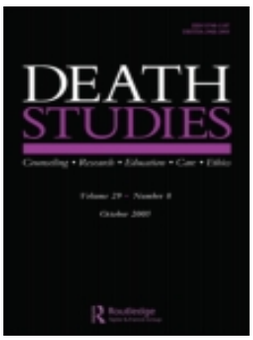

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GRIEF: LESSONS FROM THE PAST, VISIONS FOR THE FUTURE

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Over the last millennium, patterns of mortality have changed and have determined who grieves and how. At all times grief has been recognized as a threat to physical and mental health. More recently the scientific study of bereavement has enabled us to quantify such effects and to develop theoretical explanations for them. This article reviews our evolving understanding of grief, focusing especially on the developments in research, theory, and practice that have come about in the last century. Wars and similar conflicts are associated with repression of grief, but methods of helping by facilitating its expression that developed during the 2 World Wars are less needed and effective at other times. In recent years more attention has been paid to the social context in which grief arises and, particularly, to the nature of the attachments that precede and influence the reaction to bereavement and to other traumatic life events. At the same time a range of caring resources has become available and acceptable to bereaved people and the results of scientific evaluation of these gives promise that we are moving toward an era in which more sensitive and appropriate care will be provided to the bereaved by both voluntary and professional caregivers.

Grief in the Last Millenium

Written over a millenium ago, the poem *Beowulf* records the reaction of his subjects to the death of the hero/king, Beowulf, who died of wounds after slaying the Firedrake, a dragon 50-feet long.

> The people of the Geats then made ready for him on the ground, a firm-built funeral pyre, hung round with helmets, battle shields, bright corselets as he

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> had bid them do. Then mighty men, lamenting, laid in its midst the famous prince, their beloved lord. . . . the roaring flame mingled with the sound of weeping. Depressed in soul, they uttered forth their misery, and mourned their lord's death . . . . Heaven swallowed up the smoke.
>
> Then the people of the Geats raised a mound upon the cliff, which was high and broad and visible from far by voyagers on sea . . . the warriors, brave in battle. . . . rode round the barrow; they would lament their loss, mourn for their king, utter a dirge and speak about their hero. They reverenced his manliness, extolled highly his deeds of valour—so it is meet that man should praise his friend and lord in words, and cherish him in heart when he must needs be led forth from the body. (Hall, 1950, pp. 126–127)

It seems that in the late 8th century even warriors could cry when their great chief died and that it was seen as right and proper for them to talk of him and praise his great deeds. Many barrows were raised in Britain above the dead to ensure that they were not forgotten.

Of course, this was the privilege of the great and important dead. Humble folk had humble graves then, as they do now. We tend to think of it as normal to die in old age, but the first millenium was a time of strife and early death. Few people survived to old age and the greatest mortality was in the first year of life. This melancholy fact remained true until the last hundred years in the West and is still the case in the so-called Third World. During most of the millennium, many deaths took place in infancy and it was sometimes said that you were not a woman until you had lost your first child. In this day and age, the death of a child is recognized as one of the most traumatic experiences and we all view the very thought with horror.

Were our predecessors psychologically scarred by all these horrors? I think not. Very little was written about the death of children, and essayists, such as Montaigne, wrote "I have lost two or three children in their infancy, not without regret, but without great sorrow" (1603). One is reminded of the recent research of Nancy Sheper-Hughes (1992) among the poor people of North-East Brazil, where the infant mortality rate is still very high. She entitled her book *Death Without Weeping* and recorded her own sense of shock when, in great distress, she told a mother that the baby she had been taking to hospital had died. The mother, surprised at her distress, reassured her "It's only a baby!" In such cases there is no funeral. The baby is entrusted to a procession of children who carry the body to the cemetery for burial. It is believed that the souls of dead babies are immediately promoted to become cherubs in heaven and it is

they who welcome their mother when she comes to join them. Some mothers boast of the number of cherubs they have contributed.

