

**Moments of Assimilation and Accommodation
in the Bereavement Counselling Process**

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The candidate confirms that the work submitted is his own and that appropriate credit has been given where reference has been made to the work of others.

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Abstract

Based on the proposition of leading researchers who view grieving as a process of meaning-making and adaptation, the author posited that grief resolution requires learnt adaptation to loss via a process of assimilation and accommodation. This is analogous to constructivist learning seen in children; a view supported by adherents to the psychology of personal constructs. This position was tested with a theory-building case study approach devised by Stiles (2007). An observational protocol was devised which reconciles scientific positivism with relativist methodologies. The counselling sessions of ten bereaved clients were digitally recorded and the transcriptions were subjected to assimilation analysis. Client progress was scored using Stiles' (2001) Assimilation of Problematic Experiences Scale (APES). Scores were subjected to inter-rater reliability measures to mitigate observer bias.

The biology of grief, as evolved adaptive behaviour, was explored. The role of adaptation through assimilation appeared pertinent for some, but not all clients; particularly those whose assumptive world was little changed by their loss. The part played by resilience in adaptation had also been underestimated. However, every client was observed assimilating and accommodating new schemas in relation to the loss. Three categories of meaning were identified: managing the grief, accepting the circumstances of the death, and renegotiating the relationship with the deceased. Using APES as a template, the author devised the Assimilation of Grief Experiences Sequence (AGES) to chart clients' meaning-making progress towards successful grief resolution.

These findings indicate a need for prudence in offering grief counselling, with a primary focus on complicating issues, rather than attachment distress. Future research in a number of areas is suggested, including developing AGES as an outcomes measure, the part played by personal resilience on grief resolution, and the role of the counsellor in facilitating the assimilation of helpful schemas; research which has implications for counsellor training.

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Abbreviations used in this thesis

ABSCo	Association of Bereavement Service Coordinators
ACC	Anterior cingulate cortex
AGES	Assimilation of Grief Experiences Scale (or Sequence)
APES	Assimilation of Problematic Experiences Scale (or Sequence)
ASDS	Association for the Study of Death in Society
BACP	British Association for Counselling and Psychotherapy
BRF	Bereavement Research Forum
BSA	Bereavement Services Association
CG	Complicated grief
CPR	Cardiopulmonary resuscitation
DPM	Dual process model (of coping with grief)
DSM-5	Diagnostic & Statistical Manual of Mental Disorders, 5th Edn.
fMRI	Functional magnetic resonance imaging
HPA	Hypothalamic-pituitary-adrenal axis
IES	Impact of Events Scale
PAG	Periacqueductal gray
PET	Positron emission tomography
PTSD	Post-traumatic stress disorder
rACC	Rostral anterior cingulate cortex
SCHBSS	Saint Catherine's Hospice Bereavement Support Service

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Definitions of concepts used: in this thesis, and in the literature cited

Assumptive world theory

A theory of mind proposed by Parkes (1971, 2009) which posits that every individual exists in a unique psychosocial world constructed from personal experience. The assumptions and certainties inherent in this narrative construction are disrupted by personal loss and trauma and result in distress reactions. The theory explains for example, reactions which can arise following amputation or other radical surgery, since the emotion displayed by such major and life-changing loss is similar to the grief from the loss of a loved one, but cannot be explained by Bowlby's (1969, 1975, 1980) Attachment theory (Parkes, 2009, pp. 30-31).

Attachment theory

A theory proposed by Bowlby (1969) to explain the distress reaction of infant mammals, in particular primates, when separated from their primary caregiver; usually the infant's mother. Bowlby posited that this infant behaviour has evolved in order to maintain a close distance between mother and baby, thus protecting the infant from predators.

Attachment style

The means by which an individual relates to others in order to get basic needs met. This was originally described in children by John Bowlby who identified three patterns of attachment: *secure*, *anxious avoidant* and *anxious resilient* (Bowlby, 1969, pp. 337-339). Main and Solomon (1986) added a fourth style: *disorganised attachment*. Working with adults, Parkes (2009) used the terms *secure*, *anxious/ambivalent*, *avoidant* and *disorganised*. An insecure attachment style has been shown by Parkes (*ibid*) to be a factor in grief complications.

Complicated grief

A constellation of behaviours observed in a bereaved individual which disrupt healthy functioning and which do not diminish with time. This can be compared with normal, or common grief. Here the same behaviour is observed soon after the loss, but changes within a few months. Stroebe et al have attempted to arrive at a definition which takes into account both the severity of the loss and the cultural background of the individual:

“A clinically significant deviation from the cultural norm (i.e. that could be expected to pertain, according to the extremity of the particular bereavement event) in either (a) the time course or intensity of specific or general symptoms of grief and/or (b) the level of impairment in social, occupational, or other important areas of functioning” (Stroebe, Hansson, Schut, & Stroebe, 2008b, p. 7).

Continuing Bond

A phrase conceived by Klass, Silverman and Nickman (1996) which recognises that most bereaved people do not relinquish the emotional connection with the deceased, but instead choose to develop a new symbolic attachment. This bond helps to sustain the resolution of grief.

Ethology

A branch of science developed by Tinbergen (1963) to study animal behaviour in a biological, particularly an evolutionary, context.

Grief work

An idea, derived from the psychoanalytic view (Deutsch, 1937) that pathological grief can only be resolved by spending time facing up to the loss and working on the emotions evoked by it. The idea is epitomised in Worden's (2008, pp. 38-53) *Tasks of Mourning*. The concept of grief work has been challenged (Stroebe, Schut, & Stroebe, 2005; Wortman & Silver, 1989, 2001).

Meaning making

The activity by which humans make sense of phenomena. The process may be internal or environmental. In the context of this thesis, meaning-making can be seen as a dynamic process of narrative construction and reconstruction (Neimeyer, 2005; Neimeyer, Baldwin, & Gillies, 2006; Neimeyer et al., 2002a). A more detailed definition of meaning making in the context of this thesis appears at the end of Chapter 4, page 53

Medicalisation

Viewing an aspect of human behaviour as pathological and, therefore, requiring a medical intervention, including medication and psychiatry. An example of this is the medicalisation of grief (Engel, 1961; Lindemann, 1944).

Resilience

Resilience is the ability of a material such that when distorted, it is able to recover elastically to its original position and form (Chambers, 2014). In psychology the phrase is applied to the ability of an individual to quickly recover from emotional stress (Cooper, Flint-Taylor, & Pearn, 2013).

Ruminative coping

A psychological coping strategy, generally perceived to be unhelpful, which consists of repeatedly and continuously thinking about a negative emotional event (for example a bereavement) without finding a solution (Nolen-Hoeksema, 2001; Nolen-Hoeksema, Parker, & Larson, 1994). The process can become recursive, such that the individual begins to experience even the *act* of rumination as negative.

Schemas, schemata

A schema is the name used by Piaget (1954) for a mental construct assimilated by a child when a previously assimilated construct can no longer be accommodated into that child's understanding of his environment. Each construct or schema is a unit of meaning which helps the child to make sense of his world. Piaget used the Latin plural 'schemata'. Psychologists such as Janoff-Bulman (1992) and Neimeyer (2001a, 2009b) have adopted the concept to describe adult sense-making in the discipline of constructivist psychology. Rather than use the Latin plural form, it is now the convention to use the word 'schemas'.

Chapter 1: Introduction

This thesis posits that any significant loss we experience will disorientate our personal world. The position is predicated on the observation that *Homo sapiens* is a meaning-making animal (Neimeyer, 2001a) and that human survival is dependent on the ability to make sense of our physical, social, emotional and intellectual environment (Immordino-Yang & Damasio, 2007). Meaning-making drives the homeostatic control of our cognitive functioning and is inextricably linked to the biological systems which maintain the body's physiological equilibrium. Just as extremes of heat, cold, dehydration, starvation and physical trauma threaten our physical wellbeing, disruptions to our social and emotional attachments upset our psychological balance (Cozolino, 2006).

The parallels between physiological and emotional homeostasis led the first theorists to posit a view of 'grief' as a form of psychological disease or injury, rather than as a normal reaction to loss which in time would be naturally resolved (Bonanno, 2010, pp. 18-20). They observed how disease is caused by pathogens within the body and portrayed the lost loved-one as a harmful presence within the mind (c.f. Freud, 1957). As medical treatment seeks to rid the diseased body of infection, the psychoanalysts sought to rid their grieving patients of the mental presence of the deceased (Deutsch, 1937; Lindemann, 1944).

The author's position is that classic theories of grief confuse the cause of the harm with the symptoms. Disease can be approached from two different perspectives: cause and effect; notably symptoms (McConnell, 2013). Pathogens cause disease. So too do environmental factors such as carcinogens, diet and lifestyle. Genetic predisposition is also a factor. Whilst medical intervention sometimes aims to remove the cause, the effects of a disease or injury are often mitigated by the symptoms. Swelling protects the wound. Vomiting and diarrhoea void the body of potentially harmful ingestion. Raised temperature helps the body fight infection. Symptoms, be they physiological or psychological, can be seen as part of a biological process essential to the restoration of homeostatic equilibrium (ibid).

Counsellors can view the manifestations of bereavement either as a process of healthy adaption to the loss or as a set of pathological symptoms (Wilson, 2014, pp. 37-43). Either way, the effect is distress, and the cause is disruption of social and emotional attachments. The brain's attempts to alleviate this distress and return to normal functioning, result in a cluster of psychological phenomena we call grief (ibid). Most people adapt to loss with neither medication nor psychological support. Individuals in this group are described as resilient (Bonanno, Boerner, & Wortman, 2008). They adapt healthily to changed circumstances without professional intervention. A second, smaller subset of bereaved people experience

prolonged grief¹ which may be helped by psychological support (Prigerson et al., 2009). Just as effective medicine aids the body in its own recovery, effective counselling for prolonged grief can assist the journey back to healthy functioning. This would suggest that in some instances, grief can be construed as symptomological, in particular when personality traits such as insecure attachment style play a part in the complexity of an individual's grief reaction (Parkes, 2009). However a third group exist; where grief is initially intense but diminishes with time. Individuals in this group can be observed adapting to circumstances changed by loss with or without counselling support. They may demonstrate features of resilience, suggesting that it is the complexity of the loss rather than the personality of the individual, which prolongs recovery. As such, those in this category exhibit healthy rather than pathological grief. Nevertheless they may still benefit from counselling. Figure 1.1 illustrates the findings of Bonnano and colleagues (op cit). Both the recovery and the resilience trajectories are indicative of normal, rather than chronic or complicated grief.

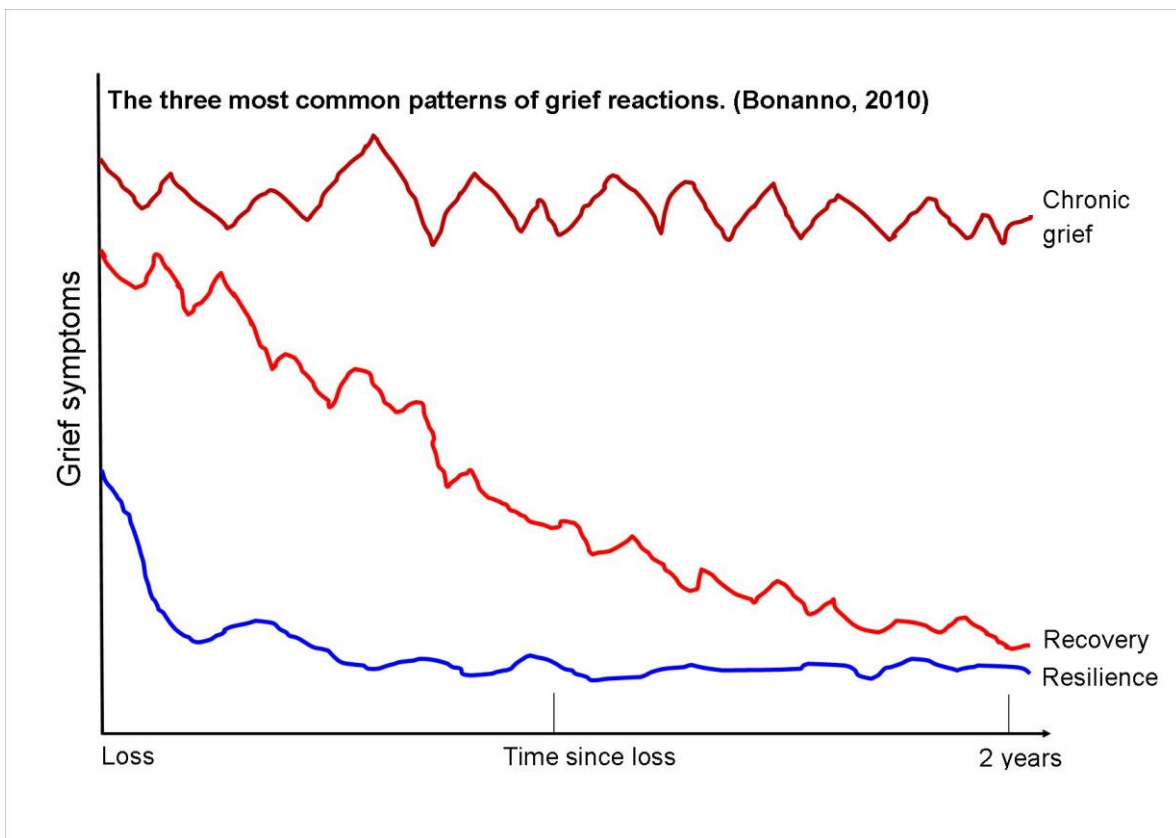


Figure 1.1 Three commonly observed grief trajectories.

Redrawn after Bonanno (2010 p.7)

¹ The term 'prolonged grief' is used by most researchers because it now appears in DSM-5 (APA 2013). Some use the term 'chronic grief' interchangeably; see Bonanno in Figure 1.1.

Whether grief is regarded as a pathological reaction or a process of healthy adaptation the author begins by synthesising the available evidence, from the research of others and from his own experience as a bereavement counsellor, into his own theory which he states thus: *The process by which bereaved people typically resolve their grief, involves making sense of their disrupted life in order to rebalance their emotional equilibrium.* The challenge is to build this theory using scientifically rigorous observations of bereavement service clients coming to terms with loss. The process of developing this thesis and reviewing literature in the field expanded and refined this theory, alongside refinements which grew from successive case studies. The development of the initial theory, adumbrated in the italics above, is described in successive chapters, in a process known as ‘theory-building’ (Stiles, 2007, McLeod, 2010). This methodology makes use of the theory building case study (McLeod, 2010, pp. 157-189). In this thesis the theory is built both on observational case studies and on the application of existing theories and models of grief to the author’s reflective and reflexive practice (Etherington, 2004).

A theory building methodology: overview

The principal method which has been used in this thesis is the theory-building case study (Stiles, 2007). The starting point is the theory which appears in italics in the paragraph above. This view of grief is neither new nor original. It is based on the work of Robert Neimeyer. Neimeyer (2006b) argues that grief is a process of reconstructing a life narrative disrupted by loss. What is new is the application of theory-building case study methodology to test this theory.

The essence of theory building is that each case study undertaken contributes to small changes in the theory. The steps involved, and summarised in Table 1.1 below, have been outlined by McLeod (2010, pp. 162-167). Having developed an initial theory, the researcher selects a case, in this instance a bereaved client, and collects a rich set of data. Next the researcher immerses himself in the data. The material is analysed in the context of the theory; hence, the theory is applied to the case (ibid p. 165). Now the completed case study is used to explore any incompleteness in the theory. As gaps come to the light, the theory is refined. Then the refined theory is tested against the next case. Successive case studies take the researcher through this circular process. Each time there are three possible outcomes: the first is that each case adds a small incremental degree of confidence in the theory; the second is the theory is modified; and the third is that the theory collapses.

This approach challenges the convention of a thesis built on a linear sequence of ‘introduction’, ‘method’, ‘results’ and ‘discussion’ (IMRaD) (Sollaci & Pereira, 2004); a sequence which traditionally is reflected in the titles of discreet chapter headings. Even the successive literature reviews which appear in Chapter 4, coupled with the reflective practice of

the author as counsellor, contribute to the development of the theory, well before it was tested against the case studies. In order to accommodate the organic process of this thesis development, the author has chosen to depart from a conventional format, in the following ways. The method chapter has been divided into two sections. The first section follows traditional conventions outlined at the planning stage of the thesis. For a number of reasons, including clients' choices not to participate in iterative procedures, and changes in the author's

Step	Description, using the verbatim item headings from MacLeod 2010, pp. 162-167	
1	Developing a theoretical starting-point	Chapters 2 to 5
2	Selection of a case	Chapter 6 Sect. 1
3	Construction of a rich case record	Chapter 6 Sect. 2
4	Immersion in the case	Chapter 7
5	Applying the theory to the case	Chapter 8
6	Identifying gaps in the theory: applying the case to the theory	
7	Refining the theory	
8	Testing a revised version of the theory against further case studies	

Table 1.1 The relationship between theory building methodology and chapters

understanding of client processes², the second section of chapter 6 describes both the essential methodological revisions and the outcomes of these revisions. Whereas in more traditional research this content would appear in a results chapter, the chapters which follow Chapter 6 report on the remaining steps of the theory building case study; steps 4 to 8 (McLeod, 2010, pp. 157-159). Hence the case studies are reported in Chapter 7. Cross case comparisons are made as part of the process of being immersed in each case; theory building step 4. In a more conventional thesis, chapter 7 would be analogous to a results chapter. Chapter 8 covers the remaining theory building steps 5 to 8. This chapter would traditionally be the discussion of the results in which the theory is refined and testing of the revised theory is discussed. In essence, the nature of a theory building case study approach is cyclic³. A traditional method/results/conclusions becomes redundant if previous conclusions influence the method and if fresh results are construed in the light of previous conclusions.

² Changes in the author's understanding of his client's processes came both from immersion in the transcripts, which in turn led to the second and third literature reviews discussed in Chapter 4.

³ Figure 8.1 shows the cyclic nature of theory-building appears at the beginning of Chapter 8, page 149

Use of the words *assimilation* and *accommodation* in this thesis

On pages 30-31 in Chapter 4, the relationship between assimilation and accommodation is discussed in detail. Because of the dynamic interplay between assimilation and accommodation, neither can stand alone. Accommodation is ‘undifferentiated from the assimilatory process’ (Piaget, 1954, p.351). In theoretical terms (ibid), and in the counselling dyad, (Neimeyer, 2006a) a moment of assimilation is completed when a schema is, to the satisfaction of the client, accommodated. Only when a schema can no longer be accommodated is further assimilation observed. Hence, accommodation is an internal process and assimilation is the observable process which facilitates it.

Meaning making in counselling and psychotherapy is predicated on a theory of narrative reconstruction (Kelly, 1963; Neimeyer, 2009b). The theory holds that narrative reconstruction involves a cyclic, dynamic process of assimilation; accommodation; cognitive dissonance and renewed assimilation. Those who write about assimilation as a therapeutic process usually exclude the word ‘accommodation’ (see for example, Brinegar, Salvi, & Stiles, 2008; Detert, Llewelyn, Hardy, Barkham, & Stiles, 2006; Henry, Stiles, & Biran, 2005; Honos-Webb, Surko, Stiles, & Greenberg, 1999; Varvin & Stiles, 1999). This exclusion describes just the observable activity. In doing these researchers adopt shorthand for the whole ‘assimilatory process’ (Piaget, 1954, p.351). In this thesis, the author uses the words *assimilation* and *accommodation* together. Although only assimilation is observable, accommodation is equally important to the client’s dynamic process of narrative reconstruction (see page 51). An exception is made in the discussion of Tinbergen’s (1963) Four Questions since they relate to observable activity. (see pages 60 to 62 and the footnote on page 60). Shorthand is also adopted in naming The Assimilation of Grief Experiences Scale (see page 178).

Use of personal pronouns

Except where specific individuals are discussed, the feminine forms ‘she’ and ‘her’ are used. This convention has been chosen since eight of the ten clients in the study were female. The rule, of the default client being female, is continued at the beginning of Chapter 4, where the author describes some typical statements made by bereaved female clients. For example, ‘Why did *he* die?’ (see page 26). Thereafter, feminine personal pronouns are used.

