contact:

The Journal Production Editor
Grief Matters
Australian Centre for Grief and Bereavement
253 Wellington Road
Mulgrave VIC 3170
Email: griefmatters@grief.org.au

Donations

Although partly funded by the Victorian Government Department of Health, ACGB relies on the generosity of the public to support bereaved and grieving people through a wide range of services, including counselling, support groups, newsletters, events, research, education and training. Your generous donation, big or small, helps us to provide greater support to children, adolescents, adults and families who are struggling with the pain of losing a loved one. Donations over \$2 are tax deductible.

ACGB Online

For all the latest news, information and resources, visit the ACGB website at: www.grief.org.au

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Australian Centre for Grief and Bereavement
253 Wellington Road, Mulgrave, Victoria 3170
Telephone +61 3 9265 2100 **Freecall** 1800 642 066
Email griefmatters@grief.org.au **Website** <http://www.grief.org.au>