But we would be wrong to assume that the deaths of infants inoculated people against the effects of other griefs. There is plenty of evidence that other types of bereavement, including the death of older children, could have devastating effects. Montaigne (1603) also described the reaction of John, King of Hungaria, to the death of his son; "He only, without framing word or closing his eyes, but earnestly viewing the dead body of his son, stood still upright, till the vehemence of his sad sorrow, having suppressed and choaked his vital spirits, fell'd him stark dead to the ground." (pp. 3–4)

The idea that you can die of a broken heart goes back to Biblical times and we find "griefe" listed as a cause of death in Heberden's statistics of causes of death for the city of London in 1657. But it was not until my own statistical study with Benjamin and Fitzgerald was published in 1969 that clear evidence of an increased mortality rate from heart disease was found among widowers during the first year of bereavement. Since then, several other studies have confirmed the finding and indicate that men are more likely than women to die of a "broken heart."

In 1621, when Robert Burton published his influential *Anatomy of Melancholy*, he adopted the classical humoral system which attributed depression or "melancholy" to an excess of "Black Bile." But the flow of bile could also be caused by grief and Burton described grief or sorrow as "the epitome, symptome and chief cause of melancholy." In this, he preceded Freud and Lindemann by 200 years.

Vogther (1703) published a Ph.D. thesis entitled "De Morbis Moerentium," which translates as "The Illnesses of Grief" or, to use modern language, "Pathological Grief Reactions." He lists a number of prescriptions for grief. It seems that the idea that bereavement can cause mental illness goes back a long way.

In 1835, we find the American physician Benjamin Rush, one of the signatories to the Declaration of Independence, describing dissection of the body of persons who had died of grief. He found "Inflammation of the heart, with rupture of its auricles and ventricles." This alarming finding caused him to recommend that "Persons afflicted with grief should be carried from the room in which their relatives have died, nor should they ever see their bodies afterwards." He went on to prescribe "liberal doses of opium."

Rush's recommendations do not seem to have deterred bereaved people from adopting ever more flamboyant customs of mourning during Queen Victoria's reign. In 1853 there were no less than four "mourning warehouses" in London's Regent Street (Morley, 1971). Victoria's own grief for the death of her husband Prince Albert was severe and protracted.

Grief in the Twentieth Century

According to Geoffrey Gorer (1965), it was the rising death rate in the trenches during the first World War that put paid to shows of mourning. By the time the war ended, the "stiff upper lip" had become the ideal and grief was under firm control. Repression of grief is not uncommon among warriors and other people at time of war.

And so we come to Sigmund Freud, whose classical paper "Mourning and Melancholia" (1917) proposed that grieving or "mourning," as it was inaccurately translated, is a job of work in the course of which emotional energy, or libido, is withdrawn from a loved person before it can be redirected elsewhere. "When the work of mourning is completed," he wrote, "the ego can become free and uninhibited again." He also compared grief to clinical depression, or "melancholia," and suggested that although depression resembles grief its causes are symbolic rather than real losses and that their roots are to be found in earlier traumatic experiences.

Freud's paper had much influence on the psychoanalytic theory of depression but it was not until the end of the second World War that its relevance for bereavement was given further attention. At this time, two important papers were written. The first, by Eric Lindemann (1944), described "The Symptomatology and Management of Acute Grief" and provided a clear account of the reaction to bereavement, its short-term course, and the treatment of the problems that arise when it is delayed or distorted. Lindemann was a psychoanalyst and he found confirmation in his work with bereaved people for Freud's theory of repression. In his view, "the essential task of the psychiatrist is that of sharing the patient's grief work." This, he claimed could be done in 8–10 interviews. He also acknowledged the possibility that this work could be done by non-psychiatrists and, in doing so, sewed the seeds of bereavement counseling.

Lindemann's paper was a great success. Before long his recommendations were being followed widely and applied to many kinds of loss. At last we had a simple, short-term psychotherapy for grief.

However, there were limitations to this theory. Anderson (1949) published an account of the psychiatric consequences of bereavement in which he described a type of problem that had not been given weight by Lindemann and which was not so easily explained. This was the chronic grief syndrome. People with chronic grief did not show any signs of repressing their grief, rather they grieved intensely from the start and continued to do so long after they were expected to stop grieving. Anderson's work did not have the same impact as Lindemann's, perhaps because it did not come up with a simple solution to the problem.