Thesis synopsis

Chapter 2 outlines an historical overview of grief research, from seventeenth century grief diaries of bereaved aristocrats, to twenty-first century scientific studies. Two strands emerge from this overview. The first to be considered is a biological view of grief, from

Charles Darwin's exploration of the evolutionary development of emotion (Darwin, 1872) to John Bowlby's exploration of attachment behaviour as a form of adaptation to environment (Bowlby, 1969, 1980). In juxtaposition is the *grief as illness* hypothesis, which, whilst it acknowledges the healthy adaptive properties of grief for most people, leaves its adherents ready to pathologise and medicalise grief should it become prolonged or complex.

Chapter 3 begins with a short account of the author's background. Although this is revisited in the methodology section as a possible contributor to observer bias, it is mentioned at this early point because the author's science-based observational background is central to the development of the thesis. Observational practice informs the author's understanding of those twentieth and twenty first century theorists and researchers who see grief as predominantly a healthy adaptation to bereavement rather than as a pathological disorder which can be treated (See for example, Bonanno et al., 2008; Stroebe et al., 2007a; Wortman & Silver, 2001). In chapter 3 the author critically reviews dominant research in this field in the light of his reflective practice and client observations as a bereavement counsellor. The chapter is concluded with the author's suggestion that grief resolution is dependent on a client's ability to make sense of loss, and that since some bereavements are more complex than others, it is to be expected that some bereaved people may need professional help. Before any relationship between grief complexity and the need for counselling, can be developed into a testable theory, a focused review of the relevant literature is discussed in Chapter 4 (see pages 26-33).

Chapter 4 focuses on the literature introduced in Chapters 2 and 3. The chapter is divided into three discrete sections. The first explores meaning-making and how the processes are operationalised through assimilation and accommodation. Bereavement is seen by the author as a disruption to personal narrative, and active grief as the restoration of this disruption through the reconstruction of a new, post-loss world (Attig, 2011; Neimeyer, 2001b). Yet because it would be remiss of the author to ignore the recognised effects of grief on the neurobiology of the individual, current research into the neuroscience of grief is explored in a second literature review. In the reconstruction of new narratives the individual is required not only to make sense of events and emotions, but also of their own affect-driven behaviour.

During the data collecting phase of the research it became clear that some clients, including those bereaved of very close family members in the most difficult of circumstances, opted to successfully manage their grief with little or no bereavement counselling. Some appeared to be inherently resilient. Others found it easy to construct new meaning and the author considered the possibility that resilience might be defined, not just by the ability to bounce back from adversity, but also by the ability to quickly adapt to new situations, through assimilating new ways of being. As an outcome of this observation, a third literature review of research into resilience was completed. The author concludes that there are observable connections between resilience and meaning-making ability such that resilience plays a part in

the construction of an observable and testable theory of narrative reconstruction through assimilation and accommodation.

In chapter 5 the author begins to move towards developing his initial theory of grief (pages 1-3) so that it can be tested against the chosen methodology. As the theory is developed, it embraces the role of attachment in the manifestation of grief. It also draws on the stress of psychosocial change described in Parkes' assumptive world theory (Parkes, 1971, 2009) and Neimeyer's view of bereavement as narrative disruption (Neimeyer, 2001b). Seen in this light, grief, for most individuals is a healthy process of relearning and reconstruction of life without the deceased. Thus in the context of bereavement counselling, effective support would enhance this process. The theory is valid if observations of clients confirm disrupted attachment behaviour resulting in a state of emotional disequilibrium. Further validation comes from observations demonstrating the reconstruction of narrative during the counselling process.

In approaching a methodology, it is essential to explore the philosophical position of the qualitative researchers in the field. In spite of the biological and evolutionary nature of grief, all counselling research has been influenced by a predominantly post-modern thought, and has moved away from the positivist approaches to scientific realism (Perry & Mace, 2010; Wilson et al., 2014). Central to planning this project was an exploration of the tension between positivism and post-modern social constructionism. Clarity in the nature of a scientific approach to bereavement counselling research is also a prerequisite of designing an appropriate methodology. A compromise is reached in the form of a new methodology the author has called Cautious Positivism. This position attempts to reconcile the complexity of individual behaviour with positivist generalisations constructed from careful observation. This is discussed in detail on pages 56-58.

There are historical precedents for a biological approach to grief research and these are discussed in chapter 5. Of great significance was the influence of Tinbergen's work (Tinbergen, 1963) on Bowlby's theory of attachment (Bowlby, 1969). The four questions which Tinbergen proposed in developing the science of ethology are applied by the author in developing a theory of grief assimilation. Also considered in this section are the scientific limitations of the theory in the context of Popper's principles of falsifiability (Popper, 1963). A theory of meaning reconstruction as a means of grief resolution would be falsified if clients resolved their grief without any evidence of bereaved clients assimilating post-loss changes in their life.

A case study methodology is appropriate for a biological and observational approach to developing this theory. The case study has long been used in counselling and psychotherapy research, including in grief counselling (Balk & Vesta, 1998; Neimeyer, 2006a). Whilst some hold that the observational studies have low status in research (Gysels & Higginson, 2007), the

case study has its champions (Flyvbjerg, 2006; Stiles, 1993). In response to the critics, champions of qualitative methodology call for rigour and transparency, and as in quantitative research, an honest acknowledgement of the potential for observer bias, coupled with rigorous attempts to address this issue (ibid). Aside from the ethics of the dual researcher/practitioner relationship used in this study and discussed in chapter 5, in reaching conclusions the influence of the counsellor's interventions must also be taken into account. One way of adding weight to the generalisations drawn from observation is to adopt a multiple case study approach, with each case study adding a small degree of confidence to the theoretical proposition. The chosen way forward is to adopt Stiles' theory building approach to each case study (Stiles, 2007, 2009b). In chapter 5 this approach is described in detail together with Stiles' (2001) Assimilation of Problematic Experiences Scale (APES); used both in interpreting the data in this project and as a template for the Assimilation of Grief Experiences Scale (AGES) developed in chapter 8. Table 5.1 on page 72 illustrates APES (Stiles, 2001). Possible tensions between positivist and relativist/constructionist methodologies are discussed. The author adopts a methodology called *Cautious Positivism* (Wilson, Gabriel & James, 2014) as a means of reconciling the tension.

For the reasons discussed above, Chapter 6 is divided into two sections. Section 1 describes the method of data collection which in its simplest terms involves recording the assessment session and every counselling session of clients who have given informed consent to take part in the research. This is described in the context and setting of the counselling of Saint Catherine's Hospice, Scarborough⁴. Research ethics are discussed, including the potential risks to clients and plans to address such eventualities, effect of the research on the client and practitioner relationship, and structures in place to safeguard the confidentiality of the data. Ethical permission for the research was obtained from both the York St John Research Ethics Sub Committee and Saint Catherine's Hospice Trustees and Medical Directors.

Section 2 of Chapter 6 is entitled *Methodological revisions and outcomes*. In this the author discusses the difficulties encountered in implementing the method. This includes arriving at a procedure for determining salient passages of each counselling session and designing an efficient and effective means of transcribing relevant material. The weight and richness of data collected was potentially problematic and the solutions developed, to manage both the quality and quantity of the transcribed material, are discussed.

⁴ In discussion with the Hospice Chief Executive and the Medical Director, a decision was made to be open and transparent about the setting in which the research to place. The author's place of work is already widely known by the bereavement counselling and research community. For this reason, clients who gave informed consent were aware that the counselling service would be named. Of the 500 clients each year seen by the service, careful measures were introduced to pseudonymise the identity of the clients mentioned in this study.

Chapter 7 begins with revisiting the concept of assimilation and accommodation and considers the technique of assimilation analysis. After a synopsis of the ten case studies, cross case comparisons are made. Each client is described within the framework of the eight APES stages (Stiles, 1999) until his or her counselling ends. Preliminary conclusions are drawn as to the nature of each client's assimilation and accommodation, ahead of the more rigorous theory building protocols applied in chapter 8.

In chapter 8, Stiles' (2007) theory building protocol is applied to all ten case studies. The theory which is developed in chapters 2 to 5 is summarised as a seven-point checklist which is applied to each case study. Next, each case study is applied to the theory. The conclusions drawn refine the theory. The refined theory is tested with the data from one of the case study clients given the pseudonym 'Sophie'. Finally the revised theory is tested against further cases drawn from the author's clinical practice.

Chapter 9 concludes the thesis. The author refutes the need to medicalise grief in most instances. Even where antidepressants are used, this does not necessarily define that client's grief as a mental disorder, since grief and depression can be distinguished from one another. The author also sees a prolonged or chronic period of grief as normal in circumstances where the trajectory moves steadily towards resolution. The author cites evidence for the contradiction of the twentieth century grief work hypothesis (Bonanno, 2010; Stroebe & Stroebe, 1991; Wortman & Silver, 1989), and concludes that there is evidence from the case studies which validates the Dual Process Model (Stroebe & Schut, 1999). The validity of other models and theories is discussed. Attachment theory is revisited in the light of advances in the neuroscience of grief. The place of resilience in grief adaptation is explored.

In the light of the findings of this study, the strengths and limitations of person centred practice for grief counselling are considered. Implications for good practice are discussed. The author makes suggestions for further research in the field.

Chapter 2: An historical overview of grief research

Early written accounts

Before the 20th century written accounts of grief and mourning are restricted to the journals of the educated aristocracy (Jupp & Gittings, 1999). Some of these provide a highly personalised accounts of mourning. The writings of Sir Kenelm Digby (Gabrieli, 1955, 1956, 1957) following the death of his wife Lady Venetia Stanley in 1633 could, as Jupp and Gittings have pointed out, be taken from any modern bereavement textbook (op cit, pp 165-166). However it was not until the 19th and 20th centuries that writers began to take an academic interest in the subject. In *The Expression of the Emotions in Man and Animals* (Darwin, 1872) Charles Darwin studied the muscles behind facial expressions of grief and concluded that the same muscle movements are seen in screaming children.

Influenced by Darwin's work, Alexander Faulkner Shand (1914) attempted to adumbrate a science of character founded on his conception of the laws of psychology and ethology. Shand proposed a system of emotions: of which the primary emotions he saw as: fear; anger; disgust; curiosity; joy; and sorrow. He saw sorrow as 'the most difficult to interpret' due to its 'many and even opposite tendencies' (ibid, p.301). While he did not specifically develop a theory of grief, Shand saw sorrow as an aspect of grief (pp. 301, 305). He observed four common varieties or types of sorrow: 1) expressive and tearful; 2) tearless and mute; 3) depressive and paralysing; and 4) frenzied energetic sorrow (ibid, pp 301-304). Shand concluded that mute and tearless sorrow arises from suppression due to self-control and consideration for others whereas frenzied sorrow is mixed with the primary emotion of anger. Thus, he claimed, if sorrow as a primary emotion is disconnected from other systems of emotion and sentiment (in particular fear, anger and love), we are left with just two varieties of sorrow: depressed; and excited (ibid, p.309). Shand (ibid, p. 305) saw sadness as 'a chronic state of subdued sorrow or grief' and distinguished it from melancholy which he saw as including 'fear, suspicion, and discontent as well as sorrow'. Melancholia was, Shand believed, melancholy together with loss of self-control owing to delusions or hallucinations.

Shand drew his inspiration from the great literary works of the English and French languages rather than from field observations. He acknowledged being heavily influenced by John Stuart Mill's (1856) conception of ethology (p.13). Ethology as a discipline in this sense petered out and Shand is not considered to be an ethologist in the modern sense (Cahan & White, 1992). This, however, did not prevent John Bowlby from acknowledging Shand's contribution to developing an understanding of grief (Bowlby, 1980, p. 24). Inspired by Darwin and Shand, Bowlby sought an understanding of attachment and loss based less on the psychoanalytic interpretations of the Freudian school, in particular Melanie Klein, and more

towards the evolutionary biologists (Wilson 2014), Bowlby (1969, 1975, 1980) was particularly inspired by the work of Konrad Lorenz (1937) and Niko Tinbergen (1963). As a result, Bowlby was drawn to a biological and observational approach in developing his theory of attachment (Wilson 2014). Together with Colin Murray Parkes, Bowlby developed a stage model of grief (Bowlby & Parkes, 1970).

Psychoanalytic perspectives and the medicalisation of grief

In spite of these early scientific endeavours to study grief from a biological perspective, the dominance of psychoanalysis in the first half of the 20th century shifted the research emphasis. In his seminal work, *Mourning and Melancholia*, Freud (1917/1957) posited ‘a correlation between mourning and melancholia’ (p. 243) which in spite of the admittedly small number of cases that he had observed, he saw as sharing common features. Freud did not see melancholia as an inevitable consequence of loss but concluded that it would be the reaction of those of ‘a pathological disposition’ (ibid p. 243). Freud said that in spite of the bereaved individual’s ‘reality testing’ that the loved one no longer exists, the libido becomes bound to the love object which is hypercatheted and the existence of the love object is ‘psychically prolonged’ (p.245). Only by the breaking of this bond can the pain of loss be ended: ‘When the work of mourning is completed the ego becomes free and uninhibited again’ (p.245). In this quotation, Freud is the first to conceptualise ‘grief work’, a concept that has endured into the 21st century. In distinguishing mourning, which he saw as a normal process from mourning which becomes melancholic (pp.243-244), Freud was the first to separate normal and complicated grief.

Karl Abraham (1949) resisted Freud's ideas about mourning and melancholia until he was faced with his own grief reaction following the death of his father. Abraham was struck by the temporary greying of his own hair, which he interpreted as an introjection of his late father's hair colour (p. 438). Thus he came to agree with Freud that grief was a form of obsessional neurosis; an introject of the lost loved one which leads to disengagement of the libido from the external world (p.419). Abraham distinguished between normal mourning and mourning which he associated with melancholia. He concluded that introjection was a feature both of normal and melancholic grief (p.437). Like Freud, Abraham (1949) concluded that relinquishing cathexis to the lost love object was essential to effective grief work.

In 1937, Helene Deutsch published her observations on four bereaved patients for whom there was “a complete absence of the manifestations of mourning” (Deutsch, 1937, p. 12). Deutsch drew on Freudian concepts to explain her belief that these patients may have been avoiding grief:

‘because of its unendurability by a weak ego, a submission to other claims on the ego, or the existence of previous conflict with the lost object.’ (ibid, p.12).

This psychoanalytic view of grief continued with the work of psychoanalyst Eric Lindemann in his paper *Symptomatology and Management of Acute Grief* (Lindemann, 1944). In this study of 101 bereaved people, Lindemann describes working, in his view successfully, with the bereaved relatives of a major disaster; a fire in a nightclub in which many people died. He concluded that acute grief is ‘a definite syndrome with psychological and somatic symptomatology.’ (ibid, p. 155). Outcomes depended on the success of grief work which Lindemann described as ‘emancipation from the bondage to the deceased’ (ibid, p. 156), a task which he saw as requiring ‘proper psychiatric management’ (ibid, p. 159). In spite of his claims he produced no objective evidence that his patients had been helped (Bonanno, 2010, p. 20). Nevertheless, since this was the first paper to be published on working with grief it is regarded as a sufficiently important classic to have been reproduced as a fiftieth anniversary reprint in the American Journal of Psychiatry (Lindemann, 1994).

Lindemann’s article set the tone from the medicalisation of grief. In 1961 George Engel published an article entitled *Is Grief a Disease? A challenge for medical research* (Engel, 1961). He justified his claims by saying that the arguments in this paper legitimised medical research. In what he described as a “Socratic dialogue” (ibid, p. 18), Engel listed the commonly observed symptoms of grief and concluded that any symptom which disables the subject can be classified as a disease. In anticipation of those that would argue that normal grief does not require medical intervention, Engel replied that many common ailments that do not require a doctor are nonetheless classified as diseases. Of the eight articles that Engel cited, four bore his own name, one was Lindemann’s 1944 article, and one was Freud’s *Mourning and Melancholia* (Wilson, 2014, pp. 58-59).

Counters to medicalisation - the observational theorists

In the United Kingdom, the pendulum swung away from a Freudian psychoanalytic emphasis. Under the series title ‘Anthropology and Ethnology’, the research of Peter Marris into the lives of East London widows was published as *Widows and their Families* (Marris, 1958). The research had been conducted under the auspices of the Institute of Community Studies of which John Bowlby was a member. Bowlby also wrote the foreword to the book.

After qualifying in medicine, John Bowlby had trained in psychoanalysis and became a member of the British Psychoanalytical Society. Although he considered himself a psychoanalyst for all of his life, he attempted to move away from Freudian concepts towards a more scientific approach (Bowlby, 1980, p. 1). As his research into Attachment Theory progressed, Bowlby became more interested in psychosocial and environmental aspects of human behaviour than in theories of innate psychological drives. This brought him into

conflict with his peers; in particular Anna Freud and Melanie Klein (Senn, 1977). In 1960 John Bowlby published a paper on grief in children (Bowlby, 1960) which contradicted Klein's long held theory of maternal attachment. This caused the lasting schism between Bowlby and Klein (Wilson, 2014, p. 62). Bowlby's collaborative future moved to different territory.

When Colin Murray Parkes was preparing to write his dissertation for his diploma in psychological medicine he noticed how little literature there was on grief from a biological perspective; in particular, grief in human animals. John Bowlby had been researching separation anxiety in children since the early 1950s and had drawn parallels with anxiety in non-human primates and other mammals. After hearing of Bowlby's work in this field, in particular his controversial 1960 paper, and realising that Bowlby had reached similar conclusions to his own, Parkes sent John Bowlby a copy of his dissertation. In 1962 Colin Murray Parkes joined Bowlby's team at the Tavistock Institute for Human Relations and so began a long collaboration in grief research (Parkes, 1972, p. 30).

The research that Parkes conducted moved grief theory away from a psychoanalytical interpretation and towards human biology. From 1958 to 1960 Parkes studied 21 bereaved patients at the Bethlem Royal and Maudsley hospitals in London. Results were published five years later (Parkes, 1965). As a result of this study, and a further study on 22 London widows (Parkes, 1970), Parkes noted patterns of typical and atypical grief. This led him to put together a team for what became known as The Harvard Study; an investigation into the grief of bereaved spouses (Parkes & Brown, 1972).

Meanwhile John Bowlby continued to work on his trilogy of attachment (Bowlby, 1969), separation (Bowlby, 1975) and loss (Bowlby, 1980). Bowlby had noted similarities between separation distress in children and grief behaviour in adults. He published a three phase model of grief (Bowlby, 1961) which was later changed to a four phase model (Bowlby & Parkes, 1970): a phase of numbness; a phase of yearning and searching; a phase of disorganisation and despair; and a phase of greater or lesser degree of reorganisation.

By the late 1960s and early 1970s, psychosocial and environmental precursors of grief had become an established paradigm. In 1968 James Averill published a paper entitled *Grief: Its Nature and Significance*. Averill considered both the biological and cultural aspects of grief. He posited that grief has an adaptive function and called for grief to be researched as a human emotion. Parkes considered the psychosocial aspects of grief as it changed the everyday lives of the bereaved. He named this 'Assumptive World Theory' (Parkes, 1971).

Enduring influence of psychoanalysis and the concept of grief work

The influence of Sigmund Freud did, however, continue. In 1983, John William Worden published the first edition of his influential book *Grief Counselling and Grief Therapy* (Worden, 1983). As Worden reiterates in the fourth edition, he chose the term 'tasks' rather

than Bowlby and Parkes ‘phases’ of mourning, since the concept of task “is much more consonant with Freud’s concept of grief work” (Worden, 2009, p. 37). The concept of grief work, as reintroduced by Worden, proved popular with bereavement practitioners throughout the 1980s and early 1990s. The phases of grief introduced by Bowlby and Parkes began to be used prescriptively for normal grief. This had never been intended (Parkes, 2009, p. 29).

Challenges to grief work theory

By 1980, Camille Wortman and Roxane Silver were questioning the validity of the ‘grief work’ concept (Silver & Wortman, 1980). In 1989 they published *The Myths of Coping with Loss* (Wortman & Silver, 1989). Here they questioned the commonly held belief that it was important for bereaved people to work through their loss and that failure to do so was indicative of a pathological condition. In a paper rhetorically titled *Does “grief work” work?* Margaret and Wolfgang Stroebe presented their research into 60 cases of spousal bereavement. They concluded that of the widows in the group, there was no difference in the depression scores between those who confronted and those who avoided grief work, although widowers who did work through their grief made a better adjustment. Three further articles which followed (Stroebe, 1993; Stroebe, Stroebe, Schut, Zech, & van den Bout, 2002; Stroebe et al., 2005) also challenged the grief work concept. Notably this work, reinforced Margaret Stroebe’s observation that ‘grief work’ was not a universally recognised construct (Stroebe, 2011). This in turn led to the development of the Dual Process Model of grief (Stroebe & Schut, 1999) (figure 2.1).

