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Strategies of professional assistance after traumatic deaths. Empowerment or disempowerment?

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Abstract

Referring to research and theory in the field, this discussion paper addresses the more overarching question of current strategies for professional assistance to populations bereaved by traumatic death. The issues and controversies that have long surrounded the "medicalisation" of mental health arise anew with respect to the medicalisation and professionalisation of psychosocial help for people who have been traumatically bereaved. Who should provide what help and how? To what extent should the bereaved be expected to help themselves, receive help and support from friends and family, or even the wider community; and to what extent should the bereaved be able to access appropriate professional help when they are in crisis? Recent studies have indicated that bereaved parents want to receive help from mainstream crisis psychology, and this is not always available. Families experiencing traumatic bereavement are not able to access appropriate services along the same lines as those suffering similar levels of somatic complaints. It is argued that the main factors contributing to this situation are the lack of knowledge and inadequate organisation of services; the fact that somatic issues take priority over psychosocial difficulties and dysfunction, and curative services over prophylactic intervention; and particularly the de-medicalisation ideology. By not listening to the needs of user groups, the de-medicalisation movement disempowers rather than empowers users – the very opposite of the desired effect.

Key words: medicalisation, empowerment, traumatic deaths, postvention, client perspective.

Introduction

The findings of a nationwide research project[1] in Norway rendered it necessary to revisit the old controversies around the "limits of medicine" (Illich, 1975). The project focused on the experiences of bereaved whose lives were affected adversely by death – a life turning experience. Although the results showed that they struggled with serious problems, they received limited professional assistance. Two very important and practical questions arose:

1. What determines the nature and extent of the professional assistance that is available to people facing a life crisis, as opposed to what they should and could handle by themselves or with help from their social networks?

2. Does the availability of professional assistance empower or disempower people in a psychosocial crisis?

For years, philosophers, sociologists, psychologists, and psychiatrists have attempted to answer these questions. Discourses of medicalisation have assumed that once people are defined as "patients", they are necessarily made powerless. It has been argued that in order to prevent people from being disempowered, one should "free the patient from the doctor" – and, by extension, from the psychologist, the therapist, the psychiatrist, and so on. However, most such arguments have been theoretical and have not taken account of findings from studies of what "user groups" themselves want – a kind of disempowerment by theorists one could say.

This discussion paper aims at connecting the theoretical debates with the voices of real people from a particular area – namely parents who have experienced psychosocial crises after sudden, traumatic death. Referring to previous research and

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[1] "Support and care for survivors of suicide, SIDS and accident: Evaluation of recipients and providers of care" – Abbreviated: "The Support and Care Study" (Dyregrov, Dyregrov, & Nordanger, 1999*; Dyregrov, Nordanger & Dyregrov, 2000; Dyregrov, Nordanger & Dyregrov, 2003; Dyregrov, 2002b; Dyregrov, in manuscript).*

theory in the field, the paper addresses the more overarching question of current strategies for professional assistance to these populations. After a brief introduction to central fields for the coming discussion (medicalisation and empowerment), the parental impact of traumatic loss is described. Thereafter, the paper presents bereaved's own wishes for help, which correspond to the type of help now available in mainstream crisis psychology. The next section examines the great lack of public professional assistance to bereaved groups, which seem to be linked to different strategies and ideologies. Finally, the discrepancy between the effects of a de-medicalisation strategy aimed at defending "patients" against professional domination and the great need for professional and/or non-professional help articulated by the bereaved people is critically discussed.

The medicalisation critique

The medicalisation critique can be traced back to literature in medical sociology from the 1960s and 1970s, dominated by liberal humanism, as well as by Marxist and feminist perspectives. Essentially, the concept of medicalisation refers to an increased tendency to *"define behaviour as a medical problem, or illness, and mandating or licensing the medical profession to provide some type of treatment for it"* (Conrad, 1975:12). According to Strong (1979), the key propositions of the medicalisation thesis were as follows:

Insert figure 1. here

Many theorists have traditionally agreed on the phenomenon, but they have differed considerably in their views as to the causes of medicalisation. Whereas Illich (1975) emphasised medicalisation as part of wider processes of industrialisation and bureaucratisation, Freidson (1970) argued that medicine had begun to take on the role of social regulation traditionally performed by religion and the law. Later,

Waitzkin (1983) argued that medicalisation was a means of serving the interests of the ruling capitalist class, whereas feminist writers stressed the ways in which women's bodies and lives were increasingly subjected to control by a patriarchal medical profession (Oakley, 1984). Thus, the notion that individuals have their autonomy constrained by more powerful others is central to the medicalisation thesis.