Lindemann's work triggered a great deal of interest in the topic of bereavement that has continued to this day. Any attempt to summarize the research that has followed must pick and choose between a large number of contenders and I apologize if my own review is highly selective and leaves out your favorite paper.

My own interest in the subject arose when, as a trainee psychiatrist, I met two people who had been admitted to the Maudsley Hospital for treatment of depression following bereavement. Reading what literature there was on the subject alerted me to the possibility that the study of bereavement might make a useful contribution, not only to our understanding of bereavement but also of the many other stresses that contribute to cause mental illness.

My first study, published in 1965, focused on people seeking psychiatric help after bereavement. It showed that bereavement could trigger a wide range of psychiatric disorders of which affective disorders were the most frequent. It also showed that a minority of these patients were suffering from the forms of pathological grief which had been described by Lindemann and by Anderson. It confirmed Anderson's claim that chronic grief was more frequent than delayed.

Part of the problem faced by researchers at this time was the absence of any systematic studies of normal or uncomplicated grief. What was the range of normality, how long did grief last, was there a pattern to it? In 1962, John Bowlby, who was studying the reactions of small children to the experience of separation from their mothers, invited me to join his unit at the Tavistock Institute of Human Relations. Here I was able to study a relatively unselected sample of young women who had lost their husbands through the course of their first year of bereavement.

Robertson and Bowlby (1952) had observed that young children separated from their mothers expressed a distinctive pattern of grieving moving in sequence from a phase of acute Separation Anxiety, in which they cried a great deal, to a period of disorganization and despair to a final phase of recovery in which they began to reach out to others and make new relationships. I found something very similar in my own study of young widows, the only difference being that many widows reported an initial phase of blunting or numbness, which preceded the phase of crying and yearning. From the start, Bowlby and I recognized that there was a great deal of individual variation in the response to bereavement and that not everybody went through these phases in the same way or at the same speed (Bowlby & Parkes, 1970).

It was in 1964 that I visited the United States for the first time. I had read a paper on "The Dying Patient's Grief" by Prof. Knight Aldrich in Chicago (1963) and he invited me to speak about my own studies of bereavement at Billing's Hospital. Here I met a remarkable young trainee working in his department on the problems of cancer patients. Her name was Elizabeth Kubler Ross and she subsequently adapted Robertson, Bowlby and Parkes's (1970) phases of grief to describe the phases of dying. I mention this because Kubler Ross has sometimes been credited with discovering the phases of grief as well as the phases of dying. Both of these concepts have subsequently given rise to a fair amount of controversy and several alternative models have been described.

While working at the Tavistock, I met Gerald Caplan who played a large part in the development of Community Psychiatry in the United States. His name is associated with crisis theory and he was a friend and colleague of Eric Lindemann. Gerald invited me to join his unit at Harvard for a year to direct the Harvard Bereavement Project. This was a systematic short longitudinal study of unselected widows and widowers over the first four years of their bereavement. Its aim was to discover why some people did well after bereavement and came through without the need for help from outside their families while others did not. It enabled us to identify risk indicators that could be used to recognize people before or at the time of a bereavement who were at risk of problems later. We also described the characteristic reactions that followed sudden, unexpected, and untimely deaths, the deaths of partners on whom the bereaved person had been very dependent and the conflicted grief of people whose relationships were highly ambivalent (Parkes & Weiss, 1983).

TABLE 1 Risk Factors in Bereavement

Mode of Loss
Sudden or unexpected losses for which people are unprepared
Multiple losses
Violent or horrific losses
Losses for which the person feels responsible
Losses for which others are seen as responsible
Disenfranchised losses (i.e. losses that cannot be acknowledged or mourned)
Personal Vulnerability
Dependent on deceased person (or *vice versa*)
Ambivalence to deceased person
Persons lacking in self-esteem and/or trust in others
Persons with previous history of psychological vulnerability
Lack of Social Support
Family absent or seen as unsupportive
Social isolation

Since that time many other researchers have contributed to our understanding of bereavement risk. The current thinking is summarized in Table 1. Of particular note is Doka's category of disenfranchised grief (1989). This arises in situations in which, for various reasons, grief is discouraged and social supports are absent.