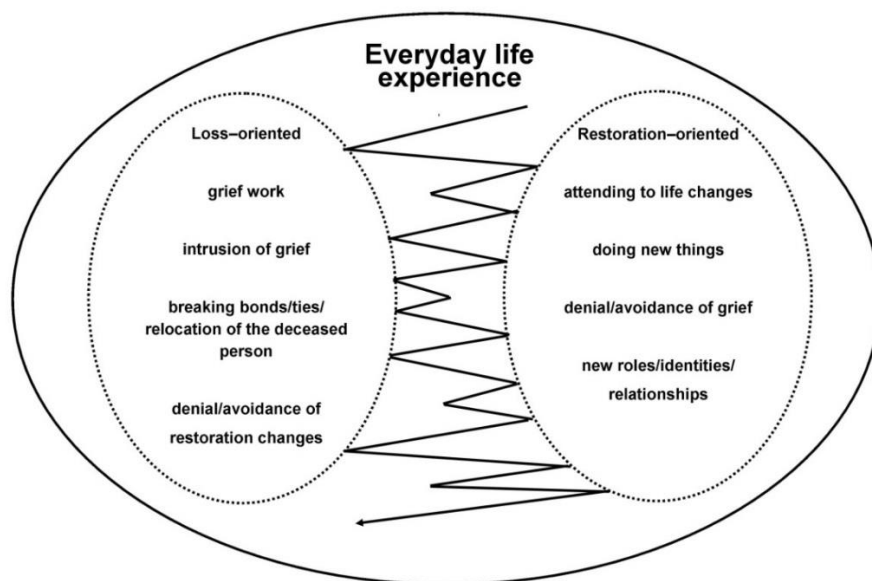


Figure 2.1 The Dual Process Model (Stroebe & Schut 1999)

The Dual Process Model, DPM (Figure 2.1), describes a bereaved person's oscillation between grief work and restorative activities. The model offers a mechanism to explain how some bereaved people demonstrate resilience in their grief. It had been suggested that many individuals have a natural resilience to loss (Bonanno et al., 2002; Bonanno, Wortman, & Nesse, 2004). Machin and colleagues (Machin, 2013; Machin & Spall, 2004; Relf, Machin, & Archer, 2010) attributed resilience to an individual's ability to move between grief and restoration activities.

Freud's grief hypothesis, questioned in the research described in the previous two paragraphs, was also challenged by Klass and colleagues (Klass et al., 1996). Freud (1917/1957) had maintained that pathological grief would continue until the bereaved subject broke the bond which tied them to the lost love object. Klass observed what many bereavement counselling practitioners had already discovered for themselves (Wilson, 2014, p. 131); that many, if not most bereaved people form a continuing bond with the deceased which they maintain healthily throughout their remaining life.

The establishment of an evidence base to grief research

The 20th and 21st centuries are bridged by the three editions of the Handbook of Bereavement Research (Stroebe, Hansson, Schut, & Stroebe, 2008c; Stroebe, Hansson, Stroebe, & Schut, 2001b; Stroebe, Stroebe, & Hansson, 1993). These handbooks provided a platform for new ideas in bereavement theory, including disenfranchised grief (Doka, 2008), variations in grief trajectories (Bonanno et al., 2008), ruminative coping as adjustment to bereavement (Nolen-Hoeksema, 2001) and grief from an evolutionary perspective (Archer, 2001). The first three of these ideas are based on the observation of human variation in response to grief and the fourth takes a biological view.

The contemporary position is that mainstream grief research has adopted scientific paradigms. Grief is, in most instances, seen as a healthy adaptation to loss rather than a disease. It is recognised that grief is expressed with a wide range of individual variation. Even grief avoidance is, in many instances, seen as part of this adaptation rather than a pathological response. This does not mean that grief cannot become pathological. Alongside his claim that most people either demonstrate resilience in their grief or recover within a normal grief trajectory, George Bonanno (2010; Bonanno et al., 2008) has identified those bereaved who continue to suffer from chronic grief for many years. Most practitioners would recognise that some people actively grieve for a longer period than others do. What remains in question is for how long is it normal to grieve for a loved one before grief is considered prolonged or complicated?

In spite of many years of academic discussion, there is still no definitive evidence to answer this question. There are those who have worked for many years to have complicated

grief recognised as a mental disorder (Prigerson et al., 1996; Shear et al., 2011b) but despite their best efforts complicated grief is still not recognised by the compilers of the Diagnostic and Statistical Manual of Mental Disorders DSM-5 (APA, 2013). What is, however, recognised in the Fifth Edition is a diagnosis of Prolonged Grief. An edited book (Stroebe, Schut, & van den Bout, 2013) has allowed the arguments on both sides to be cogently expressed. This is discussed in Chapter 3.

No account of the history of bereavement research would be complete without a mention of Meaning-making Theory. The concept of meaning making is central to the work of Robert Neimeyer and his colleagues (Currier & Neimeyer, 2007; Neimeyer, 2001b; Neimeyer et al., 2006; Neimeyer et al., 2002a). From his qualitative and quantitative research Neimeyer (Neimeyer, 2009a) concluded that there are three faces of meaning making: sense making; benefit finding; and identity reconstruction. In a study of 156 bereaved parents, Lichtenthal, Currier, Neimeyer, and Keesee (2010) concluded that although 45% of parents struggled with making sense of the death of their child, the ability to make sense was still the most potent mediator of complicated grief, outweighing such factors as the nature of the death and the length of time since the loss. Spiritual interpretations were the most common ways parents made meaning of their child's death.

The contribution of neuroscience

Advances in neuroscience, in particular the opportunities presented by functional magnetic resonance imaging (fMRI) have been appearing in grief research for more than a decade (Freed & Mann, 2007; Freed, Yanagihara, Hirsch, & Mann, 2009; Gündel, O'Connor, Littrell, Fort, & Lane, 2003; O'Connor, 2005). Although in its infancy, the neuroscience of grief has much to contribute to the field and is discussed in detail in Chapter 4, pages 34-47

Conclusion

It is 100 years since Freud published *Mourning and Melancholia*. In that time, workers in the field have collected evidence to further human understanding of loss and grief. Although many contradictions remain, little of the material collected over the last century can be completely abandoned. Those who approach research from a scientific perspective would no longer entertain Freud's notion of instinctual drives (Bowlby, 1980). The value of grief work has been challenged, yet so long as there is a lack of clarity about what 'grief work' means (Archer, 2008) it is difficult to draw incontrovertible conclusions about its value or otherwise. Rather than abandon hard-won understanding, Stroebe and colleagues have said that answers lie in the extension of existing ideas rather than a 'major change' in the scope of research (Stroebe, Hansson, Schut, & Stroebe, 2008a, p. 600). Stroebe and her colleagues have called

for a cross fertilisation from different disciplines (Stroebe, Hansson, Stroebe, & Schut, 2001a, p. 744). This thesis is offered as a contribution to that endeavour.

Chapter 3 A critical evaluation of the links between theory and practice

In this chapter the author will briefly outline the background which informs his interpretation of bereavement theory, before evaluating the historical evidence presented in the last chapter and making the case for this thesis. The reader should note that the illustrative examples given in this chapter precede the research which is described in later chapters. These cases from the author's practice are mentioned in detail because they inform the focus and direction of the research which followed and which is outlined in the ten case studies described in later chapters.

The author's background: a personal reflection

I have an extensive background in observational science which directly informs the content. In 1968 I became the laboratory technician to a government scientist, Dr Brian Greenwood who at the time was researching the part played by monocytes in wound healing (Greenwood, 1969, 1971). Brian Greenwood was an outstanding teacher and this post provided an excellent apprenticeship in thinking scientifically, in particular making deductions and inductions from observation. The experience also taught me to think critically, report with integrity, be open to unexpected possibilities and be aware of the potential for observer bias.

In 1969 I moved from a career in laboratory work to begin a career in education. In 1972 I completed the dissertation component of my first degree (Wilson, 1972). This was a field study of a colony of badgers in a South Yorkshire wood. Many hours of meticulous observation were required for this project. I learnt to see patterns in animal behaviour from which it was possible to draw tentative conclusions. I qualified as a teacher in 1972 and worked in a primary school classroom until 1988 when I became a senior lecturer in early years education at Leeds Metropolitan University. There I taught science education to intending teachers. This experience, coupled with observation of children in the classroom, consolidated my understanding of the teaching of Jean Piaget (1950, 1952, 1954) describing the child's assimilation and accommodation of scientific ideas.

In writing a dissertation as part of a master's degree (Wilson, 1993), observational skills, which had been practised down the eyepiece of a microscope and consolidated in the badger study, were now transferred to the observation of children in the primary school classroom, in particular to the ways children come to understand scientific ideas as described in the preceding paragraph.

After a career change from education to therapeutic counselling in 1997, I began working as a bereavement counsellor in 2000 at a service attached to a hospice. My

observational skills proved useful in the counselling room and the scientific approach to interpretation I had gained in the previous decades had taught me to be critical in linking contemporary bereavement theory to clinical practice. By 2004 I was teaching bereavement theory and practice to others, including counsellors, nurses and physicians. In 2007, as part of my dual teacher/practitioner role, one day each week was set aside to be either teaching time or as preparation for teaching. This generous time allocation coupled with access to the extensive Hospice library and to electronic journals in the NHS online library, has afforded me the opportunity to keep abreast with new developments in the field of bereavement research and practice. A steady caseload of clients has allowed me to be reflective and reflexive in my practice. As part of this I have had the opportunity to evaluate critically each mainstream bereavement theory as observed in the behaviour of his clients. Unusually for a hospice based bereavement service, clients may be bereaved from any cause⁵. This has given me access to a full spectrum of losses including sudden and violent deaths. My clients are male and female, of all ages from 18 into advanced old age. In 2013 I completed my first book on the subject which was published a few months later (Wilson, 2014). This helped to consolidate much of my thinking on bereavement theory and helped focus on the present study.

Evaluating theory in the light of practice

The sections which follow are based on reflective practice. Although some of the accounts are anecdotal, the author is reminded that any scientific hypothesis begins with a series of observations (Ziman, 1978, pp. 70-72). If re-occurring patterns begin to emerge, these patterns pose questions which in turn lead to more focused observation. Repeating patterns generate hypotheses for which systematic investigations are planned and executed. This is the nature of observational science (Collins, 1985, pp. 29-49).

The eight numbered subheadings which appear below reflect the concepts introduced in the previous chapter; notably i) the notion of grief work and the challenges to this concept, ii) Bowlby and Parkes' work on childhood attachment and iii) the phase model of grief which this work generated, iv) Stroebe and Schut's Dual Process Model, v) the theory of continuing bonds as a counter to relinquishing the memory of the deceased, vi) resilience in grief, vii) the medicalising and pathologising of grief, and viii) grief as adaptation through the human activity of meaning making. Each of these concepts resonates with the author and his commentary is based both on his reflexive and reflective practice as a counsellor and his

⁵ Most hospices only support relatives bereaved of a family member who had been treated by the hospice, due to the finance and resource implications of wider work. Saint Catherine's Hospice took over the funding and organisation of a community-based bereavement service which had originally been established independently of the Hospice, and has continued to work with the same remit.

observational skills as a behavioural scientist. As was stated in this chapter's introduction, cases quoted are from the author's practice, not from the research case studies.

i) The concept of grief work

Of the clients referred to the bereavement support service where the author practices, the mean number of sessions a client receives is ten. This number is skewed by a few clients receiving long-term support and most clients receive six sessions or fewer. This would indicate that even for the small proportion of the local bereaved population who seek support, many of them do not need to pursue support that could be construed as "grief work". It is the author's experience that bereaved people exhibit the trajectories of grieving which match a study described by Bonanno and colleagues (Bonanno et al., 2008). More than half of bereaved subjects demonstrated little or no depression following bereavement. They showed few clinical symptoms following the loss although three quarters of these resilient individuals did report pangs of grief and yearning for the deceased, particularly in the first few weeks of the loss. This is consistent with a pattern of healthy normal grief frequently observed by the author when meeting potential clients for the first time.

Based on his experience of working with many hundreds of clients over the past 17 years, the author has found that most people manage their grief without any professional help. A subset of clients use counselling in order to work to resolve their grief. The author's observations show that they work *on* their grief, but they do not "work *through*" their grief (author's italics) (See also Wortman & Silver, 1989, p. 351) in any way implied by a prescriptive, Task Model of grief (Worden, 2008).

ii) The part played by attachment

The author has worked with many bereaved clients where prolonged and intense grief with complications correlates with disrupted attachments in childhood. In one case, a male client bereaved of his wife presented with severe distress. Soon after his wife's death he had begun another close relationship. This was short lived after they argued repeatedly; his new partner saying that she felt like a replacement and was not appreciated for who she was. Although the client did not acknowledge this, he did admit to feelings of neediness and said that it was hard to cope on his own, and that he needed a new partner. Further questioning established that as a very young child, he had spent an extended period in an isolation hospital where visits from his mother had been greatly restricted. The author has noticed many cases where enduring and distressing grief correlates with disrupted parental attachment; commonly linked to alcohol, domestic abuse, and diagnosed mental illness in the mother. Correlation is not causation, but these observations do accord with Parkes' (2009) study of attachment style and grief complications.

iii) Phases of grief

Nearly every client the author sees reflects to a greater or lesser extent, behaviour described in the phases of Bowlby and Parkes (1970). However these are not necessarily sequential. Clients express yearning and despair and they report searching behaviour. Clients referred early for bereavement support; typically in the first 2 to 6 months, frequently exhibit emotional and behavioural disorganisation. Those referred by their doctor earlier than this are often too numb for a proper assessment to be carried out. Stroebe and colleagues have noted that bereavement counselling in the first six months after the loss is generally ineffective, and might even be harmful (Schut, Stroebe, van den Bout, & Terheggen, 2001). This may be because even after a numb phase of warding off the emotions and cognitions connected with grief, most clients exhibit disorganisation in their thoughts, feelings and actions. The schemas that had offered order in their personal world have become so disordered by the loss that they appear not to benefit from counselling until they acquire some degree of reorganisation. It is the author's practice in assessing clients from early referrals, to reassure them by normalising their affect and behaviour, and to advise delaying the start of counselling support until six months after the loss. Experience shows that after six months many bereaved people have reached a sufficient degree of psychosocial reorganisation to manage without professional support.

The author concurs with the view that neither the phases of grief nor the tasks of mourning are a prescription for counselling which takes clients sequentially through each stage (Bonanno, 2010, p. 6; Parkes, 2009, p. 29). In the author's experience, what appears to be more helpful to clients is for the counsellor to listen for reported behaviour which indicates a phase, and to support the client with his or her individualised need.

iv) The Dual Process Model, including avoidance as a chosen strategy

The author could report many cases which support the validity of the Dual Process Model (DPM) (Figure 2.1 page 14). Two are described here⁶.

The reaction of Client A when she was bereaved of her husband was to pursue a life of restoration activities. She remodelled the interior of her house, and redesigned the garden to be lower maintenance. She joined two clubs which gave her access to social events, took on increased responsibilities at work and threw herself into her career. She chose two regular opportunities for loss orientation. The first was to allow herself tears during her counselling

⁶ Neither client A or B were clients that were included in the theory building case studies. They are included as typical examples of clients within the author's caseload. Examples such as these did however inform the development of the project, as illustrated in Figure 4.1 (page 28)

sessions when talking about her husband's illness and death. She also talked and cried with one of her adult children several times each month for the first year.

This contrasts with client B who, following the death of her husband settled very much into loss orientation; both in her counselling sessions and in her day-to-day life. She withdrew from social activity and isolated herself. After three months of weekly counselling the author showed her a copy of the DPM and suggested a Macmillan support group that the client might join. This presented her with the door to new social activities. She made friends and joined a second social group which introduced her to a range of new activities and opportunities. Although her sense of loss remained very strong, she needed counselling sessions less frequently and after a further six months her bereavement support came to an end.

Many clients benefit from being shown the DPM. It allows them to orientate from the current position and make new choices. It can also help to normalise avoidant behaviour, in particular for those clients who intuitively have found it helpful. Machin (2013) suggests that by definition, resilient clients are those able to move easily between loss and restoration activities. This is also the author's experience, although the ten case studies to be described in this thesis allowed the author to explore Machin's ideas.

v) Continuing bonds

Although many clients intuitively build a continuing bond with the person they have lost, some need help to do this. One of the author's clients became stuck in a despairing and yearning phase of her grief and had not entertained the idea that a continuing bond with her husband was possible. Counselling facilitated a change. Later she talked of how helpful the idea had been and it allowed her to move forward with her grief. For many clients, photographs are very helpful way of fostering this continuing bond.

vi) Resilience in grief

As has been suggested in the paragraph above, the concept of resilience as it applies to bereaved clients is complex. Truly resilient clients, as described by Bonanno (2010) have no need to present for bereavement support, although many resilient clients frightened by the intensity of their initial grief reaction, end up being assessed by the author. An important part of this process is the ability of the assessor to accurately determine resilient characteristics and behaviour in the presenting client. In Chapters 4 and 9 the author explores the nature of resilience in grief.

vii) Grief as pathology: the idea of complicated grief

Not all researchers and practitioners are convinced of the validity of complicated grief (CG). Some claim that CG is a specific disorder (Prigerson et al., 1996; Shear et al., 2011b)

whilst others see grief as a continuum of responses from resilience, through moderate distress which eases with time, and intense enduring distress at the extreme end (Burke & Neimeyer, 2013). The current author subscribes to a version of the latter view. In his professional experience, few clients either present for counselling with intense enduring distress, or maintain a prolonged phase of this state over the course of their counselling (Wilson, 2014). Of course it may be that many clients with intense, lasting grief never seek counselling because they do not believe it will help them. Some at the extremes of grief will have been given mental health rather than counselling referrals, particularly if they have a history of mental illness. Nevertheless, the author's position is that grief reactions exist on a continuum, and that intrinsic and environmental factors complicate each bereaved person's grief in an individual and unique way.

Table 3.1 illustrates a summary of Burke and Neimeyer's (2013) review and analysis of risk for CG based on 43 published studies. Based on his clinical experience the author recognises and has worked with each of these complications. He would also add others, including disenfranchised grief, traumatising illness preceding death, and concurrent losses or major life changes. The extent of potential complicating factors underlines the uniqueness of grief in every case. The author suggests that the greater the number of grief complications, the greater the more complex will be the grief reaction.

Risk factors for complicated grief. From Burke & Neimeyer, 2013 p.149

Confirmed risk factors

Spouse or parent of the deceased (especially for a mother)
 Low level of social support
 Anxious, avoidant, insecure attachment style
 Found, saw or identified the body following a violent death
 Issues related to how the death was notified
 High pre-bereavement marital dependency

Potential risk factors

Violent death
 Sudden, unexpected death
 Deceased's age (both younger and older)
 Younger age of bereaved
 Being female
 Less education
 Experience of prior losses
 Low income
 Problematic relationship with the deceased
 Lack of family cohesion

Table 3.1, Risk factors for grief complications

viii) Meaning making

Meaning making theorists posit that an individual's ability to make sense of the unique aspects of his or her loss and grief is a central factor in grief resolution. In a study of 157 parents bereaved of a child, Keesee and her colleagues (Keesee, Currier, & Neimeyer, 2008) found that the ability to make sense of the death was 'the most salient predictor of grief severity' (p. 1145). Robert Neimeyer and his team have conducted several other studies which add to the weight of evidence confirming the importance of meaning-making. This is discussed in detail in Chapter 4. This author takes the position that each client's ability to make sense of their situation permeates all aspects of the grief experience, including feelings of disrupted attachment, coming to terms with the emotional upheaval, accommodating a changed assumptive world, making sense of the circumstances of the death and finding ways of developing a continuing bond with the deceased. Added to this are the myriad of circumstances unique to the individual, some of which have been identified as risk factors in Table 3.1 above.

Three further ideas in bereavement counselling

There are three more concepts that have arisen from late twentieth and early twenty-first century research. They are mentioned here specifically because of their importance in bereavement counselling practice, since even though further investigation of family systems and disenfranchised grief fell outside of the research focus, they remain potential complicating factors for some clients. However further investigation into ruminative coping proved to be important in developing an understanding of resilience.