The critique of medicalisation took on new dimensions from the early 1980s onwards, when a new and more thorough debate emerged, influenced by the Foucauldian scholarship (Lupton, 1997). Medicalisation from this latter viewpoint, involves not simply new forms of surveillance but the fabrication of new subjectivities, from the so-called health promoting self to the dying person and the whole self (Williams, 2001). According to Foucault, power, as it operates in the medical encounter, is a disciplinary power that provides guidelines about how patients should understand, regulate, and experience their bodies (Lupton, 1997). Thus, it is claimed, health professionals increasingly amass power and influence by controlling more and more of the life-world of human beings. The term "medicalisation" is generally used in a negative sense; to be medicalised is never desirable.

The empowerment debate

Countering medicalisation, according to most critics, includes challenging the right of medical and other health professionals to make claims about their power to define and treat illness and disease. Thus, the latter is linked to "the empowerment debate", which aims at restoring the power and control of the patient (often renamed consumers or "users"). Thompson (1993) defines empowerment as "*The process of giving power to clients in whatever ways possible – resources, education, political and self-awareness and so on*" (pp. 32). In this manner, empowerment is considered

as a <u>goal</u> to escape from a suppressed position, and at the same time, the concept describes a <u>method</u> to achieve social change, i.e. both an ideology and a methodological approach. Braye and Preston-Shoot (1995) point out the following common elements of empowerment:

Insert figure 2. here

<u>The psychosocial situation of bereaved parents</u>

When a young family member dies suddenly and unexpectedly, as by suicide, accidental deaths, and Sudden Infant Death Syndrome (SIDS), the experience often results in serious and long lasting psychosocial problems for the bereaved (Cleiren & Diekstra, 1995; Dyregrov & Dyregrov, 1999; Jordan, 2001; Murphy & Johnson, 2002; Rönnmark, 1999; Thuen & Schlytter, 1996; Vance, Foster, Najman, Thearle, Embleton & Boyle, 1993).

Results from the Norwegian nationwide "Support and Care Study" (Dyregrov et al., 2003), showed that one and a half year after the sudden death of an offspring by suicide (< 30 years), SIDS (< 2 years) or accident (< 18 years), the bereaved parents reported serious physical, social, and psychological problems. Sixty percent of all parents (N=232) scored above a cut-off point for high levels (> 4) of psychosocial and physical complaints as mapped by the General Health Questionnaire (GHQ) (Goldberg & Williams, 1988). These findings include psychic distress as somatic symptoms, anxiety and insomnia, social dysfunction and severe depression that might lead to long-term impairment of life-quality. The results also showed that 52% of the parents suffered from high levels (cut-off point > 35) of post-traumatic distress as measured by the Impact of Event Scale (IES) (Horowitz, Wilner & Alvarez, 1979). Thus, they experienced unwanted thoughts and images (intrusion reactions), strong anxiety and negative emotional reactions (arousal reactions), as

well as denial of the event and its consequences (avoidance reactions). As found by other researchers, many survivors of crisis events suffer from levels of post-traumatic psychological distress indicating a high risk of Post Traumatic Stress Disorder (PTSD) (Joseph, 2000; Yule, 1999). Moreover, considering the accumulating number of bereaved over time, the findings endorse a recent study concluding that sudden unexpected death of a loved one accounts for approximately one third of PTSD cases in the community (Breslau, Essler, Chilcoat, Schulz, Davis & Adreski, 1998). Finally, a huge proportion (74%) of all the parents in the "Support and Care Study" scored above recommended cut-off levels (> 25) for complicated grief reactions (Dyregrov et al., 2003) as mapped by The Inventory of Complicated Grief (ICG) (Prigerson, Maciejewski, Reynolds, Bierhals, Newsom, Fasiczka, et al., 1995). Identifying symptoms distinct from bereavement-related depression, the measure shows that parents are preoccupied with thoughts of their child, searching and yearning for it, experiencing disbelief about the death and are stunned by, and have difficulties in accepting the death. The results from the ICG are consistent with other findings showing that sudden, untimely, preventable, and violent death may also lead to delayed, or distorted mourning; or what is proposed as the new syndrome of complicated/traumatic grief (Prigerson et al., 1995; Prigerson, Shear, Jacobs, Kasl, Maciejewski, Silverman et. al., 2000).