While in the United States, I received a visit from Cicely Saunders, a physician whom I had previously met in London. She brought with her the plans of a new kind of therapeutic community for people with late-stage cancers. I was most impressed by her work and delighted when, in 1966, she invited me to join her in setting up support services for the families of her patients.

St. Christopher's Hospice provided a test bed in which I was able to make use of the findings from the Harvard Study to identify family members at risk and to offer them the help of a carefully trained and selected volunteer counselor. The idea of sending volunteers into the homes of newly bereaved people proved controversial, even at St. Christopher's. It was only after the suicide of a young widow who had not sought help that I was able to persuade the staff to let me carry out a random-allocation study to find out if we were doing good or harm. Fortunately for me, the results of this study fully confirmed the value of our intervention (Parkes, 1981). The effects of the counseling was to improve

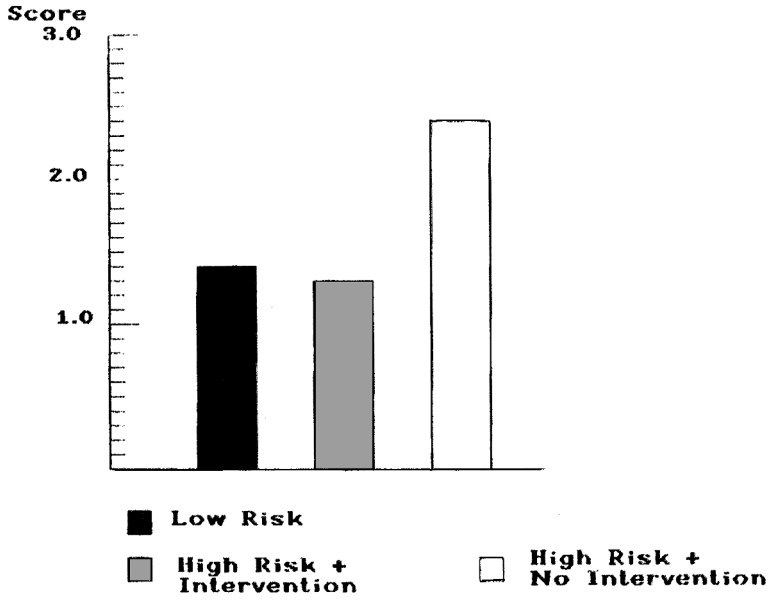


FIGURE 1 Mean Outcome Scores c. 20 months after Bereavement.

outcome to about the same level as that of a low-risk group who received no counseling.

None of this work was taking place in a vacuum. A colleague who was also working in Caplan's unit was David Maddison. He returned from Boston to Australia where he carried out a study of risk factors in bereavement and came up with similar results (Maddison & Walker, 1967; Maddison, Viola, & Walker, 1969). One of his trainees, Beverley Raphael, set up her own bereavement service and carried out an evaluation of the effects of intervention in high-risk bereaved people using a very similar method to my own and also with very similar results (Raphael, 1977). The main differences between her study and mine was that we were in different continents and that, in her case, all of the interventions were provided by a highly trained psychiatrist specializing in bereavement problems (i.e., herself), whereas mine were provided by volunteers.

Under Raphael's influence, the Australian National Association for Loss and Grief has developed training courses for professionals who provide a high standard of care for bereaved people. In recent years, many of these have been used by firms of funeral directors who are able to offer

counseling as part of the package of services provided when somebody dies.

In the United Kingdom it is voluntary services for the bereaved that have flourished, some of them linked with hospices and others based in the community. The best organized of these is *Cruse Bereavement Care*, which has branches in most parts of the United Kingdom and which publishes the journal *Bereavement Care*. This has now become an international journal for all who work with bereaved people.