Family systemic grief reactions

In bereavement support services where family therapy is a possibility, this way of working may be the best way of supporting bereaved family members. In one-to-one support the client's grief is often complicated by family relationships. The author counselled a client following a road traffic crash which resulted in the death of one of his children. The client sought to control his own grief for the first 12 months following the loss in order to be emotionally available for his family. This grief behaviour in men has been observed by Stroebe who has reported that men bereaved of a child survive on the restoration side of the DPM until it feels safe to engage with the loss (Stroebe, 2011; Stroebe & Schut, 2010). The client's grief was further complicated by trying to manage the grief of his wife and remaining children, and by the trauma surrounding the death. The author believes that in deciding how to work with the client's grief, a systemic view should always be considered.

Disenfranchised grief

Doka (2008, 2002) adopted the term 'disenfranchised grief' to describe a client for whom others may not recognise his or her legitimacy to grieve. Such situations typically involve secret relationships or 'affairs', such as the death of a same-sex partner or any partner where legitimacy of the relationship was not recognised; either by others whose views matter to the client or by society in general. A situation familiar to the author is one in which a spouse dies during the process of separation or divorce. When one is bereaved of the other, grief is complicated unless others fully recognise the legitimacy of any remaining love. In other instances a bereaved person may feel that they had a spousal relationship which because it was not formally legitimised, is not recognised by others.

Ruminative coping

Ruminative coping is defined by Nolen-Hoeksema (1994) as 'thoughts and behaviours that focus one's attention and depressive symptoms and the meaning of the symptoms' (p. 92). Clients who ruminate over their grief tended to remain distressed for longer than those who adopt more active coping strategies (Parkes & Weiss, 1983). The author would support the view that rumination is an unhelpful strategy that typically complicates grief.

Summary

A combination of the author's observational skills and 17 years of reflective practice in the field of bereavement has equipped him to use his experience as a bereavement counsellor to critically evaluate the validity of contemporary grief theories. Evidence presented here suggests that bereaved people resolve their grief by making sense of their loss. Intrinsic and environmental factors in each person's loss contribute to the uniqueness of the subject's grief narrative. Some of these factors have the potential to complicate grief. Grief is resolved by making sense of each complicating factor. Whilst some people, identified as resilient, are able to complete this process without help, some may need the support of others. This includes individuals who can be helped by counselling.

Chapter 4 Literature review

Introduction

Chapter 2 charted the history of grief research and noted the move from the psychoanalytical paradigm of grief as pathology, towards a more scientific interpretation of grief as adaptation to loss. At the end of Chapter 3 the author stated his position that for most individuals, grief is resolved by making sense of the factors which are complicating their loss. The factors which complicate grief are diverse and unique to each individual. To be bereaved of someone who was part of your life and on whom you depended, sets life in turmoil. In the confusion of loss there are so many unanswered questions. Questions that clients ask typically include: “Why did he die?”; “Of all the people in the world, why was it him that had to die?”; “How am I going to manage without him?”; “Why am I feeling so confused?”; “How long will I feel like this?”; “Did he know how much I loved him?” ; “If I had done things differently would she still be here today?”; and “Is what I’m going through normal?”

A bereaved person needs to find her own answers to these questions in order to make sense of what is happening. She also needs to make sense of the unwelcome situation which confronts her. Potential complications will include the way her loved-one died, her own attachment style, her social and financial situation and the way she is treated by family and friends. The infinite permutations which ensue from such a loss are what make each person’s grief narrative unique. By making sense of this personal narrative, the bereaved individual resolves her grief and adapts to life without the deceased. Resilient clients construct their own way of making sense of bereavement but others can be helped by counselling (Bonanno et al., 2002; Bonanno et al., 2004).

The complexity of loss and grief, the confusion it engenders in bereaved people, and the need to find personal answers, make this a rich field for study. In Chapter 3 the author begun with his professional history, noting that it underpins observational research in the current project. Figure 4.1 on page 28 charts the development of this research as part of the author’s professional practice. A specific case study methodology called a *theory building case study* (Stiles, 2007), allowed the author to work ethically as bereavement counsellor/researcher within his existing professional setting. The literature reviews which follow were conducted in that context.

Literature review in the context of a theory building methodology

The theory building approach, which is discussed in Chapter 5, requires that each case study completed involves a re-examination of the theoretical position. Observations are described in theoretical terms in order to test the salience of the theory (Stiles, 2009b, pp. 11-

12). Successive case studies either build confidence in the original theory or lead to modifications. Evidence for a theory of meaning-making in grief, through assimilation and accommodation, is substantiated in the first literature review which appears below. There is a substantial body of work which has demonstrated the salience of Stiles' (1999) assimilation model in psychotherapy research, which the author reviews in this chapter. However, to the author's knowledge, assimilation analysis (Honos-Webb et al., 2003; Honos-Webb et al., 2006; Varvin & Stiles, 1999) has not previously been used in bereavement counselling research. Observations from each case study presented in this thesis demonstrate differences between psychological change in grief when compared with other fields of counselling and psychotherapy. In order to understand the theoretical differences, two further literature reviews are reported which, alongside the evidence from the case studies, build a theory of psychological change in grief resolution. Figure 4.1 illustrates a time line which sets the literature reviews in the context of the case studies.

Literature searches

The author has taught bereavement theory since 2003 and soon became conversant with the bereavement field of literature. Well before this project officially began, the author had assembled a large (600+) Reference Manager (Thomson Reuters 2008) database of journal articles, books and book chapters on bereavement theory and practice, both for writing his book (Wilson, 2014) and for preparing the research proposal. In preparation for putting together the proposal, he joined The Bereavement Research Forum (BRF); The Bereavement Services Association (BSA)⁷; and The Association for the Study of Death in Society (ASDS). Since beginning the project in 2011, he has also joined the Association of Bereavement Service Coordinators (ABSCo). The benefits of networking, conferences and full text access to journals that this level of involvement granted was instrumental in extending the author's initial Reference Manager database, notwithstanding an extensive library within the author's place of employment and access to an OpenAthens account via the National Health Service (NHS) Healthcare database and library of electronic journals.

In 2008 the author accessed the literature review of Wimpenny (2006), which had been carried out as part of a review of the field of bereavement in developing evidenced-based care in Scotland. Using a range of search terms, including 'bereavement + care', 'grief', 'loss', 'death', 'dying', 'end of life', and 'funeral', Wimpenny and his team found 6,252 papers and considered 407 of these to be relevant in developing good practice in bereavement care (ibid, p. 2). To this list of publications was added the work of the major academic contributors in the

⁷ The Bereavement Research Forum has since been incorporated into the Bereavement Services Association.

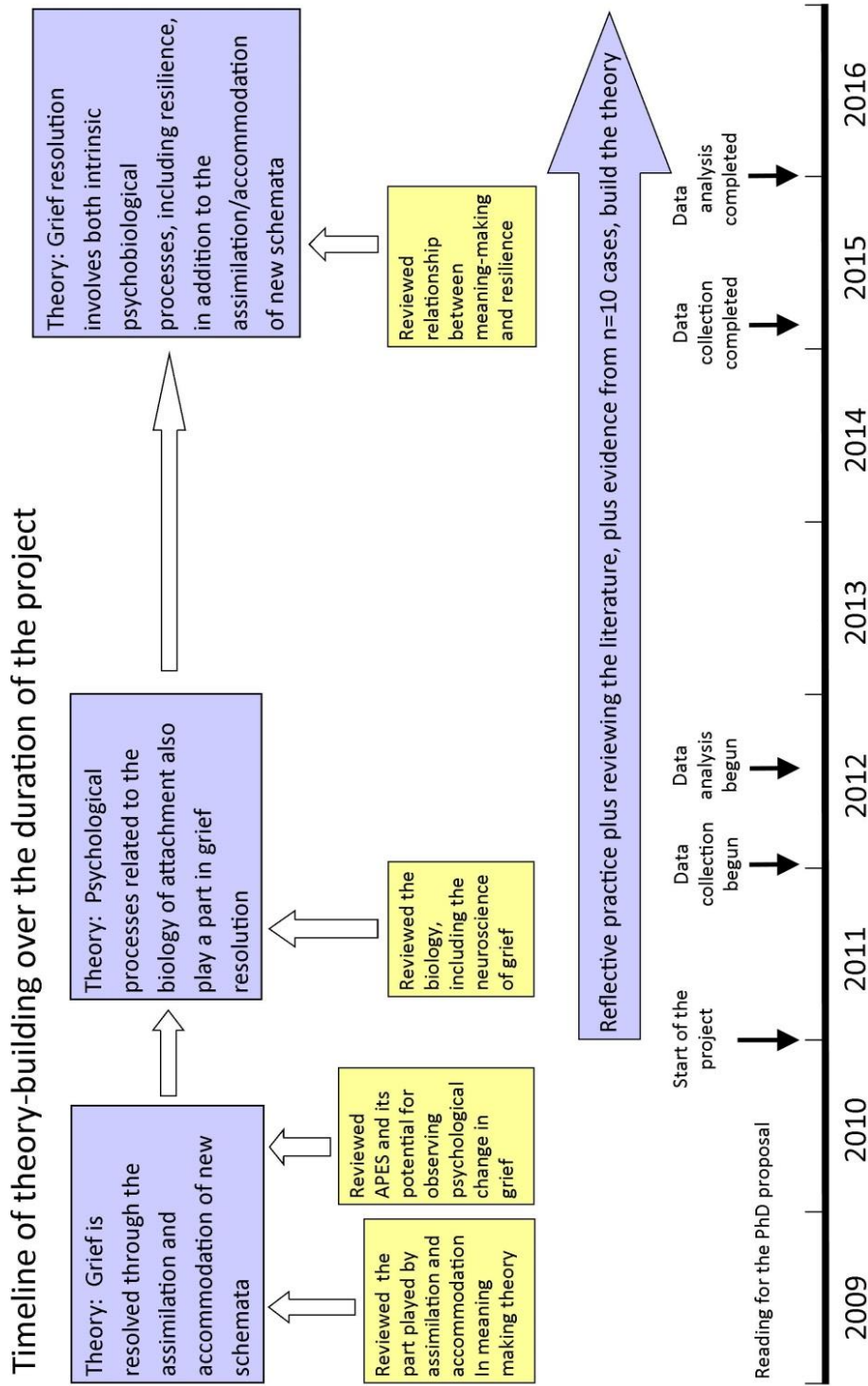


Figure 4.1 Timeline of theory building over the duration of the project

field. This list proved to be a valuable resource for the author who was then able to systematically work through Wimpenny's list of 407 titles; seeking full text access to potentially relevant material. The author made use the NHS online library, using the EBSCOhost search engine and accessing CINAHL and MEDLINE databases. The reference lists in each relevant journal article were also followed up and in this way the Reference Manager database was added to. The reference lists at the end of each article in the three Handbooks of Bereavement Research (Stroebe et al., 2008c; Stroebe et al., 2001b; Stroebe et al., 1993) were also a fruitful source of material. The growing Reference Manager database was supplemented with the integral PubMed search facility using the terms 'bereavement + care', 'bereavement + counselling (and the American spelling, 'counseling')'. The words 'care' and 'counselling' were also used with the search terms 'loss', 'grief' and mourning. Each search was repeated with the addition of the words 'complicated', 'prolonged', 'chronic' and 'pathological'.

One the project became focused on a constructivist approach to theories of loss and grief, additional searches were carried using the search engine Google Scholar and adding the terms, 'meaning making', 'constructivist', 'constructivism', 'schemas', 'schemata', 'assimilation' and 'accommodation' to the terms 'bereavement', 'loss', 'grief' and 'mourning'. Searches using the words 'assimilation' and 'accommodation' in relation to bereavement, loss, grief and mourning proved fruitful. However the word 'assimilation' alone and in relation to loss was unhelpful, since the word encompasses social and cultural interpretations of the concept rather than the narrower meaning as it relates to constructivist psychology and psychotherapy. During the process of writing the original postgraduate research proposal the author attended a workshop of Stiles (2009a). It was here that he was introduced to The Assimilation of Problematic Experiences Scale (Stiles, 1999, 2001). The author noticed, however, from his experience as a science teacher (see Chapter 2), that this fitted his existing ideas, which suggested how bereaved people assimilate an understanding of their grief. Professor Stiles was generous in sharing full text access to his research and publications.

In 2013 the author transferred the Reference Manager database containing 758 citations to Endnote (Thomson Reuters 2012). Google Scholar allows citations to be downloaded directly into Endnote. A further benefit of using Google Scholar is that many full text articles are now available via the online academic social media site Researchgate as downloadable full text pdf files. Endnote allows these files to be linked to each reference in the database.

Further literature searches were carried out for neuroscience and for resilience. These are discussed in the sections below.

Historical, rather than critical, review

It should be noted that for the purposes of this thesis, the author intentionally reports here on an historical review for meaning making. This review should be considered alongside the diagram on page 28. Critically selective processes were conducted in the writing of the research proposal, alongside the completion of the author's book. The database of published research assembled from the work of Wimpenny (2006) was used by the author to select the work of researchers known and respected by the bereavement research community. The credibility of this body of published work is exemplified by its inclusion in the research handbooks of Margaret Stroebe's editorial team (Stroebe, Hansson, Schut, & Stroebe, 2008c; Stroebe, Hansson, Stroebe, & Schut, 2001b; Stroebe, Stroebe, & Hansson, 1993).

Literature review 1: Meaning making

From this initial review of theories of psychological adaptation to environment, the author has built an assimilation theory of grief based on the ability of the individual to make sense of the many aspects of the loss. This is described in Chapter 5. Here the current literature is reviewed under three headings, meaning-making as: i) a process of assimilation and accommodation; ii) as reconstructed narrative; and iii) as adaptation to stressful events. These headings exist only for conceptual clarity; as three ways of viewing one and the same process.

i) Assimilation and accommodation

A theory of psychological adaptation to environmental change begins with Jean Piaget's theories of cognition and intelligence (Piaget, 1950, 1952, 1954). Piaget's twin concepts of assimilation and accommodation have proved useful to grief theorists in explaining human adaptation to loss (Janoff-Bulman, 1992; Neimeyer, 2001a). Piaget (1950, 1954) saw assimilation and accommodation as the child's attempt to adapt to a continually changing environment. He saw this adaptive process as a dynamic interplay between assimilation and accommodation. Piaget distinguished between 'things', by which he meant objects, and events in the child's environment, and the mental constructs, or 'schemata', that the child assimilates from these environmental phenomena. In the early stages of life the child only has access to basic, innate schemata, such as sucking and grasping, all of which need to be accommodated to things in the environment. At this stage:

'Accommodation remains so undifferentiated from the assimilatory process that it does not give rise to any special active behaviour pattern but merely consists of adjustment of the pattern to the details of the things assimilated.' (Piaget, 1954, p.351).

As the child's intelligence develops, the child is able to differentiate herself from her environment. Schemata are acquired that are personal and unique. Assimilation and accommodation also become differentiated. Piaget (1954) described accommodation as 'the source of changes in response to the challenges posed by the environment (ibid, p. 352), whereas assimilation 'always resists new accommodation' (ibid, p. 353). If the need to accommodate persists it is because existing schemata do not address environmental change and new assimilation takes place until such time as the child has successfully adapted to the new circumstances. The greater the environmental challenges placed on the individual the greater the need to accommodate, which in turn generates the assimilation of new schemata. There is reciprocity in this process since, as Piaget (1954) explained, accommodation only occurs when pre-existing schemata fail to meet the challenges of the environment. Thus accommodation is triggered when the individual unsuccessfully matches existing schemata with new information coming in from the environment and ceases when a new schema is constructed which matches the new experience. Hence without assimilated schemata there can be no accommodation (ibid, p. 354).

George Kelly and Jean Piaget were contemporaries, but in spite of striking similarities in their respective theories, neither referred to the other's work. Kelly's theory of constructivism grew from his psychotherapeutic practice in rural American communities, and as such he was the first to develop a theory of constructivist psychology in the therapeutic setting (Neimeyer, 2009b). What both have in common is a principle of adaptation to environment through cognitive processing conceptualised as a personal construction system. Whereas Piaget used the term *schema*, Kelly chose *constructs* (Kelly, 1963, p. 9). He envisaged each construct as a personal pattern for construing a universe that exists in reality. The pattern is 'tried on for size' (ibid, p.9) to create the best possible fit with reality. In making sense of the world, each person builds up a repertoire of constructs, which undergo constant revision and modification. Kelly named this process of assimilation and accommodation 'reconstruction' and acknowledged: 'A person's reconstruction of life is a process which goes on all the time.' (Kelly, 1963, p. 134). In Kelly's view, constructs equip us to make predictions so as to survive in a constantly changing world. Kelly adopted the term *man-the-scientist* (ibid, p. 4) to describe this human characteristic.

As is described below, others in the field of therapy research approach the field from a constructivist dimension. Janoff-Bulman's (1992, pp. 28-29) concept of assimilation and accommodation of schemas closely matches Piaget's ideas. Stiles and colleagues have said that a client's problematic experiences can also be viewed as schemas (Stiles, Honos-Webb, & Lani, 1999, p. 1214). Indeed, Stile's idea, of assimilating of problematic experiences (Stiles, 2001), is predicated on the concept charting the counselling client's progress as she forms new

mental constructs (schemas) which allow her to accommodate changed aspects of her personal world.

ii) Meaning making theories

In championing Kelly's contribution to psychology, Robert Neimeyer (2009b) introduces the term *self-narrative* to describe the story each person constructs around their life. Stressful events elicit “*dominant narratives* that become the initial focus of therapeutic attention” (Neimeyer, 2009b, p. 97, original italics). Self-narratives can be “re-authored” in therapeutic dialogue (ibid, pp. 97-100). Neimeyer (2000) introduced the idea of self-narrative disrupted by loss and grief; a disruption that can be addressed by the reconstruction of meaning. Neimeyer's (2009b) position is that narrative is reconstructed through making meaning. Like Piaget and Janoff-Bulman (op cit.), Neimeyer (2006b) uses the terminology ‘assimilation’ and ‘accommodation’ as well as the word ‘schema’ as a mental construct, choosing the plural form ‘schemas’ over the Latin ‘schemata’ used by Piaget. As a researcher with a therapeutic caseload, Neimeyer's qualitative research (Neimeyer, 2006a, 2006c) is rich in examples of his constructivist psychotherapy. With others, his quantitative and mixed methods research (Holland, Currier, & Neimeyer, 2006; Neimeyer et al., 2006) has demonstrated the value of a meaning-making approach with bereaved clients.

Davis and colleagues (Davis, Wortman, Lehman, & Silver, 2000) investigated the limitations of attempting to make meaning. In a study of 124 parents grieving a sudden infant death, 14% reported never searching for meaning and 18% reported that, although they had initially searched for meaning, they quickly abandoned the search. Of the remaining 68% (n=91 parents), only 38 reported finding some meaning in the loss. Around half of these found the religious interpretation. Others managed to find at least one positive aspect in the loss, such as being more appreciative of other children in the family, or a sense of becoming closer to their partner (ibid, p. 504). Distressing grief symptoms perpetuated in those searching for, but not finding, meaning. Those who found meaning experienced a decrease in their distress but this was not significantly different to those who had never searched for meaning. It was also evident that, unless meaning was found soon after the loss, the efforts to make any sense were usually fruitless and remained distressing (ibid, pp. 504-507). The indications for bereavement counselling practice are profound. Grief therapists should be mindful in supporting clients struggling to make sense of the loss, especially where there is a risk of this developing into a negative rumination (See below). When no sense can be made of the loss itself there may be benefits to be found (Davis, Nolen-Hoeksema, & Larson, 1998; Holland et al., 2006). Many clients who can find no meaning in the death are sometimes able to find meaning in the life of the deceased. Some find new meaning and purpose in their own lives in the context of the loss (Wilson, 2014, p. 117). Janice Nadeau (2001, pp. 106-107) concludes that families searching

for meaning find it helpful to eliminate what death does *not* mean as a step towards identifying what it *does* mean (original italics). Nadeau also concludes that families are helped if they can identify what death had meant to the deceased.

In more general terms, Pennebaker and colleagues (Pennebaker, Mayne, & Francis, 1997; Pennebaker, Zech, & Rime, 2001) have explored the use of written and spoken language as a predictor of health outcomes in bereavement and loss. They concluded that whilst ruminations on negative thoughts were unhelpful, linguistic forms that allowed insightful exploration of causal relationships could have positive benefits both in physical and emotional health.

iii) Adapting to a world changed by loss

Thomas Attig conceptualises the reconstruction of disrupted narrative following loss as ‘relearning the world’ (Attig, 1991; 2011, pp. 25-62). Attig is very clear that this aspect of grieving is an active process. In writing of his own work with grieving people, Attig approaches his ideas as an applied philosopher rather than a psychologist. However, according to Popper’s (1959, p. 54) assertion that investigative methods ‘must be designed in such a way that they do not protect any statement in science against falsification’, Attig’s ideas can be seen as scientific because they are falsifiable.