In the wake of traumatic death, many bereaved experience long lasting social difficulties, e.g. with their social identity and social relations, as well as problems with social interaction in the family, at school, work and among friends (Amaya-Jackson, Davidson, Hughes, Swartz, Reynolds, George et al., 1999). Additionally, as was one of the main findings in the "Support and Care Study", there is a profound tendency among bereaved to withdraw and isolate themselves from others. This self-

isolation seems to be linked to loss of energy and feelings of guilt and self-blame by parents who lose their children in sudden and traumatic deaths (Dyregrov et al., 2003). Moreover, social and emotional withdrawal often acts as a barrier to accepting offers of social support, and professional assistance (Dyregrov et al., 2003; Murray et al., 2000; Wertheimer, 1999).

Janoff-Bulman (1992) concludes that post-traumatic stress results in an existential crisis that challenges bereaved individuals' assumptions of their existence in the world, the safety previously taken for granted and what may possibly happen to them (Janoff-Bulman, 1992; Jordan, Kraus & Ware, 1993). This was also found in the "Support and Care Study" where the brutal upheaval in the lives of the parents made great demands on their capacity to confront and handle what had happened, cognitively as well as emotionally. Grief researchers argue that, given the opportunity - the bereaved may, over time, reconstruct life-assumptions or integrate what has happened in their existing assumptions of the world, themselves, and others (Janoff-Bulman, 1992). The opportunity to express thoughts and feelings about a loss to others may contribute considerably to the healing of the biographical disruption caused by the event (Neimeyer, 2000; Riches & Dawson, 1996). Thus, a process of reconstruction or re-ordering of meaning seems to be central to healing processes during grief.

An imminent question is whether the bereaved, together with their social network, are able to cope with the tremendous existential, psychological, and social difficulties they experience. Alternatively, do they also ask for professional help?

<u>What kind of help is needed – professional or network support?</u>

When asking parents in the "Support and Care Study" what kind of help they need, 88% emphasise that it is not a question of <u>either</u> formal assistance

(professionals/community based) <u>or</u> informal support (social network) in dealing with their loss (Dyregrov, 2002b). They argue that they need both forms of help because they meet different needs. Other recent reports also argue that the support from a social network cannot replace the professional assistance, or vice versa (Clark, 2001; Murphy, 2000; Provini, Everett & Pfeffer, 2000).

Still, for many years, social network support has been looked upon as the most appropriate help strategy for people in psychosocial crisis (Dunne, McIntosh & Dunne-Maxim, 1987). Moreover, a huge body of knowledge has demonstrated the important role of social support in reducing the impact of sudden loss on grief symptomatology (Dunne et al., 1987; Reed, 1998; Sherkat & Reed, 1992; Thuen, 1997). "The Support and Care Study" confirms that bereaved groups received extensive support from family, friends, work colleagues, neighbours, etc., especially in the first weeks following the loss. Close friends and family came to comfort them or simply stayed with them at home. They brought food, helped them with housework, took them for a walk, or tried to break their social isolation. Many parents also received warm letters, poems, or books, and they very much appreciated most of the network contact (Dyregrov, in press).

It is, however, important to acknowledge the fact that there are different reasons why social network support may be insufficient or might be experienced as unhelpful or even harmful and thus contradictory to its purpose (Brabant, Forsyth & McFarlain, 1995; Dyregrov et al., 2003; Thoits, 1995; Wertheimer, 1999). First, not everybody, for different reasons, has a well-functioning social network system. Secondly, many bereaved may withdraw from their network (Dyregrov, in press; Murray et al., 2000; Wertheimer, 1999). Third, if a network exists, network members often show ineptitude on how to encounter people in crisis (Dyregrov, in press;