In the United States things seem to have taken a rather different turn. Death education has come to play a major part in the training of the caring professions under the aegis of the Association for Death Education and Counseling (ADEC) and a variety of excellent professional services are now available including some run by funeral directors. The use of trained volunteers is largely confined to hospices and palliative care units but it is mutual help groups that have come to dominate the scene. These owe much to another of Caplan's protégées, Phyllis Silverman, who has devoted her working life to developing Widow-to-Widow and other projects aimed at bringing bereaved people together (Silverman, 1969). Unfortunately there have been few attempts to demonstrate by scientific means the value of this work, and those that have been carried out, such as Mary Vachon's comparative study, have not shown clear-cut benefits (Vachon, Lyall, Rogers, Freedman, & Freeman, 1980).

Important contributions to teaching have also been made by Bill Worden whose "tasks of grieving" constitute a checklist that has been found very useful by counselors (Worden, 1982).

Related Fields of Study

Psychological Trauma

While these approaches were being developed, other research was taking place that, although not primarily focused on bereavement, has come to overlap with this field and to have triggered important developments. This is the field of stress studies that developed largely independently of the field of loss and grief. There is no space here to go into this in detail but the work of Horowitz and his colleagues in San Francisco who developed the Impact of Events Scale, has done much to bridge the gap between these overlapping areas of study (Horowitz, Wilner, & Alvarez, 1979; Horowitz, 1986).

A landmark event whose influence is still not fully appreciated was the inclusion of post-traumatic stress disorder (PTSD) in the 3rd and subsequent editions of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994). This is the bible of psychiatric diagnosis and the inclusion of PTSD acknowledged that a particular psychiatric disorder could follow a particular life event. This has opened the door to the possibility that other life events will be recognized as causes of other syndromes.

Raphael and Martinek (1997) and Horowitz, Bonnano, and Holen (1993) have tried to formulate criteria for the diagnosis of pathological grief but the most impressive work in this field stems from Holly Prigerson and her colleagues whose recent systematic studies have established clear diagnostic criteria for what they are calling "traumatic grief" (Jacobs, 1999). This should not be confused with bereavement by traumatic death and it includes most of the disorders that have previously been categorized as chronic grief, delayed grief, morbid grief, etcetera. The distinctive feature of traumatic grief, which distinguishes it from most other disorders, is pining for a person who is lost. This places it in the category of separation disorders, a concept that owes much to attachment theory.

Attachments

Attachment theory stems from the seminal work of John Bowlby whose magnum opus "Attachment and Loss" was published in three volumes in 1969, 1973, and 1980. He greatly extended our understanding of the bonds that tie people to each other and of the consequences when separations and losses occur. Bowlby formulated the concept of the "secure base." In childhood this is provided, or should be provided, by a secure relationship with one or both parents and by the familiar home in which the child grows up. Given a secure base, children learn to explore their world and cope with the challenges they meet. Lack of a secure base, however, can give rise to serious problems that interfere with cognitive and emotional development. Bowlby went on to show how therapists and counselors can provide a secure base within the therapeutic relationship (Bowlby, 1988).

The further development of this field owes much to the American psychologist, Mary Ainsworth. She developed a systematic way of studying the attachments between parent and child in her Strange Situation Test

(Ainsworth, Blehar, Waters, & Wall, 1978). As a result she distinguished between secure and insecure attachments and, with the help of her colleague Mary Main (Main & Hesse, 1990; Main & Solomon, 1991), identified three main types of insecure attachment, the anxious/ambivalent pattern, avoidant pattern, and disorganized/disoriented pattern.

Anxious/ambivalent children have anxious, overprotective parents who are insensitive to their needs for autonomy. They tend to become anxious and clinging. Avoidant children have parents who are intolerant of closeness. They learn to inhibit attachment but their apparent independence masks underlying anxiety. Each of these types of children have learned to cope with their parents, the former by staying close, the latter by keeping their distance. Children in the disorganized/disoriented category have no such strategies for survival. They grow up in families in which high levels of stress and depression make their parents unpredictable and inconsistent in their parenting. The children grow up unhappy and helpless. These patterns have turned out to be remarkably stable and, indeed, to predict attachment problems later in life.