As Attig (2001, 2011) conceptualises ‘relearning the world’ as a means of coming to terms with bereavement, so Parkes (2009, pp. 31-32) writes of adjusting to an ‘assumptive world’ changed by bereavement. Parkes (*ibid*, pp. 31-32) acknowledges Neimeyer’s contribution to what he describes as a theory of psychosocial transition (See also Parkes, 1971), and relates ‘assumptive world’ to Neimeyer’s (2001b) extensive writing in which he describes the narratives people used to construct a personal world. Parkes (*ibid*, p. 31) said that our assumptions include ‘the countless cognitions which make up the complex structures on which our sense of meaning and purpose in life depends’. Janoff-Bullman (1992, p. 5) has also used the term ‘assumptive world’ in the context of her work on traumatic loss.

Literature review 1: Conclusions

Within the field of bereavement and other research into loss and trauma, there is broad agreement that grief involves adaptation to a life without the presence of the deceased. This process includes making sense of the loss, of the emotions and behaviour that come with grief, and of the world in which the deceased is missing. A constructivist approach to meaning making involves the assimilation of new meanings leading to the reconstruction of the narrative disrupted by the loss. The disrupted narrative caused by the bereavement engenders a state of disequilibrium, which is rebalanced in the process of reconstruction.

Literature review 2: Grief-related neuroscience

Neuroscience literature search

From observation of the case study material, discussed in Chapters 6 to 8, the author concludes that in cases where grief is prolonged, meaning making theories alone are insufficient to explain some of observations, and that an attachment based component of grief is needed to build the theory. During the process of constructing the large database of bereavement research discussed above, the author came across the work of O'Connor and colleagues (2005; 2008), and that of Freed and Mann (2007). It became clear to the author that he needed to extend his knowledge of neuroscience in order to become familiar with the brain regions discussed in the literature on the neuroscience of grief. Searches of Google Books using the terms 'neurology' and 'neuroscience' revealed four helpful texts on neuroscience (Cozolino, 2006; Cozolino, 2010; Panksepp, 1998; Ward, 2012). Searches of Google Scholar: PubMed; PsycINFO; ProQuest; CINAHL; and MEDLINE, were conducted using the terms 'neuroanatomy', 'fMRI + grief', 'neuroscience + attachment', 'neuroscience + grief', 'neuroscience + mourning', 'neuroscience + affect' and 'neuroscience + emotion'. All searches were repeated substituting the word 'neurology' for 'neuroscience'. Other searches replaced 'grief' with 'mourning'⁸.

The author was keen to find a mechanism that would explain the motivational drive that keeps bereaved people close to the object of lost attachment and which may explain attachment distress. Freed and Mann (2007) had cited the work of Berridge and Robinson (2003). A search was conducted using the terms 'Berridge + neuroscience + motivation'. This yielded two further papers (Berridge & Kringelbach, 2008; Berridge & Robinson, 1998).

The Neuroscience of Grief

Any study which approaches grief from a biological perspective would be incomplete without an exploration of the role the brain plays in the grieving process. The author posits that a major loss, such as bereavement, destabilizes a person's homeostatic equilibrium and that active grief is the human attempt to return to a stable state. If the role of the brain is one of 'reading the body's condition' (Immordino-Yang & Damasio, 2007, p. 6) then by examining the neurological processes involved, one can better understand the range of emotional and cognitive reactions typified by bereavement and loss. If this is to be of practical use to counsellors and psychotherapists it must not only shed light on the client's processes, it should also light the way to new therapeutic practice.

The author's literature review of developments in neuroscience was broad, in that it

⁸ The author has noticed that many American authors use the word 'mourning' (see for example, Neimeyer, Prigerson, & Davies, 2002b) whereas European authors are more likely to refer to 'grief' and 'grieving' (see for example, Parkes, 2002).

encompassed evidence drawn from research into all the emotions likely to be involved in loss and grief. This included the work of Panksepp (1998; 2011a) on mammalian brain circuitry. In more recent developments in the field, functional magnetic resonance imaging, fMRI scans have allowed the brains of bereaved people to be observed whilst they are actively engaged in grieving.

What questions might neuroscience answer about grief?

In constructing a psychobiological theory of grief, neuroscience may provide important answers to key questions. What for example, might it contribute to attachment theory? Can the neurobiology of attachment be observed in the brain through experimental neuroscience? Might it explain why secure people are less likely to experience complicated grief? Could activity in the brain involved in cognition, schema building, meaning making and autobiographical narrative be observed by neuroimaging?

Emotion systems in the mammalian brain

Panksepp (2005) has identified seven emotion systems or circuits in the mammalian brain. Each has been identified by stimulating the brain mechanically or with electrodes and observing the animal's behaviour. In his published work, Panksepp writes these core systems in upper case to emphasise their importance, since the experimental observations of cause and effect are homologous between species. Because the physical site of each of these systems is subcortical they are shared with other animals on an evolution hierarchy. The seven systems are SEEKING, RAGE, FEAR, LUST, CARE, PANIC⁹ and PLAY (Panksepp, 2005). Other primitive or primal emotions arise from these seven emotion systems. If Panksepp is right in identifying these systems then it is clear that SEEKING, RAGE, FEAR and PANIC are all likely to be implicated in a typical grief reaction. The CARE circuits will be implicated in close family bereavements.

RAGE circuits run from the major areas of the amygdala through the medial hypothalamus (see figure 4.3) and into specific areas of the periaqueductal gray (PAG)¹⁰ (see figure 4.2) in the midbrain. Rage can be fuelled by testosterone in both males and females. Also, in animals including humans, low levels of brain serotonin leaves the subject prone to aggression possibly due to monoamine oxidase-A which breaks down serotonin (Panksepp, 1998 p.189).

⁹ In some published work, for example Panksepp & Watt (2011) PANIC is referred to as a PANIC/GRIEF system.

¹⁰ 'gray' is spelled 'grey' by some European neuroscientists. However the former spelling is used by Panksepp and has been adopted in this thesis.

As unpleasant as a fearful experience can be, FEAR circuits, according to Panksepp, help to keep us safe:

‘Evolution created several coherently operating neural systems that help orchestrate and coordinate the sexual, behavioural and physiological changes that promote survival in the face of danger.’ (Panksepp, *ibid* p.206).

Panksepp (1998 pp. 207-208) suggests that both intense fear after a traumatic event and chronic anxiety arising from a sense of insecurity originate from the same fear circuits. He believes that due to the complexity of neural control, most of the mammalian brain has some part to play in fear recognition and reaction. However, the regions which can be electrically stimulated to cause fearful behaviour are in the lateral and central amygdala, the anterior and medial hypothalamus (see figure 4.3) and down to the mesencephalic periaqueductal gray (see figure 4.2). Fear can be learned from experience. Pain and fear are closely related. The pain of grief, therefore, is likely to trigger new fear circuits. Thoughts can trigger fear. Whilst it is not known whether smell mediates human fear directly, smell evokes conscious memories (*ibid* p. 221): for example the smell of the hospital may remind a grieving relative of a death in a cancer ward. The smoke of burning oil may serve as a painful reminder of a road traffic collision.

Panksepp’s emotion systems, grief and attachment separation

The SEEKING emotion systems described by Panksepp (1998) have unsurprisingly been shown to play a part in reactions to separation and loss. In some higher mammals, separation distress, indicated by distress vocalisations, can also be caused by stimulating the anterior part of the cingulate gyrus cortex (see figure 4.2), parts of the amygdala and parts of the hypothalamus (see figure 4.3) (Panksepp, 1998 p. 267). Anger is frequently reported as a grief reaction, as is fear. Panksepp suggests that the RAGE circuit may be aroused top down by frustrations arising from expectation and reward mismatches in the ‘seeking’ system. This ‘frustration-aggression hypothesis’ postulates that aggression is directly proportion to the degree of frustration (*ibid* p.191). When all attempts to be reunited with the lost loved-one have failed, anger surely follows.

It would be no surprise to find the FEAR circuit activated in individuals who have been bereaved in traumatic circumstances, and this does appear to be the case (Currier & Neimeyer, 2007). Memories of fearful events will also reactivate fear circuits so learning also plays a part. Bereaved people often report a fear of being unable to cope with life without the

deceased, and express fear of the unfamiliar evoked by a shattered assumptive world (Janoff-Bulman, 1992; Parkes, 1971).

The bond of the infant to its mother is not the same as the maternal bond from mother to child. Different neural circuits are involved (Panksepp, 1998). Nevertheless, the reaction of a mother separated from her baby will, according to Panksepp, arouse primitive neurological circuits which elicit seeking behaviour. If the search remains unrewarded, then almost certainly the PANIC, FEAR and RAGE circuits will be aroused. It is the author's experience that grieving mothers in counselling oscillate between fear, anger and sadness. In non-human species, sadness and separation despair may happen over a shorter period of time (See for example Cronin, van Leeuwen, Mulenga, & Bodamer, 2011). Against this finding, human mothers who seek professional help after losing a child are often told that rather than "getting over" this loss, they will "learn to live with it" (Morawetz, 2007).

Might grief-related depression be a functional adaptation?

Panksepp and Watt (2011b) asked which of the seven subcortical systems play a part in developing an understanding of depression. They concluded, as Bowlby (1980) had done before them, that the PANIC/GRIEF of separation distress plays an important part. Furthermore they considered that the seeking system may have a role in the depression of emotion on those unsuccessful occasions when the arousal and agitation of separation gives way to the despair phase of grief. They suggested that the diminished activity typical of depressed behaviour could conserve the subject's energy which may confer an evolutionary advantage. Triangulating a neurological model of sadness from guinea pig and human studies of the neural circuitry, Panksepp and Watt have concluded that PANIC/GRIEF circuitry starts in the midbrain region known as the periaqueductal gray (see figure 4.2), and ascends via medial diencephalic structures, in particular the dorsomedial thalamus (see figure 4.3), terminating in certain basal forebrain regions and the subcallosal anterior cingulate cortex (see figure 4.2). They suggest that the PANIC/GRIEF system evolved from physical pain mechanisms. As the author records below, others have considered the possibility that the depression-like symptoms which frequently accompany other grief reactions (See for example, Freed & Mann, 2007), may serve a useful purpose.

The neuroimaging of grief in humans

The first neuroimaging study specifically linked to human bereavement was by Gündel and colleagues (Gündel et al., 2003). They showed eight bereaved women photographs of their deceased loved-one against pictures of a stranger as a control, adding emotive words versus neutral words. They found that many inter-related areas of the brain were involved in grief,

reflecting the subjectivity and uniqueness of individual grief reactions. They observed that grief appears to be mediated by a distributed neural network instrumental in modulating and coordinating a range of functions, namely processing emotion, assisting mental reflection, retrieving episodic memories, processing familiar faces, visual imagery, and autonomic regulation. Many areas of the brain were involved. In a later paper, O'Connor (2005), one of Gündel's (op cit) collaborators invited a conversation between bereavement researchers and neuroscientists, based on the premise that the former know what questions neuroscientists should be asking and what grief theories and models should be investigated by neuroscience. O'Connor summarized the 2003 research noting just how many areas of the brain are triggered by the complexity of grief. However, she described the most important areas and explained the theoretical implications in neuroscientific terms.

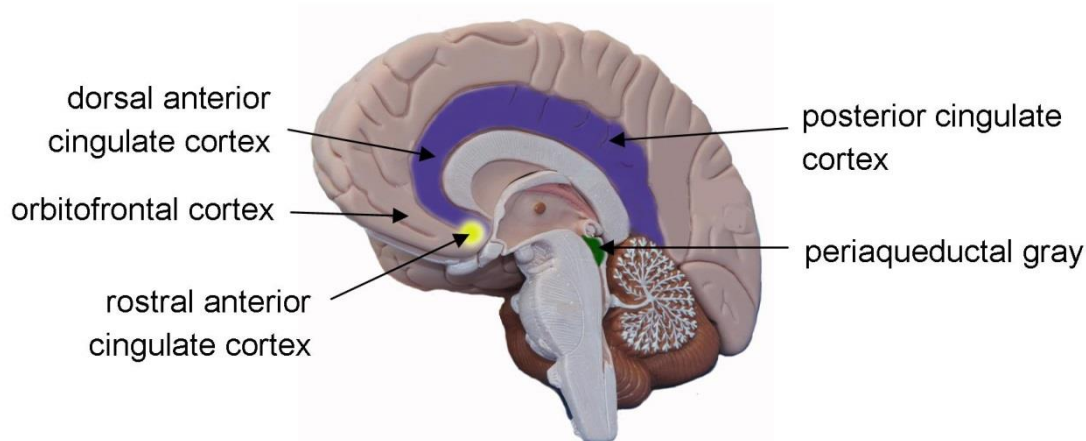


Figure 4.2 Longitudinal brain section

The first important area O'Connor stressed was the posterior cingulate cortex (see figure 4.2), an area linked to autobiographical memories (Maddock, Garrett, & Buonocore, 2001) but also in threat-related words in people suffering from panic disorder (Maddock, Buonocore, Kile, & Garrett, 2003). She concluded that the reason that grief elicitation triggered this area is 'most likely due to its role in the interaction between memory and emotion' (op cit, p. 910). The second regions O'Connor described were the anterior cingulate cortex and the insula (see figure 4.4). The anterior cingulate cortex (see figure 4.2) she proposed as part of the brain responsible for attention to and awareness of other parts of the body and the insula (see figure 4.4) processes visceromotor information. The two regions working together, she suggested, creates an awareness of somatic sensation, perhaps 'in the role of attention to the bodily state' (ibid; p.910). O'Connor noted that this study did not record any amygdala activity and postulated that the widows involved in the study may have reached a stage in their grief beyond this being likely.

Amygdala activity was, however, recorded by Freed and colleagues (Freed et al., 2009) who performed fMRI scans on twenty subjects bereaved of either a pet cat or dog in the previous three months. By eliciting grief in their subjects they found activity in the amygdala, insula (see figure 4.4) and temporoparietal regions. They concluded that activity in the amygdala suggested that it has a role in detecting separation distress.

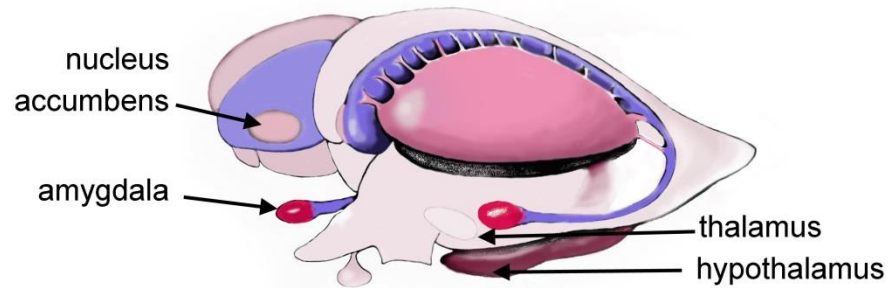


Figure 4.3 Brain regions concerned with primary emotions

A correlation between feelings of attachment insecurity and amygdala activity was demonstrated by Lemche et al. (2006). They presented 12 subjects with 32 agree/disagree statements on self-centred and other-centred statements after priming their subjects with unpleasant sentences describing attachment experiences designed to elicit stress. These stressing sentences were paired with neutral ones matched for number of words; which served as the control. Each priming statements was shown subliminally for 30 milliseconds such that the subjects were not consciously aware of the statements. The times for responding to the ensuing 32 statements tended to be slower after the stressing prime, the mean difference in reaction time was known to be related to attachment security, such that the slower the response the greater the insecurity. The attachment priming task had previously been piloted and validated. Lemche's team measured skin conductance to determine autonomic response and carried out fMRI imaging on each subject. The brain regions that correlated with attachment insecurity were the ventrolateral prefrontal cortex (see figure 4.4); right dorsal anterior cingulate gyrus; left middle and superior temporal gyri; and left inferior parietal cortex. They also found positive correlations between magnitudes of autonomic response and neural response within left ventrolateral prefrontal cortex; left middle temporal gyrus; left anterior insula; and left inferior parietal cortex. However, these regions were activated following both the neutral and stressful priming. The only brain region that correlated positively with measures of attachment insecurity and autonomic response was the amygdala (see figure 4.3). Lemche and his team concluded that the amygdala has a role in mediating the autonomic nervous system in response to feelings of attachment insecurity.

Neuroscience has practical implications for bereavement counselling

A good example of the importance of linking grief theory to psychobiology and neuroscience can be found in a theoretical paper by Freed and Mann (2007), in which they cited the case of a graduate student receiving counselling for the loss of a family member. They noticed her sadness and questioned whether in counselling she should be encouraged in her grief or distracted from it. Their perceived dilemma was based on opposing interpretations of the function of sadness in grief. On the one hand they proposed a function based on the protest stage of loss and on the other a function based on the despair stage. Attachment theorists who have proposed stage or phase models of grief have suggested that the evolutionary purpose of protest is to keep the caregiver close by. Protest, however, loses its usefulness when the caregiver dies. If despair takes over from protest, this may serve the biological function of detaching the griever from the lost caregiver and enabling them to accept the reality of the loss. This idea was explored by Panksepp and Watt (2011b) and is discussed above.

Freed and Mann (op cit) also explored the phenomenology of sadness and concluded that there appeared to be a difference between sad *emotions*, which are of short duration and which clients say offers some relief, and sad *mood*, which appears to be enduringly painful and unremitting. They suggested that sad emotion may be a manifestation of despair, and enduring sadness a feature of protest. Finally they suggested the possibility that neuroimaging would in time reveal differences in the brains of bereaved people according to the adopted model of sadness following loss. These differences may inform the approach that a bereavement counsellor would take. If sadness is part of the process of detachment and acceptance of the reality of the loss, then the client can be encouraged to express grief. If, however, the sadness is part of the process of remaining attached to the deceased, the client may best be distracted from grieving and encouraged to consider spending time on restorative activities.

A year after Freed and Mann (2007) had suggested that protest and despair models of sadness might be observed by neuroimaging, O'Connor and her team (O'Connor et al., 2008) demonstrated that this was possible, explicitly linking her findings to Freed and Mann's (2007) paper. O'Connor scanned the brains of 23 women who had lost either a mother or a sister to cancer. All 23 were first given a questionnaire to test their grief reaction. Twelve of the 23 scored high enough for a diagnosis of complicated grief. Then, fMRI scans were carried out as they were each shown photographs of their deceased loved-one to elicit a sad response and they were invited to talk about their loss. O'Connor was looking for evidence of either the protest (yearning) or the despair (accepting) model of grief in the brains of her subjects. The brains of the complicated grievers were different to the normal grievers. Both groups showed pain related brain activity, assumed to be a response to their sadness. In those women with complicated grief there was additional activity in a part of the brain called the nucleus

accumbens (see figure 4.3). This area is commonly believed to be associated with reward (O'Connor et al., 2008). O'Connor concluded that both the despair model and the protest model of grief, which Freed and Mann (2007) had proposed, are true for different people, and may be phases of their grief that change with time.

The idea that a “reward or reinforcement system” equates to the SEEKING system has, according to Panksepp, “long been misconceptualized” (Panksepp, 1998, p.53). Panksepp argues that to call this a ‘reward system’ or, as some researchers have called it, a ‘pleasure system’, is misleading since reward implies that a consummatory state has been reached in which instance one might expect the system to become inhibited (ibid p. 144). Panksepp describes a SEEKING system which runs along the lateral hypothalamic continuum from the ventral tegmental area to the nucleus accumbens (see figure 4.3). The SEEKING system drives the animal to anticipate and find what it needs for survival. The system is driven by dopamine which can promote the state of eagerness. This incentivises the creature to seek and anticipate the fruits of its efforts. This makes sense when our loved one is alive, because thinking about them gives us a warm feeling. When we cannot wait to see them again we seek them out. However in bereavement and when combined with sadness, seeking behaviour prolongs the attachment to the deceased long after all reality of seeing them again has ended.