Harris, 1992; Thompson & Range, 1992; Wertheimer, 1999). Lack of an appropriate understanding of the time perspective of grief and withdrawal of support far too early is experienced as causing the most strain in the encounter with social networks (Dyregrov, in press; Murphy, 2000; Wertheimer, 1999). Finally, some problems, e.g. PTSD, family communicational problems, or difficulties due to lack of information, may require assistance from specific professional groups, which of course the network neither can nor should be responsible to handle. In fact, bereaved groups often refuse to burden their close friends or family members with their worst thoughts of guilt or shame, images ("flashbacks") of the dead or the death scene, or problems of a personal character, something which indicates a need for professional assistance as a supplement to social network support.

Bereaveds' wishes for professional help correspond with specialists'
recommendations

When asked to describe ideal professional help, the bereaved wish for: a) early help, b) outreach help from trained personnel, c) information about the event and reactions that may arise, d) possibility to meet with others who have experienced the same or a similar situation, e) more help for surviving children and e) help over time. They also emphasise the importance of practical and economic help and help with legal issues (Amaya-Jackson et al., 1999; Clark, 2001; Dyregrov & Dyregrov, 1999; Dyregrov, 2002b; Murphy, 2000; Murray et al., 2000; Provini et al., 2000). Although it is important to remember that some bereaved refuse help "from outside" and/or are able to handle their situation with help from their social network, the following question arises: Is the Welfare State prepared to provide the professional help that most bereaved are asking for?

In recent years, crisis interventions have been developed to meet the expressed needs of bereaved and traumatised people (Bryant, Harvey, Dang & Sackville, 1998; Dyregrov, 2001; Dyregrov 2002a; Wertheimer, 1999). Mainstream crisis psychology advocate two phases of intervention – early and long-term, acknowledging that there, (e.g. due to the seriousness of the trauma, exposure, and individual and familial vulnerability factors), will always be a considerable variation concerning the necessary content and duration of the professional assistance (Dyregrov, 2002a; Hodgkinson & Stewart, 1998; Raphael & Wilson, 2000; Yule, 1999). Several authors have pointed out the importance of re-establishing order and structure provided through information, rituals, and counselling (Amaya-Jackson et al., 1999; Clark, 2001; Dyregrov, 2002a; Murphy, Johnson, Cain, Gupta, Dimond, Lohan et al., 1998; Murray et al., 2000). Thus, the strategy implies that the bereaved will be contacted one of the first days by e.g. a crisis team who knows of their situation (active outreach). Initially, they will be given various forms of written and oral information, social network support will be activated (if not already functioning), and necessary help for children provided. It is considered especially important to offer those who are most traumatised cognitive behavioural therapy instead of non-specific therapies in preventing chronic PTSD (Bryant et al., 1998). Murray et al. (2000) demonstrated that bereaved populations, who are identified prior to intervention as being at the highest risk of developing complicated grief, benefit the most from a postvention program. Long-term follow-up is found to be especially important in reducing the risk of complicated bereavement and PTSD (Dyregrov, 2002a; Murray et al., 2000).

In most welfare states, local authorities are responsible for meeting the needs of the bereaved population both by curative and prophylactic means. Nevertheless, there is a huge variation among local authorities when it comes to their strategies of

how to help the bereaved after sudden, traumatic deaths. Whereas 85% of the communities in Norway offer <u>some</u> kind of acute help (priest, MD, nurse), only 13% of the communities provide long-term follow up (a year or more) (Dyregrov et al., 1999; Dyregrov, 2002b). Why do not bereaved populations get the professional help that is available and needed?

<u>Current strategies defining the limits of professional assistance</u>

In "the Support and Care study" (Dyregrov et al., 1999; Dyregrov, 2002b) four different strategies for psychosocial assistance (i.e. help with the psychological as well as the social problems) after traumatic deaths were identified among 321 local communities in Norway; 1. "The prevention strategy" (early intervention and follow-up), 2. "The treatment strategy" (late intervention), 3. "The ignorance strategy" (no intervention due to ignorance and/or priority), and 4. "The de-medicalisation strategy" (no intervention based on ideological motives). Probably, these strategies, which seem to be based on more or less explicit ideologies, exist in varying degrees and forms in many Western countries today. In the following, the strategies are elaborated in more detail.