This work has initiated a lot of new studies in all parts of the world; as a result the field is developing very rapidly. Among other things is the identification of similar categories of attachment in adult life (Bartholomew & Perlman, 1994). My own work in recent years has included an attempt to map out the attachment patterns of people who seek psychiatric help after a bereavement. I have developed a retrospective questionnaire that confirms that people who report having had secure attachments to their parents show less grief and have lower scores on distress than those who have had insecure attachments. In fact most of their psychiatric consultations have been triggered by unusually traumatic bereavements. (Much of this awaits publication, however Parkes, 1995, gives some preliminary results.)

Among those with insecure attachments, predictions based on attachment theory have mostly been confirmed. To summarize conclusions from a large number of statistical correlations:

Adults who describe themselves as having been anxious/ambivalent children tended, in later life, to have conflicted relationships with their partners. Following bereavement they suffer protracted grief and a continued tendency to cling. Adults who, as children, learned to avoid attachments remain aggressive and assertive in adult life. They have difficulty in expressing both affection and grief. Adults who grew up with family rejection, violence, danger, and depression describe themselves as

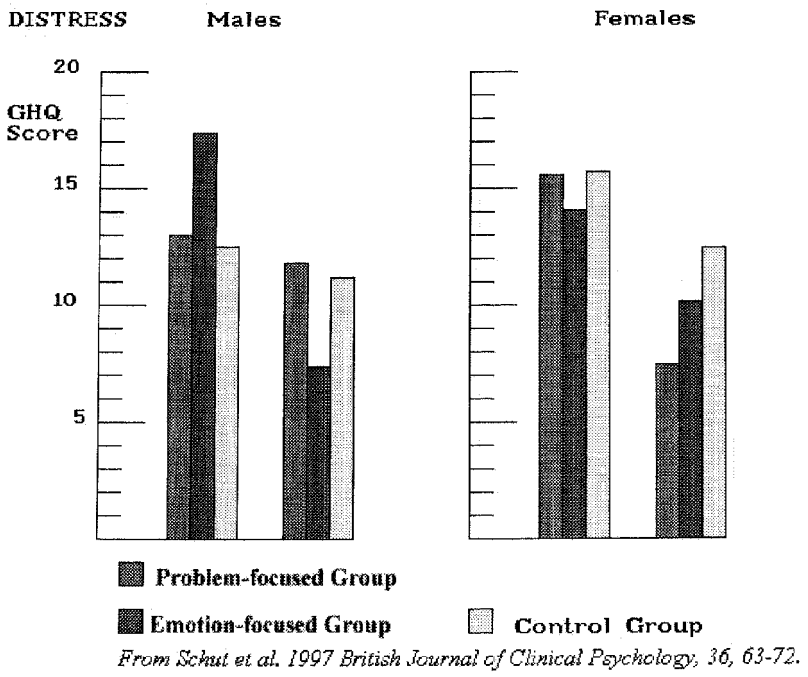
unhappy children. They exemplify Main's disorganized/disoriented pattern of attachment. As adults they lack trust in themselves and others. Under stress they turn in on themselves and may even harm themselves. Following bereavement they become anxious, panicky, and/or depressed. They may turn to alcohol for escape. I have dwelt on these findings because I believe that they reconcile some of the arguments that have arisen in recent years between exponents of various approaches to bereavement care.

Controversies and Recent Developments

During this time psychologists and sociologists have challenged several of the assumptions made by the pioneers. Freud's concept of "grief work" has been questioned by Wortman and Silver (1989) and by Stroebe and Stroebe (1991). Wortman based her argument on the observation that people who show the most distress before bereavement are more, not less, distressed afterwards. She equated high initial distress with "grief work." This argument only holds water if we assume that distress is the same thing as "grief work" and that lack of "grief work" is the only or main cause of problems in bereavement. My work suggests that this type of severe reaction is to be expected in people whose attachments are anxious/ambivalent or disorganized.