Grief and emotional pain

When bereaved people talk of the pain of loss, they do not speak metaphorically. Evidence is accumulating to confirm that both physical and emotional pain, are processed by the same brain regions and neural networks. Panksepp believes that the periaqueductal gray (PAG) (see figure 4.2) is implicated in primitive emotions which include ‘pain, fear, anger, separation distress, sexual and maternal behaviour systems’ (Panksepp, 1998, p. 312), all of which are emotions relevant to the experience of grief and the process of grieving. PANIC systems that have been mapped out by electrical brain stimulation indicate an evolutionary link with the physical pain. The panic system arises from the midbrain periaqueductal gray (see figure 4.2) very close to a brain region where artificial electrical stimulation triggers a physical pain reaction. O'Connor et al. (2008) noted the significant activation of three areas related to pain processing in human subjects experiencing both normal and complicated grief. These areas are the periaqueductal gray (PAG) (see figure 4.2), the anterior cingulate cortex (ACC) cortex (see figure 4.2) and the insula (see figure 4.4). They found no significant difference in complicated versus non complicated grief in the PAG and the ACC but more activity in both of these regions in the non-complicated grief group when shown grief related versus neutral words. Peyron, Laurent and Garcia-Larrea (2000) conducted a meta-analysis of positron emission tomography (PET) and functional magnetic resonance imaging (fMRI) studies, which

established the role of the PAG, ACC (see figure 4.2) and the insula (see figure 4.4) in processing pain. Craig (2003) concluded that pain is both a sensation and a ‘specific emotion that reflects homeostatic behavioural drive, similar to temperature, itch, hunger and thirst’ (ibid, p. 303). Like Panksepp, he implicated the PAG (see figure 4.2) and associated regions. Kersting et al (2009) noted significantly greater functional connectivity between the thalamus (see figure 4.3), inferior frontal gyrus and cingulate gyrus¹¹ (see figure 4.2) in women grieving the loss of an unborn child when compared to the brain activity in women delivered of healthy babies. Connectivity between these regions is typical in the experiencing of physical pain (ibid).

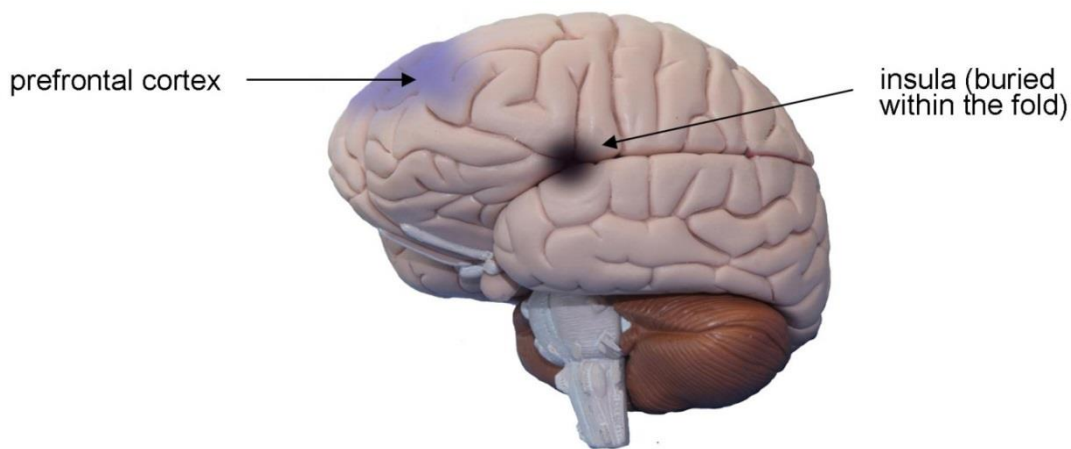


Figure 4.4 Structures of the cortex implicated in grief reactions

A neurological mechanism for attachment behaviour

As observations of clients in each study progressed, (See figure 4.1) the author was able to observe the distress of broken attachment, which appeared to be separate from the distress of narrative disruption. Whereas the latter could be worked on through the assimilation and accommodation of new schemas, attachment distress seemed to be a far more basic human emotion. New schemas to accommodate this distress seemed to be concerned with recognising the need to be patient. The role of the author as counsellor was to normalise and reassure the client, to help them acquire strategies to take time out from grieving and to assist in the construction of self-reassuring schemas.

Technology was limited in John Bowlby’s working lifetime, and he was never able to reconcile attachment theory with neuroscience. Before Bowlby’s death in 1990, Jaak Panksepp was working on the neurobiology of attachment discussed above. In more recent years the

¹¹ A *gyrus* (plural *gyri*) is a raised surface of a cortex, as opposed to the folds, which is called a *sulcus* (plural *sulci*) (Ward, 2012).

development of fMRI has meant that the intense want of an individual to be close to a love object, coupled with the joy of closeness, can be seen in action. An operational mechanism for this neurological process is called *incentive salience* (Berridge & Robinson, 2003).

Incentive salience: the neuroscience of wanting

Incentive salience refers to one of the psychological components of reward (Berridge & Robinson, 2003). Rewarding behaviour has to be learned from experience; i.e, some experiences bring rewards and learning is reinforced by the hedonic outcome. Rewarding experiences are, therefore, motivational and can condition our response to stimuli. As we learn, we acquire knowledge about the relationships between a stimulus and our response to it. In short, we learn what makes us happy. We use our knowledge to predict rewards, to respond to cues with anticipation and for goal-directed actions. The processes by which we learn to respond involve either associative or cognitive learning. Associative learning involves learning the association between either two stimuli or a between a behaviour and a stimulus (*ibid*). It can involve the prediction of a reward.

Incentive salience as a motivational process

In normal usage of the word ‘wanting’ generally refers to a conscious desire, whereas in Berridge and Robinson’s (2003) terms, ‘wanting’ specifically refers to the motivational process called incentive salience. Whereas it was once believed that ‘wanting’ and ‘liking’ were inseparable, some neuroscientists now believe that by manipulating the mammalian brain experimentally, ‘wanting’ and ‘liking’ have been found to originate in different regions of the brain (Berridge & Kringelbach, 2008; Berridge & Robinson, 2003).

Incentive salience is a motivational component of reward systems, as opposed to ‘liking’ which is an affective component. Incentive salience takes the sensory stimulus of an image or object and through the neurotransmission of dopamine, makes it become strongly desired. Brain substrates thought to be involved include the nucleus accumbens and connections to the amygdala (see figure 4.3), basal forebrain and cortex. This happens when incentive salience is triggered by a stimulus. This may be a direct sensory stimulus that the brain has attributed with incentive salience. It becomes, what Berridge and Robinson refer to as, a ‘motivational magnet’ (Berridge & Robinson, 2003, p. 508), causing appetitive and consummatory behaviour. Sometimes incentive salience is triggered by a cue, or conditioned stimulus (*ibid*, pp 510-511). For example, the sight of drug paraphernalia can motivate former drug users to start using again (Rohsenow, Childress, Monti, Niaura, & Abrams, 1991).

The motivational component of reward described above is compared to the cognitive component of wanting. Cognition and learning play a part in reward incentive due to learned

expectations that what is wanted will be liked. In other words, potential rewards have hedonic value based on learning and memory. The neural substrates of cognitive incentive are the neocortical structures, including the orbitofrontal cortex (see figure 4.2) and insular cortex. Interconnected neural circuits allow interaction between learning, ‘wanting’ and ‘liking’ (Berridge & Kringelbach, 2008; Berridge & Robinson, 2003).

Relationship of incentive salience to grief

The triggering of a ‘wanting’ to be reunited with the deceased suggested to Freed and colleagues (Freed & Mann, 2007; Freed et al., 2009) that incentive salience, measured by activity in the nucleus accumbens, plays a part in mediating grief. The two alternative hypotheses to explain sadness discussed earlier in this chapter, lead to either a *protest* model; evolved to bring about a reunion with the missing love object or a *despair* model. After the death of the lost love object, reunion is not possible and protest is fruitless. Incentive salience, that intense wanting or yearning often associated with grief, may lead to despair. The resultant grief related depression may ultimately help with disengagement from the lost love object.

An understanding of incentive salience has practical implications for bereavement counselling. It suggests that chronically grieving people seeking constant reminders of the lost loved one should at least for some of the time, be encouraged not to dwell on the loss, since this would risk prolonging the grief. This is the conceptual basis of the Dual Process Model of grief (Stroebe & Schut, 1999) arrived at independently of neurobiological theory but which has been demonstrated as being effective (Richardson, 2007). It also suggests a negative value of unfocused ‘grief work’, discussed later in Chapter 3 and again in Chapter 9. In addition it explains how Continuing Bonds Theory (Klass et al., 1996) discussed in Chapters 3 and 9, can be helpful in bringing about a degree of reunion, albeit symbolic, with the deceased.

Grief, stress and impaired resolution of emotional conflict

In the process of counselling, clients frequently experience emotional conflict. Stiles (1999) has characterised this phenomenon using the metaphor of “opposing voices” (ibid, p.11). Examples from the author’s own practice would include the many instances where a bereaved client talks about engaging in restorative activities but feels guilt and disloyalty towards the deceased when she experiences moments of joy. Etkin et al. (2006) have investigated the neurological aspects of emotional conflict. Subjects were asked to respond to photographs of faces displaying basic emotions, overlaid with either congruent or incongruent emotive words. For example, a fearful face over which was written the word ‘happy’. This is an adaptation of the Stroop Test (Stroop, 1935) in which colour names: red, green, blue etc. are written in colours which do not match the colour name, for example, the word ‘green’ written

in purple ink. The original Stroop Test was designed to test cognitive conflict, and the time taken to correctly identify the ink colour was taken as a measure of the degree of conflict. Etkin and colleagues' (2006) test of emotional conflict measured the time subjects took to identify the facial emotion whilst ignoring the emotive word written over the face. Subjects were placed inside an fMRI scanner to determine which brain areas were activated by the test.

The results showed that emotional conflict activates the amygdala (see figure 4.3) and that the rostral anterior cingulate cortex (rACC) cortex (see figure 4.2) mediates in the resolution of emotional conflict. It appears that the rACC exerts a top-down control of the amygdala by inhibiting amygdalar activity. Those experimental subjects best able to resolve the emotional conflict showed increased rACC activity and reduced activity in the amygdala (see figure 4.3). This is consistent with Freed and colleagues' (2009) conclusions cited above, with Hull's (2002) comprehensive review, linking reduced anterior cingulate activity and increased amygdalar activity in response to trauma, and to work by Kumari et al. (2003), who linked rACC hypoactivity with treatment-resistant depression. Bereaved clients may exhibit signs of trauma and depression as a correlate of grief. The resultant uninhibited amygdalar response would explain the commonly observed emotional confusion witnessed in bereaved people.

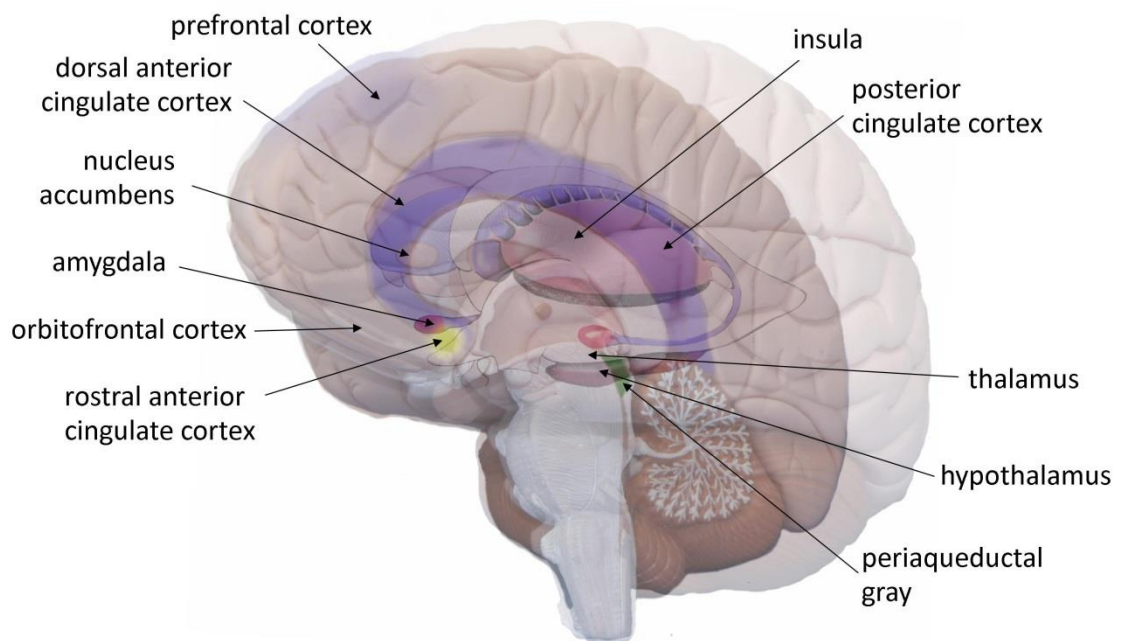


Figure 4.5 Schematic view of the whole brain, combining the previous three diagrams

Literature review 2: Conclusions

Bereavement typically causes a significant shock to mind and body. The brain's attempt to re-establish equilibrium is at the heart of the grieving process and it has been suggested that a counsellor's knowledge of the affective neurological processes involved can benefit the therapeutic dyad (Freed & Mann, 2007; O'Connor, 2005). The author concurs with this view. The neuroscience of grief is an emerging area of research that has the benefit of a range of fast developing technologies, notably functional magnetic resonance imaging (fMRI). However, the foundations of modern techniques rest on Panksepp's (Panksepp, 1998, 2005; Panksepp & Watt, 2011a, 2011b) canon of Affective Neuroscience. This posits that human emotion is experienced in the subcortical regions of the brain shared with our mammalian ancestors and that these regions deliver a neurological operating system essential to survival, which has evolved over millions of years of mammalian, even reptilian and avian natural history.

There are differences in both the methods and the conclusions when Panksepp's (1998) brain stimulation techniques are compared with the research using fMRI scans. These differences are notable in the field of attachment theory, where Panksepp concentrates on the primal emotional system of SEEKING and others on the concept of a reward system. However, both schools of thought implicate the nucleus accumbens in their respective theories. Indeed there is considerable agreement between researchers as to the brain regions apparently involved in grief reactions (figures 4.2 to 4.5).

Developments over the past two decades have taken us from an understanding of a limbic system primarily concerned with fear responses and reflexes, to a view of a subcortex which is a sophisticated seat of primary emotions (Gündel et al., 2003; O'Connor et al., 2008). The full complexity of this neural system is far from completely understood but experimental neuroscience is beginning to explain some of the behaviour associated with grief. Of particular importance is the weight that new findings are giving to attachment theory (Berridge & Kringelbach, 2008; Freed, 2009; Freed & Mann, 2007; O'Connor et al., 2008). However, it must be remembered that this branch of science is at an early stage; that correlation between emotion and observed neurological activity is not necessarily causation, nor does it do any more than suggest theoretical operations. In spite of all the caveats, a biological model of grief through neuroscience is being developed which confirms the centrality of attachment theory in understanding the nature of grief. It remains unclear as to whether grief per se is functionally adaptive. However, it begins to look as if the sadness and protest phases of loss may have evolved as a function of behavioural adaptiveness.

Neuroscientific evidence that supports meaning making theory is limited at the present time other than research which suggests where and how the brain assimilates information based on prior experience. Precise techniques to observe assimilation and accommodation by

neuroimaging do not yet exist, however, the use of fMRI to observe the resolution of conflicting schemas is being developed.

Literature review 3: Resilience

In Chapter 2 the idea was introduced that individuals with resilient qualities can resolve their grief without the need for grief work. This raises questions on the nature of human resilience and the means by which it is achieved.

Definitions

Resilience is a term used in psychology (Tugade & Fredrickson, 2004) which has been taken from physics; where it is defined as the property of a material such that when distorted, it is able to return elastically to its original position and form (Chambers, 2014). When applied to human experience, Cooper, Flint-Taylor and Pearn (2013, p. 1) define personal resilience as ‘being able to bounce back from setbacks and to stay effective in the face of tough demands and difficult circumstances.’ In another definition, ‘Psychological resilience refers to effective coping and adaptation although faced with loss, hardship, or adversity.’ (Tugade & Fredrickson, 2004, p. 320).

The neurobiology of resilience

In a review of the relevant neuroscience, Feder, Charney and Collins (2011) introduce the term *allostatic load*. They define this as “the physiological cost of adaptation to stressors” (ibid p. 2) as the body attempts to maintain homeostasis. This load: the price the body pays in its attempt to maintain equilibrium, “is inversely proportional to the degree of resilience” (ibid, p.2). In other words, more resilient individuals experience a smaller allostatic load. They suggest a number of sites in the brain which may be subjected to allostatic load and which will produce symptoms of acute stress. This includes the hypothalamic-pituitary-adrenal axis HPA which produces the stress hormone cortisol. They suggest that resilient individuals have the neurological capacity to quickly trigger the HPA system but are able to deactivate it rapidly when the threat has passed (ibid, p.3).

Personal resilience

Cooper and colleagues suggest that individuals vary in their resilience and that even the most resilient people “have their limits”. They take the position that rather than resilience being a fixed trait, it can be developed (ibid, p. 7), and have posited a model of personal resilience building clustered into four categories: 1) personal confidence and positive self-belief; 2) purposefulness; 3) social support network; and 4) adaptability (ibid, p. 41).

In the field of bereavement and loss, Bonanno and colleagues (2002) have identified a high proportion (46%) of bereaved individuals personally resilient in response to grief and a second group (11%) who become vulnerable after bereavement but who regain resilience over time. Citing Bonanno's conceptualisation of resilience in her own research, Bennett (2010) re-examined the qualitative data from two studies of English widowers. She identified 38% of the sample (n=60) as resilient, compared to Bonanno's 46%. Of this group, three men (13%) were resilient throughout their grief, nine (39%) gradually achieved resilience, eight (38%) achieved resilience following an identifiable event in their lives, and three (13%) experienced gradual change combined with a memorable moment. For this group of three it was a conscious decision to do something positive that cemented the change. Of those who changed following an identifiable moment, for one it was meeting a bereavement counsellor. Others joined clubs or started to engage in other cultural or social activities. This lends weight to observations of the efficacy of restoration activities in the dual process model (Stroebe & Schut, 1999). Machin (2013) has proposed that resilience is acquired through the oscillation between active grieving and avoidant activities. This author can cite many examples where clients' grief symptoms are alleviated by a deliberate shift from dwelling on the loss to engaging in social activities.

Bennett (op cit) noted that the nine widowers who gradually became resilient following their loss were helped by having skills which made life less difficult than otherwise it might, for example, domestic skills including the ability to cook for themselves. One could reasonably argue that possession of such skills lessens the impact of a changed assumptive world (Parkes, 1971). In other words, even if a man in this group is showing signs of resilience, there are fewer complications to his grief if he can feed himself. If resilience is defined both as the ability to adapt to change (Cooper et al., 2013, p. 15), *and* as the ability to "maintain a stable equilibrium" following a stressful event (Bonanno, 2004, p. 102), then a positive feedback loop becomes apparent. In adapting to change, resilient people become more resilient and thus more able to adapt to change.

Does meaning making promote resilience?

If, as the author suspects, the ability to make sense of a stressful situation is a prerequisite of adapting to it and resilience can be defined as adaptation to stressful events (Tugade & Fredrickson, 2004), then it would follow that meaning making and resilience go hand-in-hand. A literature search of Google Scholar; PubMed; PsycINFO; ProQuest; CINAHL; and MEDLINE, was conducted to explore the link. Although there is a long history of research into promoting resilience in children beset by troubled lives (Condly, 2006), these searches, using the terms 'fostering AND resilience AND adults' yielded results

for young people and families, but no useful information for adults. There is, however, a huge body of research into the part played by meaning making in adaptation to change. Park (2010) conducted an extensive and thorough review of this literature. The results highlight conflicting conclusions; not helped by the lack of definitive conceptualisations of the term ‘meaning making’. Park attempted to draw together the large body of research which suggests that an individual becomes distressed when the meanings he derives from a stressful situation challenges his broader, global understanding of the world. Stress decreases and equilibrium is restored as discrepancy between the situational and global meaning of the situation is reduced (p.257). Adherents to this interpretation of meaning making as adaptation include Bonanno and Kaltman (1999), Davis, Wortman, Lehman and Silver, (2000) Gillies and Neimeyer (2006) and Janoff-Bulman (1992). There is however no agreement that meaning making is essential for adaptation. Bonanno and Kaltman (1999) conclude that meaning making is not essential. Davis, Wortman, Lehman and Silver (2000) observe that not all people who adapt to loss do so through meaning making. Nolen-Hoeksema (2001; Nolen-Hoeksema et al., 1994) posits that if the search for meaning involves ruminative coping this will be maladaptive to grief. Margaret Stroebe and colleagues (Stroebe & Schut, 2000) distinguish between individuals who benefit from meaning making and those who may be harmed by it.