1) "The prevention strategy" corresponds with the above-mentioned mainstream crisis psychology. Its main intention is to prevent dysfunction through early crisis intervention followed by an individually/family adapted long-term follow-up. It is important to stress that this strategy differs distinctly from merely short initial debriefings, which are of little value if not combined with a long-term follow-up (Mayou, Ehlers & Hobbs, 2000; Rose, Bisson & Churchill, & Wessely, 2002). It is considered to be an important task to normalise the situation and minimise recovery time, in collaboration with the bereaved, by reducing distress, and restoring function in individuals, families, and local communities (Dyregrov, 2001).

The strategy also emphasises the need to mobilise resources; of the bereaved, in social networks, among professionals, or others who have experienced similar kinds of loss. Altogether, the strategy acknowledges that some experiences are so atrocious for human beings that, in order to reduce the risks for dysfunction and to ease the situation, professionals introduce systematic efforts without the bereaved having to ask for it.

2) "The treatment strategy" is probably one of the most common strategies in most countries today. It implies late professional help, if any at all. This strategy acknowledges the traumatic event as a serious impact, but involves an attitude of "wait and see, and cure if necessary". An important principle is that atrocities in people's lives should be handled by "the natural healing processes" of the individual together with social networks. Professionals should not act upon the traumatic event until a problem manifests itself. Usually, this means a manifestation of traditional medical symptoms. Thus, many bereaved are treated later on for depression, anxiety disorders, headache/migraine, and several other physical diseases like flu and infections, documented to have an increased prevalence in bereaved populations (Sèguin, Lesage & Kiely, 1995; Vance et al., 1993). The reasons for rejecting preventive intervention on an individual level are explained by Weisæth (2000), *"In general, the axiom of early intervention has to be challenged as long as there are insufficient data to support it in a convincing way, and even more so when professional health workers carry out the interventions and not lay people"* (p. 55).

The strategy fits in with traditional medical practice assuming that bereaved act upon, define and present their problems to professionals, and actively ask for help. The professionals will help if, and when, they are asked to. Whereas the first strategy is most advocated by crisis psychologists, the second is more common among

representatives of the medical profession. The latter strategy has obvious links to the third and fourth strategy.

3) "The ignorance strategy" reflects the fact that many countries as well as some professionals in Norway still are ignorant of the psychosocial impact of traumatic events, or do not give it priority among all the demands on the local authorities. As knowledge in the field of psychosocial crisis intervention is relatively new compared to the history of psychology and medicine, there is great variation world wide as to the distribution of this knowledge. However, professionals are obviously more updated in countries where basic somatic diseases are under control, and in countries that acknowledge and treat psychiatric diseases. Still, in the "Support and Care Study," a number of Norwegian communities revealed that lack of knowledge, organisation, and resources were the main reasons for lacking provisions for the bereaved (Dyregrov, 2002b). Whereas the health authorities in many communities worked to improve on the shortcomings, others did not and stated: "*It should not be given priority*". The latter attitude may be linked to the next strategy.

4) "The de-medicalisation strategy" also implies no psychosocial intervention, for ideological reasons, rather than the reasons mentioned under the previous strategy. Although the traumatic impact and hardships for the bereaved are acknowledged to a certain extent, the ideology asserts that atrocities are part of normal human life. The best help is provided by the bereaved together with their social networks, and professionals may make things worse. The ideology is very often implicit and not verbalised among community professionals, or explained as different "values", "priorities" and "attitudes" regarding psychosocial assistance. A heated debate in Norwegian newspapers instigated by Kringlen, a senior professor in psychiatry, may

exemplify this strategy. Through headlines like "Crisis-psychiatry makes things worse", "Crisis-psychiatry – cosmetic medicine", and "Crisis-psychology as industry" (Bergens Tidende, 2001; Kringlen, 2001) he provoked the bereaved, and was strongly resisted by professionals working in the field. Professional crisis intervention was compared to "life-style medicine" of removing wrinkles, shaping noses, enlarging breasts, and bleaching teeth (Bergens Tidende, 12.02.2001). Referring to a study of short debriefing sessions to victims of traffic accidents, criticised for its serious methodological weaknesses (Mayou et al., 2000), Kringlen concluded that professional help to trauma victims should cease. Generally, he warned against the professionalisation of support and care, and argued that crisis psychology may interfere with natural healing. His conclusion was that members of social networks are the best helpers.