More constructive than Wortman's approach is the dual process model of bereavement put forward by Margaret Stroebe and Henk Schut at the University of Utrecht (Stroebe & Schut, 1999). They pointed out that, in the acute phase of grief, people tend to oscillate between the so-called "pangs" of grief—when they are focused on thoughts of loss and pining for the lost person and periods when they put their grief aside—are less distressed and able to begin to look forward and make plans. They termed these *loss orientation* and *restoration orientation.* Both facing loss and turning away are appropriate responses so long as they do not last too long. Some people, however, become preoccupied with the loss orientation and others with restoration. The former equates with chronic grief, the latter with avoided grief.

This model does seem to correspond reasonably well with the observed evidence and with my own research which, as we have seen, explains why it is that some people find it hard to stop grieving, while others avoid it. In both cases it would seem likely that the provision of a



From Schut et al. 1997 British Journal of Clinical Psychology, 36, 63-72.

FIGURE 2

secure base in which people can feel safe enough, either to let go of the person 'out there' and move into the restoration mode or to relinquish avoidance and begin to face the pain of loss orientation.

The Dual Process Model also conforms with the findings of another study by the Utrecht group (Schut, Stroebe, van den Bout, & de Keijser, 1997). They assigned people with problematic bereavements, at random, to one of three groups: an emotion-focused group that used Lindemann's traditional method of helping people to express grief; a problem-focused group who adopted a more cognitive, forward-looking approach; and a waiting-list control group. When all three groups were followed up, they found that both of the counseled groups did better than the control group. Looking more closely they found that men, who in most societies are more inclined to avoidance of grief, had responded best to emotion-focused help whereas women did best with problem-focused help. It is worth noting that if they had been given a free choice the men would probably have chosen the

problem-focus and the women the emotion-focus group. What our clients want is not necessarily what they need.

Another sacred cow that has come under attack is the concept of stages of grief (Wortman & Silver, 1989). Several studies have failed to replicate earlier work and critics have suggested that it is inappropriate for counselors to attempt to impose this model on their clients. Each person will grieve in their own way and their own time. I am inclined to agree that the phases have been misused but I think that they served their purpose in providing us with the idea of grief as a process of change through which we need to pass on the way to a new view of the world.

My own studies of the reaction to amputation of a limb (Parkes, 1975) and Fitzgerald's studies of blindness (Fitzgerald, Ebert, & Chambers, 1987) gave rise to the concept of psycho-social transitions (Parkes, 1996). They showed how people faced with change need to let go of redundant assumptions about the world if they are to learn to live as an amputee or a blind person. The same applies to bereaved people. Many habits of thought and behavior that depended on the presence of the person now lost have to be given up if we are to find new ways of living in a world without the person who has died.

But letting go does not mean forgetting the dead. In fact, there are many people who find that they feel closer to the dead person when they give up trying to force them to return "out there." Only then do they realize that there is a literal truth in the saying "He (or she) lives on in my memory." The concept of continuing bonds is a useful one that has been explored by Klass, Silverman, and Nickman (1996).

Another contribution to our understanding of psycho-social transitions comes from Janoff-Bulman who points out that the assumptive world includes basic assumptions regarding our security, worth, and the protection of others. In her book *Shattered Assumptions* (1992), she described how traumatic life events can easily shatter these assumptions and leave us feeling insecure, unworthy, and unprotected.

One other area of controversy is Engel's notion of grief as a disease (Engel, 1961). Engel pointed out that grief is a cause of great mental pain, it produces a variety of bodily and psychological symptoms and it interferes with our ability to function effectively. Bereaved people find that their concentration, memory, and judgment are impaired and a period of time off work is often needed. These are the criteria normally thought of as evidence of illness. Yet the consequences of severe grief are not

covered by health insurance and bereaved people receive no medical help or legal compensation for the suffering that they undergo.

Most of those who work with bereaved people prefer to reserve the term *pathological* for the minority of bereaved people whose grief fails to follow the course that, in Western society, is regarded as "normal." They see it as unfair to bereaved people to stigmatize them with a psychiatric diagnosis and they see no reason to believe that doctors are the best people to treat grief.