Although the author does not question these assertions, they require caution on three grounds. Firstly as Park (op cit) has pointed out, there is no agreement on the definition of meaning making. If, at interview, subjects are retrospectively asked if they made sense of their situation, they may answer in the negative because they are unaware of doing so. There are situations in which meaning making is recognised as an unconscious process (Greenberg, 1995). Secondly, attempts to make sense of a loss through ruminative coping, defined as “engaging in thoughts and behaviours that maintain one’s focus on one’s negative emotions and on the possible causes and consequences of those emotions” (Nolen-Hoeksema, 2001, p. 546) are recognised as unhelpful. Thirdly, if an individual’s endeavour to make sense of the loss repeatedly invoke negative meanings, then a case can be made for avoidance in confronting the loss, particularly if this person tends towards a ruminative coping style (Stroebe & Schut, 2000).

Troy and Mauss (2011) propose a cognitive framework for adapting to stressful life events. They suggest that an individual’s evaluation and appraisal of a stressful event rather than the event per se, affect the emotional response. The appraisal of the event can be moderated through ‘cognitive emotion regulation’ (Troy & Mauss, 2011, p. 31). There are two stages to this process. The first one is control over what is attended to; in particular selective attention away from the negative and towards positive aspects of an event. The second stage involves a reappraisal and the framing of the event towards a more positive interpretation. Troy and Mauss (ibid) conclude that the ability to apply cognitive emotional regulation to a

stressful event enhances resilience. The cognitive processes that this describes can be viewed in terms of meaning making, in which positive meanings are sought and negative meanings are reframed.

Figure 4.6 illustrates this process. If for example, the stressful event is bereavement, then although it may not be possible to view this in positive terms, it is possible to take time out, through concentrating on restorative activities rather than on the loss. Cognitive reappraisal is possible if the individual with the schema ‘I cannot cope with this loss’, assimilates and accommodates a new schema, ‘I cannot at present; however I can learn to do so’. Selective attention control and cognitive reappraisal overlap ‘because attention and appraisal appear to be critically linked’ (Troy & Mauss, 2011, p. 32). This is true of resilient bereaved clients. Belief that it is possible to adapt to loss is, in the author’s clinical experience, linked to the ability to take time out from grief with distracting restorative activities.

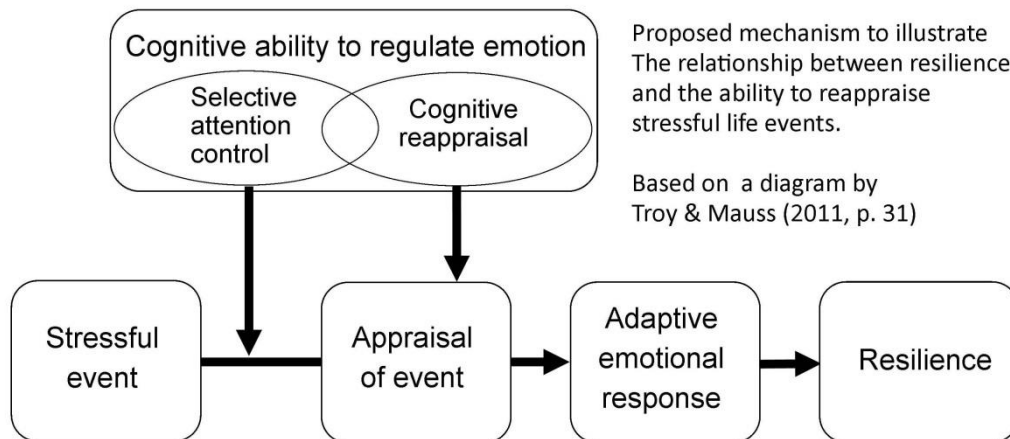


Figure 4.6 Resilience and reappraisal of stressful life events

Literature review 3: Conclusions

Even if it is accepted that one definition of resilience is the ability to adapt to change, a precise definition of meaning making is needed before an operational link can be established. Such a definition must take into account the context in which meaning making takes place. For example, a counsellor or psychotherapist aware of the pitfalls of rumination and sensitive to the idiosyncratic benefits of grief avoidance may effectively steer a client towards healthy adaptation to loss. Likewise the therapeutic space may well offer the opportunity for the bereaved client to become more proficient in the process of cognitive emotional regulation described above. In Chapter 5 both a definition and an operational context of meaning making are adumbrated.

Towards a theory of grief and grieving

The literature reviewed in Chapter 4 leads the author to a theory of grief which draws on attachment theory (Bowlby, 1975; Bowlby, 1969; Bowlby, 1980), on neurological research on grief (Gündel et al., 2003; O'Connor, 2013; O'Connor, Irwin, & Wellisch, 2009; O'Connor et al., 2008; O'Connor, Wellisch, Stanton, Olmstead, & Irwin, 2012), and on the stress of psychosocial changes which bereavement inflicts on a client's world (Janoff-Bulman, 1992; Parkes, 1971). The theory moves away from the classic psychoanalytical view of instinctive forces, with all its teleological implications and its inherent bias towards grief as illness (Deutsch, 1937; Engel, 1961; Freud, 1957/1917; Lindemann, 1944). Rather than adopt the pathology of complicated grief (Prigerson et al., 1996; Shear, Boelen, & Neimeyer, 2011a; Shear, Frank, Houck, & Reynolds, 2005; Shear et al., 2011b), the theory conceptualises grief as a healthy adaptation to bereavement which typically is complicated by a range of factors (Burke & Neimeyer, 2013). Each of these complicating factors can be viewed as a disruption to the life narrative of the client (Neimeyer, 2006b). The reader is invited to refer back to Table 3.1 on page 23 to follow the author's process in developing his theory of grief and grieving.

Based on the evidence outlined above, the author posits that the bereaved client addresses her personal narrative disruption by making sense of the various complicating factors with which she is faced. She relearns her world changed by loss (Attig, 1996, 2001). When the reconstruction of new meaning cannot be accommodated, the client either dissociates by avoiding the thoughts and feelings, or exists in a state of cognitive and affective disequilibrium until new meaning can be assimilated. Each client's reconstruction of meaning, involves making sense not just of situations, events and circumstances, but of the behavioural and affective disruptions imposed by bereavement and manifested in grief and in the process of grieving.

The theory in the context of bereavement counselling

In sum, the author's emerging theory at this point, sees human grief as a dual process: i) an unpleasant but necessary trade-off for the evolutionary advantages conferred by attachment behaviour; manifested in wanting, seeking and protest; and ii) a disruption of the personal narrative each of us constructs to maintain meaning in our lives. Effective grief counselling echoes this dual process. In support of the theory, the author suggests that the bereavement counsellor offers an empathic engagement with the client's disequilibrium of lost attachment, and purposefully facilitates the client's relearning and narrative reconstruction of a disrupted personal world.

If the author's theory has validity, the clients would be expected to show evidence of attachment behaviour and of disrupted personal narrative. Attachment, both to place and to the

deceased would be observed. This would be in the form of narrative accounts in which the client employs strategies in an attempt to keep the loved one close by, for example in displaying photographs, revisiting favourite places and leaving aspects of their home unchanged. At assessment and in the early stages of counselling the author would expect that the client would be in a state of disequilibrium, including evidence of disrupted attachment. The client would use similes, metaphors and imagery to describe his or her situation. Dissonant statements would be expected. The author's experience and reflective practice in bereavement counselling (see figure 4.1 on page 28) played a large part in developing the theory.

The validity of this theory would be strengthened if the counselling process revealed evidence of the rebuilding of a personal narrative. As evidence of the client adapting to loss, the author would expect the client to describe restorative strategies he/she is using in order to relearn their world. This will include evidence of constructing new meanings through the process of assimilation and accommodation. There would be evidence of the client's engagement as a learner within the counselling process. The client's active participation in the counselling dyad would be observed. When the client is encouraged to give feedback as to what is being helpful in the counselling process the author would expect a vocabulary of learning rather than of healing. For example a client would be more likely to say, "You have helped me to see that...." rather than, "You have made me better". This expectation is consistent with the written evaluations provided by former clients of Saint Catherine's Hospice Bereavement Support Service. It is the author's experience that those who present for counselling with a high degree of narrative disruption, for example, a wife bereaved of her spouse, generally choose to have more counselling than those whose life is not greatly changed by the circumstances of the loss. An example of the latter would be an adult son living independently of parents he does not see frequently, bereaved of his father or mother¹².

On pages 22-23, the author discussed what is known about the nature of complicated grief. It is his view (Wilson, 2014), based on reflective practice, that even when grief is prolonged, it need not be pathologised and labelled *complicated grief*. As an alternative view, it can be conceptualised as normal grief, but complicated by the intrinsic and extrinsic factors discussed by Burke and Neimeyer (2013, p. 149)¹³, and illustrated on page 23. Whichever position is taken, the author suggests that the greater the number of grief complications, the greater the more complex will be the grief reaction. Furthermore, the author would expect

¹² Grief for a parent is usually different to this where the son or daughter is part of an extended family leaving near to his/her parents.

¹³ Burke and Neimeyer (2013) suggest that the concept of normal grief with complicating factors is a valid alternative to complicated grief

there to be a relationship between the number of complicating factors and the extent of narrative disruption.

Meaning making: a working definition for this thesis

Meaning making was defined briefly on pages xxi and 5 as a dynamic process of construction and reconstruction. On page 16, Neimeyer's (2009a) exploration of this process is elaborated as having three faces: sense making, benefit finding, and identity reconstruction. On page 24 the author writes of how the centrality of meaning making permeates all aspects of grief. In the first literature review (pages 30 to 33), the author noted how Piaget's theory of assimilation and accommodation has been adopted by Janoff-Bulman (1992) and Neimeyer (2006b), to explain how meaning making occurs. At this point the author will pull these theoretical strands into a definition of meaning making in grief work, pertinent to the argument of this thesis. Meaning making is defined here as:

The human activity of constructing schemas which make sense of phenomena in the individual's internal and external environment. Schema construction occurs by the process of assimilation and accommodation.

In grief, the newly bereaved individual finds herself in a state of behavioural, cognitive and affective disequilibrium. Her external environment is changed by the loss. Familiar activities are disrupted and her sense of identity is changed. The distress of broken attachment threatens the stability of her internal world. Existing schemas which, before the bereavement, placed the client in a familiar environment, can no longer be accommodated. This places the client in a state of narrative disruption (see page 51). The assimilation of new schemas allow the client to adapt to the loss over a period of time. Each accommodated schema remains in place until it ceases to be helpful at which point a new schema is assimilated.

This thesis is predicated on the idea that moments in which schemas are assimilated can be observed through the spoken word. Furthermore, in counselling, meaning making as schema assimilation can be observed to follow a sequence in which at first the client dissociates from her feelings and avoids the need to change her internal and external view of reality. When this is followed by growing awareness that all is not well, it can motivate the client to clarify the nature of her difficulties and work towards a better understanding of her needs. A successful outcome can be described as one in which the client applies her newly assimilated understanding to workable solutions. At best this will give her the ability to make helpful generalisations should she find herself in a similar problematic situation of events. Such a sequence is described by the Assimilation of Problematic Experiences Scale, APES (Stiles, 2001) on page 72.

Chapter 5 Methodology

The philosophical position of grief research: Approaching a methodology

Choosing a methodology for observing each bereaved client's processes of assimilation and accommodation within the counselling dyad was testing. From the outset the author was clear that a case study methodology would be the best way forward in investigating human grief and its resolution. Observational research in the field of bereavement has a long history (see for example, Marris, 1958) and the author had experience of using observational methods in his first degree and MSc (see Chapter 3).

The dominant philosophies in qualitative social science research described in the literature suggested the author should adopt a post-modern, relativistic, social constructionist position. Juxtaposed with this was his past training and experience where a scientific, more positivistic approach had been adopted. This left the author doubting the appropriateness of his preferred philosophical position in a field dominated by critics of logical positivism (See for example Flyvbjerg, 2011; Lincoln, Lynham, & Guba, 2011). Although psychology is traditionally based on a positivistic approach this has moved to a post-modern, more relativistic approach in recent years (Forrester, 2010). The trend is reflected in counselling research. For example, in a special issue of *Counselling and Psychotherapy Research* devoted to evidence based counselling case studies, guest editors John McLeod and Robert Elliott (2011) cogently argue the case for case study research and present six articles: A narrative approach (Etherington & Bridges, 2011); a study of the formation of a difficult therapeutic alliance (Råbu, Halvorsen, & Haavand, 2011); a study of interpersonal change (Hill et al., 2011); a study of therapeutic alliance using impressionistic scales and questionnaires (Michel, Kramer, & De Roten, 2011); a hermeneutic single case efficacy design (Stephen, Elliott, & Macleod, 2011); and an analysis of a client's verbalised emotions during long-term psychotherapy (Gumz, Lucklum, Herrmann, Geyer, & Brähler, 2011). The author argues that each of these case studies owes more to post-positivism than to scientific realism and asks whether the tension between these extremes is a real or imagined phenomenon. The discovery of a study by Perry and Mace (2010) answers this question conclusively to his own satisfaction, and explains away the author's confusion.

Perry and Mace (2010) addressed the lack of acceptance of evolutionary approaches to human behaviour, in particular within disciplines usually allied to the social sciences. They attributed this to a number of historical reasons, including what they described as the "over-zealous application" of evolution in popular literature (p. 109), in particular *The Naked Ape* (Morris, 1967). Such books they said, wrongly infer a deterministic nature of evolution. A more serious neo-Darwinian approach to understanding social behaviour was founded in E.O.

Wilson's book, *Sociobiology: The New Synthesis* (1975). This seminal work was in many ways hijacked by political movements which originated in Wilson's own Harvard biology department. Left-leaning opponents saw the new discipline of sociobiology as being deterministic and politically motivated, linking it with eugenics, racism and Nazism, all movements which had justified their existence through a flawed interpretation of Darwinism¹⁴. Wilson strenuously denied any political motivation. Whatever the truth, he was perhaps politically naive ((Laland & Brown, 2011, p. 67). The debate became unhelpfully polarised, although as Perry and Mace (2010) point out, "[M]uch of the debate was an attack on a straw man rather than on the modern conception of evolution" (op cit, p. 111). A feature of postmodernism is the tendency of its adherents to treat scientific argument as just another social construct. As Perry and Mace note, scientists view this position as "intellectually dishonest" (ibid, p. 111).

Perceived limitations of a biological approach to human behaviour

As has been shown above, both Perry and Mace (2010) and Laland and Brown (2011) have alluded to the criticisms of an evolutionary approach made by those who reject what they see as its inherent biological determinism. Others have claimed that instinctive behaviour is over-ridden by the civilising sophistication of cultural influences. As a result, those scientists who do attempt to explain human behaviour from a biological perspective, have tended to approach the task by trying to separate the environmental factors of human evolution from the cultural and intellectual influences that undeniably distinguish humans from other animals. Some who attempt the task are evolutionary psychologists, who argue that 99% of human evolution was spent in a Pleistocene environment (Cosmides & Tooby, 1987, pp. 280-281). In an attempt to explain human behaviour from a biological standpoint, these researchers study people living as close to the Pleistocene epoch as is possible. Another attempt to separate civilising influences from the behaviour of the human animal is to distinguish between biological, psychological and cultural categories and view each category separately. Such an approach was taken by James Averill (1968). Averill separated grief, which he saw as biologically determined, from mourning, which he saw as cultural. A third way is to limit ethological studies to babies (Zeifman, 2001) and toddlers (Ainsworth, Blehar, Waters, & Wall, 1978), with the tacit hypothesis that the younger the child is, the less he or she will be influenced by cultural factors. Yet all these attempts to separate human behaviour from contextual culture and from psychology carry the inference that culture resides in the mind rather than the body; hence biological perspectives on culture are invalid. To take such a

¹⁴ Popular misunderstanding of Darwinian Theory had been reinforced by Herbert Spencer, most famous for the phrase 'survival of the fittest' (Spencer, 1864, p. 444), which is commonly misattributed to Darwin (Laland & Brown, 2011, p. 107).

stance simply introduces a novel form of Cartesian dualism. The flaws in this argument have been addressed by Henry Plotkin. (2007, p. 11). As he points out, '[T]he human capacity for culture is a product of evolution and as natural as having a bipedal gait or opposable thumb.' If this thesis is to convincingly address the critics of a biological approach to case study research, the scientific nature of the approach must be justified, and the limitations it imposes on each case study must be made clear.

The nature of a scientific approach

As has been mentioned above, Perry and Mace (2010) noted the influence of postmodernism on the social sciences in the 1970s, and questioned the postmodernist portrayal of science as 'simply another social construction of knowledge, with no consideration of the validity of its empirical arguments or the cognitive value of the scientific method' (p. 111). They argued that such a position is 'absurd to scientists' and 'intellectually dishonest' (ibid), a view with which the author concurs. What distinguishes science from other forms of knowledge is explored in Karl Popper's 1963 treatise *Conjectures and Refutations: The Growth of Scientific Knowledge*. Popper goes beyond the, 'observation/ hypothesis/ prediction/ experimentation' characterisation of the scientific method. Indeed, such a simplistic interpretation is vulnerable to attack by the postmodernists, since observations are susceptible to bias, something Popper acknowledged when he suggested that "all knowledge is human, that it is mixed up with our errors (and) prejudices" (Popper, 1963, p. 30). In accepting the fallibility of human knowledge he saw truth as existing "beyond human authority" (ibid, p.30); a different position than that of the Postmodernist implication that all truth is socially constructed. Science is the means by which humankind, however imperfectly, attempts to arrive at objectivity. A search for truth, according to Popper, becomes scientific when it engages with the protocols of falsifiability and refutation. Popper noted that it is easy to verify practically any theory if we note only the confirmations. Only confirmations which refute, rather than verify a theory, are scientific, and the strength of a scientific theory rests in its refutability; therefore, a good scientific theory should be falsifiable. Theories which are verified only by supportive confirmations remain unscientific (ibid, p. 36). In essence, falsifiability is dependent on how one poses the question.

A new methodology: Cautious Positivism

On page 7, the author noted the epistemological tension, in qualitative research in the social and psychological sciences, between positivism and social constructionism. Yet from the biological perspective of this thesis, even though the research is qualitative, a positivist perspective is arguable pertinent. Critics of a

biological, in particular an evolutionary approach, to human behaviour argue that this reduces humanity to a deterministic existence which fails to take into account the influence of environment, culture and intellectual discourse (Plotkin, 2007, Perry & Mace, 2010). As was reported on page 54, Perry & Mace (ibid) refute this argument, present a strong defence of logical positivism, and voice cogent criticism of those who view scientific realism as merely a form of social construct.

The author echoes this defence of logical positivism in recognising the observable realities of counselling research. These include replicable and generalisable observations and patterns. Examples include depressive symptoms, resilient characteristics, attachment styles and grief complications. There are also observable pathological conditions (Stroebe & Schut 2007b) and the neurological changes described on pages 34 to 47. In sum, these are considered to be the *positivist*, or realist aspects of the case studies in this thesis.

There is however, a caveat. Regardless of the realities of the phenomena described above, considerable caution is required. Relativist aspects must be taken into account as each client interprets their reality, including what she perceives to be important, what events, thoughts or feelings she chooses to focus on, what she reports to the counsellor, and the nature of felt sensations she experiences in the counselling relationship. Added to this is the counsellor/researcher's subjective experience of the client, including the focus and filtering of the client's material and the interpretation of this material from his own embodied experience. This *cautious* approach to realism tempered the author's positivist stance; hence *Cautious Positivism*.