The discrepancy between the medicalisation theorists aiming at defending the "patient" against "professional restraint" and the bereaved who ask for professional help is evident. How may this paradox be explained?

When an empowering philosophy results in disempowerment

In the following, it will be argued that bereaved groups are disempowered and not empowered by the medicalisation debate. The debate is too general, as well as too theoretical, and thus acts to protect somatic and curative medicine. Besides, the medicalisation critique underestimates and disregards the voices of those they intend to protect. Agreeing with Illich (1975), this author claims that there should be limits to medicine, i.e. limits to the use of the medical model facing human problems and suffering. However, a question too often unanswered is "Who are, and who should define the limits – the theorists, the clinicians, the user groups, "society" - or all of these?"

Recent medicalisation critics warn against a swelling welfare state that socialise professional groups to think that all illness and abnormality should be treated. Moreover, they conclude that the medical jurisdiction is still expanding, now encompassing "natural life processes" that hitherto have not been defined as medical issues; e.g. sexuality, child development, menopause, ageing, and death (Berg-Eriksen, 1990; Conrad, 1992; Fugelli, 1999; Kringlen, 2001; Summerfield, 1999). Statements like "*It is unnecessary to learn to grieve by attending courses! Professionalisation of grief is weakening the ability to regenerate, rather than being of help*" (Berg-Eriksen, 1990) (pp. 245 - my translation), are applied to the grief of bereaved experiencing an expected death of an old person, as well as to the shocking experiences of parents who loosing a 15-year-old by hanging. Apparently, such generalisations show that there must be a major discrepancy between a theoretical notion about "ordinary grief" and the reality of the bereaved who experience traumatic deaths. Williams (2001) argue that, all too often, the medicalisation critique is too general and over-simplified, and a more balanced perspective is neglected, if not negated.

The medicalisation critics should put more effort into separating what are sad, but normal experiences, from experiences that often lead to serious clinical syndromes or illness. As pointed out by Broom & Woodward (1996) medicalisation in the traditional sense should sometimes be considered helpful. When theorists tell people that they do not need help, this is not simply arrogant, but displays a singular ignorance concerning the situation of the bereaved. Does this reflect the fact that the critics are too far removed from the empirical world that they discuss? Are not the medicalisation critics caught in their own trap, when they claim to know that no professional help is the best solution for the bereaved?

A main concern of the medicalisation critics has been the potential problems of a growing part of experts focusing on risks of daily life, resulting in medicalisation of "normal life processes" and a potentially reduced tolerance of deviance. Populations bereaved by traumatic deaths experience their losses to be far more than part of normal life processes. As pointed out by the traumatic bereaved; people are offered acute treatment and routine follow-up when suffering from a heart attack or a broken leg, but when they experience a huge life-crisis, resulting in both physical and psychosocial problems, there is no service for them. Desperate utterances, like the one from a woman who lost both her ex-husband and son by suicide, is not worthy of a welfare state: *I thought of how I could break both legs, so that I might be taken care of by someone in the health services* (Dyregrov, 2002b). She explained that her situation was so critical that she was prepared to cause an acute physical injury so that the health professionals should take over her life for some time. Why is it so much more important to rely on "natural healing processes" for emotional scars than physical scars?

In many ways the medicalisation critique seems to fit in with the traditional medical discourse in Western society; (somatic) diseases are cured, difficulties defined as "somatic" take priority over psychosocial issues, and curative services take precedence over prophylactic intervention. Applying the medicalisation critique to the trauma and crisis field, Summerfield (1999) claims that one of the features of 20th century Western culture has been the way medicine and psychology have displaced religion as the source of explanations for the vicissitudes of life. With scepticism, he states that terms like stress, trauma, and emotional scarring have come into commonplace usage by the public, and used both metaphorically and as an indication for professional help (Summerfield, 1999). This shift may be explained by