Perhaps the problem lies in our prejudice about mental illness. By excluding grief from our diagnostic categories, we may collude with those who see all mental illness as permanent and shameful and, in doing so, we may perpetuate the prejudice. Yet, if we are honest, we should admit that there are times when most of us need to be relieved of our responsibilities, to take a break, unload our problems onto others and even take a drug (such as alcohol) that will relieve some of our feelings of distress.

Attitudes toward medical treatments for grief may change if the new range of anti-depressants live up to their promise, and there is a great need for research to determine the costs and benefits of these drugs to bereaved people. (There are few mothers today who reject the use of anaesthetics in childbirth simply because labor pains are "normal.")

Visions for the Future

So what of the future? It is possible that the inclusion of "traumatic grief" within the orbit of psychiatric diagnosis will pave the way to a greater recognition of the fact that losses of one sort or another impair the lives of many of us. By widening the range of mental disorder to include the temporary impairment of function that follows many of the traumatic life situations that we face, we may eventually reduce the stigma. People may come to see grief as a transient disorder for which help is needed in much the same way that we now view a broken limb.

Regardless of this, in a world in which many people can no longer rely on their own families to provide them with emotional support, non-judgmental acceptance, and tolerance, there will continue to be a need for counselors who will do just that and who understand about grief.

Recent years have seen a steady increase in the numbers of such counselors and a similar increase in the willingness of bereaved people to seek their help. The internet enables those who prefer to remain anonymous

to do so and must create its own safeguards against the unscrupulous minority who abuse it. Help is needed by people of all races and status, but especially by those who are at the bottom of the pile, who are likely to be most at risk and least likely to afford to pay for therapy. Sadly the "inverse care law" currently implies that those in most need of support are least likely to get it.

Paradoxically this also applies to those at the top of the hierarchy. Most support systems work downwards. That is to say, the people at the top of the hierarchy are expected to support those below them. But who supports the people at the top? As attitudes to counseling continue to change we may find that people in positions of power will come to recognize their own needs for support.

Anger, we know, is a part of grieving. It can also bring about the cycle of violence that can become self-perpetuating. How many times in history have terrible deeds been done because people in power were overwhelmed with grief and acted out their rage? How easily a delicate political balance can be destroyed by an act of violence. I have a dream of a cadre of specially trained "counselors" whose role would be to monitor the needs of people in positions of leadership, to ensure that they are supported as they struggle to fulfil their roles as leaders at times of crisis. Such counselors would themselves carry great responsibility and would need to be incorruptible and properly supported.

I am not pessimistic. In my lifetime, I have seen a new science and art of hospice and palliative care arise for families faced with death. I have seen training in bereavement become a part of the curriculum of many doctors and nurses and, although there has never been enough money to do things in an ideal way, I have seen important progress made whenever people who care have come together to work with each other to achieve change. Above all I have come to respect the potential of the many people who volunteer to help the dying and the bereaved.

Perhaps my most heartening experience was in Rwanda. Visiting that poor country a year after the genocidal killings that devastated that land I had little hope that the small group of psychologists and social workers employed by UNICEF under the leadership of the American psychologist, Leila Gupta, would achieve anything worthwhile. Yet, over the months that followed that little group recruited and trained groups of volunteer counselors, those volunteers each went out and trained another group until they had 21,156 teachers, caregivers, social workers, community and religious leaders, health workers, and local associations

who reached out and supported over 200,000 children and surviving families (Gupta, 2000). If anything can break the cycle of violence and restore peace in Rwanda and elsewhere it must be ventures of this kind.

So my vision for the future is of a world where Beowulf's dragons are extinct; no one needs to resort to terrorism or violence to assuage their grief; where the global village, with all its soap operas and other trivia, brings everyone who needs it within reach of proper and effective help; where parents as well as children, leaders as well as followers, receive the cherishing and support that they need; where the griefs that are a necessary part of life are recognized as such and those who suffer them receive understanding and wise counsel.

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