the fact that the western world has become increasingly more secularised, new models of explanations have been developed in the crisis field, and that people are generally better informed. In addition, in the same way as stress, trauma, and emotional scarring are more and more acted upon by the public indicating a need for help, problems such as high cholesterol, high blood-pressure, and diabetes II, were for the first time defined as medical disorders only some decades ago. Now, preventive treatment of these conditions is taken for granted, also among the medicalisation critics. When it comes to prestigious areas within in the treatment of somatic diseases, e.g. treatment of high blood pressure and cancer prevention, huge resources are also put into very uncertain prophylactic tasks. It is interesting to observe how this "new lifestyle disease" is accepted worldwide and not hit by the medicalisation critique, whereas groups of bereaved become a target for this critique. As pointed out by Williams (2001), the medicalisation critique should be aimed at targeting all existing treatments in all professional fields; otherwise, one is neglecting the fact that in one way or another they have long been medicalised.

According to the critics, one of the most serious results of medicalisation is a reduction of the individual's capacity for taking responsibility of his/her own life and health, making people powerless, unfree and dependent (Conrad, 1975; Lupton, 1997; Seymor, 1999). Applied to the crisis field, it is hard to see how the individual's autonomy should be reduced as a result of crisis intervention. Research shows that there is a far greater risk of traumatised groups being overpowered by their own reactions, isolation, and lack of support, than by crisis intervention aiming at helping the individual to regain control over their lives. The bereaved clearly state that lack of help deprives them of this possibility. The medicalisation critique neglects the fact that traumatised populations who ask for help in many ways are the best experts

when it comes to their own experiences. As claimed by Williams and Calnan (1996), lay voices are important in providing a highly needed empirical check or balance to broader theoretical claims and contentions, and empirical research on user groups should be conducted more substantially (Opie, 1998). Besides, empirical evidence suggests that the populace is in fact far more sceptical of modern medicine and technological developments than medicalisation theorists have realised (Williams & Calnan, 1996).

According to Hughes and Patterson (1997), the medicalisation debate should include a "sociology of impairment" as an important step in a process of increased awareness and control for individuals who need professional help. Through increased consciousness of the impairment, the individual and subjective experience of the problems, and the importance of the problems as seen by society, traumatised groups could more easily be helped on their own premises. Instead of criticising the fact that traumatised and bereaved people are being helped, the focus should be put on how the assistance is being offered and how to empower those being helped. Therefore, professionals who claim that crisis intervention is medicalisation of normal life-processes resulting in disempowerment are encouraged to empower the bereaved by listening to them. That would actually be in accordance with the medicalisation critique, which advocates empowerment.

Empower the bereaved by listening to them

Gutièrrez (1990) sketched some methodological principles that must underlie a professional approach in an empowerment perspective (fig. 3).

Insert fig. 3 here

The close links between the objectives of the empowerment tradition (fig. 2) and "the Preventive strategy" are obvious. These objectives are also in

correspondence with the wishes of bereaved groups. Crisis intervention is also in line with most critical voices of medicalisation that encourage people to regain control over their own health by engaging in preventive health activities (Lupton, 1997). Therefore, as stressed by Morris (1993), it is important to bear in mind that autonomy or independence is not linked to the physical or intellectual capacity to care for oneself without assistance; having assistance when and how one requires it actually creates independence. This is clearly spelled out by the disempowered groups of bereaved, who experience that they need routine psychosocial assistance to regain control over their lives (Amaya-Jackson et al., 1999; Dyregrov & Dyregrov, 1999; Dyregrov, 2002b; Murphy, 2000; Murray et al., 2000; Provini et al., 2000).

In line with the empowerment tradition emphasising that professional helpers should be regarded as a resource for the client, "the Preventive strategy" considers it important to make that relationship work, based on openness, respect, and trust. Crisis intervention intends not overstep the personal integrity of the individual, but aim at increasing coping, self-care, power and responsibility. This is what many bereaved claim to be of outmost importance regarding any kind of assistance (Dyregrov, 2002b). Moreover, "the Preventive strategy" stresses that every group or family member may grieve in different ways or at different pace. Thus, the assistance must be based on respect for the situation of the individual, and at the same time view the individual as situated in a wider social context (Dyregrov, 2001). This approach to psychosocial problems differs from the medical approach. While the former approach applies knowledge about psychological mechanisms and process to re-establish individual capacity of solving problems, the "Treatment strategy", as a bio-medical approach, still has some remnants of Parsons' expert model where the doctor "treat" the patient in order to "heal" him (Parsons, 1979).

However, although it is central to balance between attitudes of Laissez-Faire and overpowering the bereaved, it is necessary to acknowledge that the psychosocial crisis may be so profound that the bereaved sometimes claim that they want professionals to "take over their lives" for a short period of time (Dyregrov, 2002b; Dyregrov, in press).

<u>Towards a more comprehensive health practice?</u>

When studying the national "Law of Health Services for the Local Communities" from 1982, there is little doubt that traumatic bereaved groups already are entitled to public help. Pursuant to this law, local authorities are responsible for meeting the physical, psychological, and social needs of the bereaved population through curative and prophylactic relief measures. Hence, political strategies based on a willingness to take responsibility for the psychosocial problems to the same extent as for somatic complaints should be implemented. The Community Health Services should acknowledge their responsibilities for psychosocial health and initiate necessary efforts to relieve the bereaved of their heavy and often long lasting burdens. Considering the existing knowledge of the psychosocial impact of sudden and traumatic deaths on the bereaved, and the inadequacies of social network support, there should be limits as to what people in psychosocial crisis should handle without being offered professional help.

A discussion of the balance of public, social network and individual responsibilities should be conducted and further research on the efficiency and organisation of postvention services is needed. It is important that efficacy studies are carried out to ensure that the optimal help as outlined by the bereaved actually results in the best outcome for them. However, ideological and philosophical stances, or scientific results, should never overlook the voices of the user groups.

Conclusion

In view of prevailing laws and the comprehensive health concept, the lack of professional help to traumatic bereaved groups in our society is rather surprising. However, as seen from the present strategies to meet the problem, the shortcomings are likely to be the consequence of lack of knowledge and organisation of services; by somatic issues taking priority over psychosocial difficulties; and by curative services taking precedence over prophylactic intervention. Moreover, a more or less explicit de-medicalisation ideology may explain why the psychosocial welfare for families bereaved by sudden, traumatic deaths is not at the same level as for services for comparable somatic complaints. By claiming to protect the individual from being powerless and dependant on professionals, the de-medicalisation strategy prevents people in psychosocial crisis access to professional help. Thus, there is a great risk that well-intended theorising of an empowering strategy facilitates disempowering rather than empowering processes by disregarding the voices of those the theorists intend to protect. The consumer perspective based on a holistic and subjective concept of health should be taken more seriously, so that professionals would listen to the bereaved who claim that professional help would empower them to go on with their lives rather than leading to disempowerment.

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Figure 1. Medicalisation

- professionalisation of social problems

- monopolisation of service provisions

- professional rather than client control of the nature of services offered and the criteria by which such work is judged

- "empire building", including the redefinition of existing problems and the discovery of wholly new ones

- indefinite expansion of human "needs" and client "problems"

- limitless expansion of the profession itself

- tendency to perceive the aetiology of social problems in individual terms

- formulation of these social problems in predominantly medical terms

- a belief that the effective prevention of disease must, of necessity, involve major social change rather than ineffective professional "tinkering" at the individual level

- clients have, as a consequence of all this, become "addicted" to and "dependent" upon professionals, medical or otherwise.

(Strong, 1979)

Figure 2. Empowerment

- extending one's ability to take effective decisions

- individuals, groups and/or communities taking control over their circumstances and achieving their goals, thereby being able to work towards maximizing the quality of their lives

- enabling people who are disempowered to have more control over their lives, to have greater voice in institutions, services and situations which affect them, and to exercise power over someone else rather than simply being recipients of exercised power

- helping people to regain their own power

- At a psychological level, empowerment implies an increase in confidence, knowledge, and skills of individuals to encourage freedom of action and control over their lives.

(Braye and Preston-Shoot, 1995)

Figure 3. M*ethodological principles underlying professional approach in an empowerment perspective*

The professional should:

- accept his/her definition of the problem (because the client is able to identify and understand the

  situation)

- identify and tie the assistance to the client's resources

- analyse the power relationships, aiming at increasing the clients' power and control

- develop the resources of the individual to increase control in situations of daily life

- contribute to mobilise resources and advocate the interests of the client

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(Gutièrrez, *1990)*