In order to subject the concept of Cautious Positivism to peer review, the author, with others, published a paper entitled *Observing a client's grieving process: bringing logical positivism into qualitative grief counselling research* (Wilson et al., 2014). Here the authors note that Carl Rogers (1957) subscribed to rigorous scientific observations in his observations of the therapeutic process, and that this "traditional positivist scientific method" had been acknowledged by Goss and Mearns (1997, p.190). Wilson, Gabriel and James (ibid) write of other's exploration of the epistemological tension between positivism and postmodern relativism (Glaser & Strauss, 1967; Rennie & Fergus, 2006). They note that Glaser and Strauss (1967) acknowledged how, within a positivist methodology, there can be elements of relativism. Phenomena are seen as "external to the researcher and awaiting discovery" whilst at the same time acknowledging the influence of the researcher's own position and interests (Rennie and Fergus, 2006, p. 484). Rennie and Fergus (ibid) named this *methodical hermeneutics*. In their paper, Wilson, Gabriel and James (op cit) take a similar, though not

identical observational approach. They argue that the reality inherent in observational methods of grief counselling research is derived from the experience of the client. At the same time, the focus, subjectivity and bias of the observer inevitably add a relativist dimension. In comparison, *methodical hermeneutics* uses both realism and relativism creatively, accommodating to the dual approaches to extract and categorise the meaning of text. This is made possible by the ‘construing of categorizing as an embodied activity’ (Rennie & Fergus, 2006, p. 485). Both the embodied experience of the speaker’s reality, and the embodied experience of the categoriser are accommodated. Whilst Wilson, Gabriel and James (op cit) note similarities with the concrete reality of the embodied experience of grief, evidenced by the neurological changes in response to loss, they acknowledge the relativism entailed when the client speaks subjectively of her grief and the counsellor interprets from the position of his own embodied experience. The difference between *methodical hermeneutics*, and the approach taken by the author, as described in the paper discussed here, is that it employs iterative protocols (see Chapter 6, Section 2) as a means of reducing observer bias. This methodology recognises that the practitioner/ researcher observes each client’s grief through the lens of his own experience, but seeks to minimise the effect of this lens. In naming this methodology “*cautious or realistic positivism*” (Wilson et al., 2014, p. 547, original italics), this naturalistic approach to observing the process of grief within the counselling dyad has a number of advantages. It includes observations of non-verbal behaviour during the counselling sessions and it allows for clients to report events that happen between counselling sessions. Changing behaviour can be observed as a form of “grief barometer” (ibid, p. 574). Two caveats are noted. First, clients’ observations of events will be selective. However, events that have remained significant in the eyes of the client may have more salience than those that have been judged as insignificant. Secondly, the practitioner/researcher’s interventions are likely to influence the client’s response.

The authors conclude that counselling research is best served by a pluralist epistemology in which case study methodology can ‘have a foot in the positivist camp’ (p. 571). They acknowledge the intricacy of human behaviour but believe that patterns and generalisations will emerge when case studies are compared.

A biological approach to grief research: Historical precedents

There is a long tradition of naturalistic studies of human behaviour in the field of grief and its associated attachment theory. The seminal study of grief and mourning in 72 London widows, conducted by Peter Marris in 1958 was published under the heading of ‘anthropology and ethnography’ and was very much an observational study of human behaviour, from which twentieth century models of grief were developed. John Archer (1999, 2001) and Randolph

Nesse (2006, 2009) have both taken an evolutionary biologist's view of the grieving process, even though they reached different conclusions¹⁵. Bowlby's life work, represented by his attachment and loss trilogy (1969, 1975, 1980) owes much to the naturalistic approaches of his co-workers James Robertson (Bowlby & Robertson, 1953; Robertson & Bowlby, 1952), and Mary Ainsworth (Ainsworth et al., 1978). It was Bowlby's discovery of the work of scientist Niko Tinbergen, which Bowlby recalls in his interview with Milton Senn (1977), that was pivotal in developing an understanding of the biological mechanisms which underpin attachment theory. Tinbergen was one of the first to develop a modern science of ethology, the scientific study of animal behaviour, including human behaviour. In 1963, Tinbergen published a paper in which he published a framework for making sense of observed behaviour in terms of four questions. He asked:

1. What are the proximate causes of an observed behaviour? Simply put, he asked what triggers the behaviour and what switches it off again?
2. How does this behaviour help the animal to survive?
3. How does this behaviour develop and change over the life history of the animal?
4. What is the evolutionary mechanism which selects for this behaviour?

(Tinbergen, 1963)

In choosing an essentially naturalistic methodology to observe the grieving client's process of assimilation and accommodation, the author approaches this scientifically from an ethological position. As has been described above, this has a long pedigree. In recent times advances in neuroscience and physiology have lent support to those justifying a biological approach to human grief. This was explored in Chapter 4 and will be reiterated below. An ethological approach requires the author to frame Tinbergen's (1963) *Four Questions* in relation to the process of assimilation and accommodation. There is an important caveat dictated by the complexity of human behaviour, and Tinbergen's questions may have limited adequacy as a means of addressing this complexity. On the other hand, grief has origins in basic hominid behaviour. Chimpanzees have been shown to go through a short but intense grieving process (Alderton, 2011; Brown, 1879; van Lawick-Goodall, 1971) and presumably our ancestors in the genus *Homo* will have developed, through evolution and cultural transmission, grieving strategies that bring us to the current position. Certainly there are

¹⁵ Nesse concluded that grief, like pain, confers an evolutionary advantage, and listed possible advantages of the sadness behaviour that follows a loss, including signalling a need for help and securing kinship protection. On the other hand, Archer concluded that grief has no useful function; rather it is the price we may pay for the evolutionary advantages of attachment behaviour, of which grief reactions are an unfortunate bi-product.

examples of Homo neanderthalis; Neanderthal man, observing funeral rituals 100,000 years ago (Solecki, 1977).

Tinbergen's Four Questions (1963) applied to grief assimilation and accommodation¹⁶ behaviour:

Question 1. What are the proximate causes of assimilating (or seeking to assimilate) new experiences?

We seek to change our way of viewing the world when we come into awareness that our current view does not serve our best interests. Those who have developed the discipline of affective neuroscience have identified basic emotions shared by mammals and refined in primates (Panksepp, 1998). Affective distress is a manifestation of neurological, neurochemical and physiological changes. The process ceases when equilibrium is restored, when the client 'feels better' or 'feels able to cope' (Freed, 2009; O'Connor et al., 2008). It is suggested here that this is similar to the feedback mechanism that is at the root of attachment behaviour. At the time that Bowlby developed an attachment theory using ethological principles, he had no access to affective neuroscience at its current levels of sophistication. Nevertheless, nothing in the published literature on this subject contradicts the essential principles that Bowlby explained. Indeed current understanding only serves to support Bowlby's attachment theory. Emotional systems exist in the brain that served to mediate the child's attachment to the mother and the mother's attachment to the child. These systems also mediate kinship attachments and the mutual attachment of sexual partners. If grieving is viewed as an evolutionary adaptation, then it follows that there must be a psychological mechanism which drives such behaviour, both in 'switching on' the behaviour and 'switching it off' when needs have been met. Recent research on the neuroscience of reward behaviour has given rise to the concept of incentive salience (Berridge & Kringelbach, 2008; Berridge & Robinson, 2003), which was discussed in Chapter 4. The author posits that incentive salience is a proximal cause of assimilation.

Question 2. What is the survival value of assimilation in grieving clients?

In extreme situations, clients who after a significant time remain unable to satisfactorily assimilate the changes that result from bereavement may suffer varying degrees of functional impairment: including somatic illness; appetite loss; a depressed immune system; depression; and suicide (Stroebe, Schut, & Stroebe, 2007b). Being able to 'think differently',

¹⁶ For the sake of framing Tinbergen's four questions with clarity, accommodation is excluded. This is because the assimilation/accommodation dynamic involves assimilation as a response to a state of disequilibrium. This homeostatic imbalance is induced when existing schemas are no longer accommodated because they have ceased to be fit for purpose. Hence assimilation of new schemas is the active part of adapting to new situations.

that is, to view the loss in less distressing terms, is likely to reduce stress and anxiety and restore healthy functioning. The use of language in the assimilation of grief symptoms and behaviour is likely to be instrumental in this process. Observations of the language used by clients during bereavement counselling may help to answer this question.

Question 3. What is the developmental course, or ontogeny, of assimilation in the grieving process?

Jean Piaget (1950, 1952, 1954) described how the process of assimilation begins in childhood with concrete examples, and becomes more abstract over the course of development and maturation. It is widely recognised that children grieve differently from adults. Young children grieve differently from older children, and adult grief behaviour is usually exhibited by late teens (Di Ciacco, 2008). There are also likely to be differences in grief behaviour; both in relation to the needs of the griever and in relation to the person lost. Since needs change with age, this will contribute to the ontogeny of grief. Although this is a study of adults, the author's experience is that differential ontogeny of grief behaviour is observed in children. Part of this is reflected in the concrete to abstract thinking that develops in adolescence, but it is true of children that they are able to move in and out of sadness much easier than most adults are able to do.

Question 4: What is the evolutionary mechanism that favours those able to effectively assimilate change following loss?

Over the time span of Hominid evolution it seems likely that the genes of individuals and kinship groups able to assimilate and accommodate change would be selected over those unwilling and unable to adapt to new circumstances and changed environments. In terms of genetic transmission such resilient and adaptive traits could only be passed on by an individual up to the end of their reproductive capacity. Cultural transmission from kinship elders allows resilient and adaptive behaviour to be acquired through learning.

The scientific limitations of an assimilation/accommodation theory

By Popper's (1959, 1963) criterion of falsifiability, any number of incidences in which a client is observed using language to assimilate and accommodate aspects of a changed, post-loss world, cannot be construed as scientific. What is needed is a refutable theory. In positing that the progress of a client's recovery is dependent on his or her ability to assimilate and accommodate changed circumstances, this hypothesis is refutable and the author may justifiably claim a scientific approach to a case study methodology. By this logic, the author is seeking a relationship between observed instances of assimilation/accommodation, and diminution of grief reaction. Clients *not* observed assimilating and accommodating would be expected to become stuck in their grief. If there are few or no instances of assimilation and

accommodation recorded during the counselling, *and* the grief reaction diminishes, then the theory is unproven. However, because of the refutability of the original theory, the work stands as a scientific exploration.

Stiles (2003) discussed the scientific value of case study research. He defined scientific research as, '(the comparison of) ideas with observations' (p. 6). He compared the statistical hypothesis-testing research methodologies with case study research in arriving at a "good theory" which is "useful" theory (ibid, p. 7). In this thesis it is interpreted to mean 'useful' on two levels. If a case study changes ideas and ideas inform counselling practice, then changed ideas modify practice; hence usefulness is defined in utilitarian terms. At another level, a good theory is useful if it brings us closer to empirical truth. Stiles (2003) maintained that empirical truth changes with time through biological and cultural differences in human experience. He regarded theory as 'the principal product of science' and science as a form of quality control, as theories are judged by observations (p.7). Hence according to Stiles, case studies are a valid form of scientific observation. Single observations cannot be generalised with any degree of confidence. However, because a case study may contain many observations, where these are analysed and found to match a theory, they collectively contribute to a confidence in that theory.

The case study as a means of qualitative enquiry

Qualitative inquiry has long had a part to play in bereavement research (Flyvbjerg, 2011). Lindemann (1944/1994) used his interviews with traumatically bereaved people to elucidate his theory of pathological grief. The work of Marris (1958) with London widows has already been mentioned. Averill (1968) drew on anthropological studies to illustrate the universality of grief. The case study is one form of qualitative research which is, and has always been a hugely important method of scientific enquiry. In psycho-analysis, Breuer and Freud's 1893 case study of Anna O (Parkes, 1972, p 1-3) had an important part to play in Freud's early work. Bowlby (1969) used the case studies of his colleagues and collaborators as the basis of attachment theory.

Yet despite their value, many in the research community hold case studies in 'low regard' (Flyvbjerg, 2011, p. 302). Thus in constructing a hierarchy of research value in evidence-based palliative care, Gysels and Higginson (2007) valued observational studies well below experimental studies which utilise control groups (p. 121). Yin bemoans the fact that the case study 'has long been stereotyped as a weak sibling among social science methods' (Yin, 1994, p. xiii).

Flyvbjerg (2001) has explored the paradox of 'the case study's wide use and low regard' (ibid p. 302) and has concluded that common misunderstandings of the value of the case study, of the myth of inherent bias and on the generaliseability of case study findings are

at the heart of the problem. Once these are systematically addressed a more consensual methodological approach can be adopted and old antagonisms between the quantitative and qualitative communities can be abandoned (Flyvbjerg, 2011, p. 313).

If case studies are to be more widely accepted then academic rigour is paramount. Yin notes that case studies are frequently criticised for lack of rigor (Yin, 1994). He calls for construct validity, internal and external validity and reliability (ibid, pp. 32-38). McLeod (2010, pp. 32-34) also notes the criticisms frequently levelled against case studies; that they are used to illustrate the efficacy of therapeutic approaches, and are unlikely to be cited where an approach is ineffectual. McLeod calls for: 1) researcher reflexivity and transparency. This requires the researcher to be open, to themselves and to their audience, about prior professional experiences and expectations that may bias the study; 2) Bias may also be avoided by use of objective evidence which demonstrates what a client actually did or said; 3) A third way forward is to use data supplied by multiple researchers; and, 4) It is helpful if the evidence collected can be benchmarked against some form of established scale. These four criteria will be discussed in the next chapter.

The case study as a methodology for grief research: Strengths and limitations

Neimeyer and Hogan (2001) have called for a pluralism of research approaches to loss and grief and this is reflected both in the mixed method research of Neimeyer and his colleagues (Lichtenthal, Currier, Neimeyer, & Keesee, 2010) and in the case study methodology he and his team employ (Neimeyer, 2006b; Neimeyer, 2006a; Currier & Neimeyer, 2007). Neimeyer and Hogan (2001, p.110) have characterised the use of n=1 studies 'to illustrate theory or exemplify a method'. Neimeyer (2009a; 2011) also uses case study extracts in his teaching about meaning making following bereavement. None of this provides a convincing argument for the use of the case study as a primary research tool. Rather it reinforces the 'weak sibling' view described by Yin (1994) above.

A better argument for the case study is made by listening to 'Rhonda', the pseudonym given to a Kansas University student who was the primary subject of a four-year longitudinal study of grief. Balk and Vesta (1998) used qualitative methods to chart Rhonda's recovery from grief for the loss of her father, supporting it with extracts from her journal. Rhonda kept her journal independently from the quantitative study but volunteered its existence, enabling the researchers to compare her questionnaire responses with her journal entries. Rhonda also added written comments to her test responses. Balk and Vesta (ibid) reported that, when Rhonda completed the Impact of Event Scale (IES) (Horowitz, Wilner, & Alvarez, 1979), her intrusion and avoidance scores were at odds with the comments she wrote on the form. Rhonda could and did explain the reason for the low score which she felt did not reflect her actual state of mind overall. Further into the project Rhonda wrote at the bottom of the IES form, "Most of

these items are surface issues. I can portray how I feel, but inside I feel differently” (ibid, p. 31). Balk and Vesta (ibid) concluded that Rhonda’s open-ended comments were a more accurate reflection of her affect than were her scores.

What this demonstrates, in essence, is that quantitative researchers investigate a number of dissimilar cases and conclude with a generalisation, whereas a case study focuses on the uniqueness or dissimilarity of one case (Stake, 1995, p.40). Put another way, the former interprets data and the latter interprets events (ibid). Krishnasamy (2000) justified her case study on fatigue in hospice patients, their families and hospice staff because this approach allowed a focus on the particular, in this instance fatigue, as well as the general: the lived experience of patients and all those involved in their care. Krishnasamy (ibid) identified her unit of analysis as the experience of fatigue and defined a case as a patient, a family member or friend and one professional involved in the patient’s care.

Can the findings of a case study be used to make generalisations? Flyvbjerg (2006) challenged the myth that it is not possible to generalise from a single case study by pointing out that throughout the history of science, generalisations have been possible through well chosen and well executed experiments, particularly in the field of physics. If generalisations are possible in experiment, so he argues, are they in the case study. Although the knowledge gained from either a single experiment or case study may offer limited confidence in a scientific proposition, both have a part in the collective accumulation of knowledge and understanding in any scientific endeavour. Further, Flyvbjerg argues that the case study can be used to produce and test theory. In addition, by Popper’s (1957) criterion of falsifiability, it only takes one experiment or one case study to falsify a proposition.

Addressing the limitations of case study methodology

In outlining his biography as a researcher at the start of Chapter 3, the author alluded to his awareness of the inherent risk of potential bias in observational science. The danger is that we see what we expect to see and we miss the unexpected. As Parkes (1972) has pointed out, “Selecting what to see” is an important part of perception’ (p. 49). Day-to-day life is only possible because we are able to select from the barrage of sensory information constantly reaching us whilst ignoring the information we do not need. Each animal learns to select from the information barrage according to their survival needs (Wilson, 1972). Domesticated cats and dogs for example respond to the sound of a tin being opened; information that would be ignored by their wild counterparts. Human animals, and this includes scientists, are no different. The history of science shows countless examples of scientific evidence flawed by researchers seeing what they expected to see, even wanted to see (Collins, 1985; Ziman, 1978/1991). Each researcher’s personal history, the lens through which information is viewed, will contain this inherent potential for bias. Traditionally, qualitative researchers called for

objectivity in analysing data, a concept which Corbin and Strauss (2008) said was a myth. They suggested that in place of a fruitless search for objectivity the qualitative researcher strives for sensitivity (ibid, p. 32). They added that although experience can lead to data being misread, the sensitivity that comes from experience can also enhance the researcher's ability 'to notice the significance of some things more quickly' (ibid, p. 33).

McLeod (1994) refers to researcher credibility rather than objectivity (ibid, p 99). Stiles (1993) encourages the qualitative researcher to reveal rather than avoid taking into account his or her orientation and personal involvement in the research. He concludes that by evaluating data according to their impact on research participants, the emphasis is shifted from the objective truth of statements to 'understanding by people' (ibid, p.593). This stance is central to the reflexive research approach advocated by Etherington (2004). By being transparent about his personal and professional history, ideology, philosophy, and culture, and by encouraging reciprocation from other participants the author will adopt a reflexive research approach. The tripwires for qualitative researchers are ever present. If they are seen they can be avoided. The author identifies with the both the concepts of credibility and sensitivity in his work as counsellor/ researcher and relates this to the reflexive practice illustrated on his timeline of theory building over the duration of the project (see Figure 4.1, page 28).

The author as a reflexive researcher

The author's claim to be a reflexive researcher, whilst simultaneously adopting a methodology which is cautiously positivist (see pages 56-58), creates a tension to be resolved. The author defines reflexivity in this context as *self-critiquing research* which, in turn, inevitably recognises a degree of subjectivity (Marcus, 1998). It also involves the author *placing himself, in awareness, in the context of the research* (Finlay & Gough, 2003). In the author's case this is based both on his personal experience as a bereaved father, son and grandson, and on his professional background in observational research, as outlined in Chapter 3. The former informs the drive and motivation behind the choice of study, and the latter is the genesis of an observational methodology.

In this research, the author's reflexivity made use of introspection (Finlay, 2003) based both on his personal experience of bereavement, but also, and to a greater extent, on 16 years of professional experience as a bereavement counsellor. This wealth of experience equipped the author to make sense of the data. For example, by comparing the ten research case studies to those hundreds of clients worked with in the past, it was possible to predict, with reasonably accuracy, each client's grief trajectory¹⁷. The author's reflexivity addressed the subjective bias

¹⁷ This ability to build theory by predicting outcomes, based on similarities and differences in past case studies, has parallels with Yin's (2014) replication logic in multiple case study design (Yin, 2014).

inevitable in this research, but at the same time it embraced the author's credibility as a researcher through the utilisation of past experience.

The case study as a chosen methodology in this project

Grief is always complex (Attig, 2001) and grieving is an active process (Attig, 1991) invariably beset with complications (Attig, 1996). Attig's view of grieving as relearning, central to the thesis to be developed in this project, is encapsulated in his view that, 'each of us is a subjective centre of a unique unfolding experience of the world' (Attig, 1996, p.123). Case study as a methodology allows a focus on the particular: the client's process of grieving, as well as the general: the experience of bereavement support, in this study, defined as the client, the counsellor and the context of the service in which the client is seen. Yet this alone is not enough. For a case study methodology to be fit for purpose in this context, it must meet the requirements and address the caveats discussed in this chapter. First it must provide a data set capable of answering Tinbergen's four questions, secondly it must build in sufficient rigor to address the potential for bias in unconscious selective observation, and thirdly, it must be capable of falsifying the theory. The greater the number of case studies conducted, the greater the degree of confidence in an emerging theory (Stiles, 1993, 2007).

In spite of the intention to make naturalistic observations to ethological principles it would be naive to believe that interactions between counsellor and client are not heavily influenced by the counsellor's interventions. On the other hand, part of any therapeutic session includes the client describing aspects of their behaviour outside of the counselling dyad. It is also important to recognise that, for this study to be useful in developing good practice, it tests predictions of what therapeutic interventions are helpful and reaches practical and pragmatic conclusions.

The ethics of case study research

Existing research into the ethical dilemmas raised by case study research in counselling is limited in quality and quantity (McLeod, 2010, p. 60). What research does exist is centred around three issues: negotiating informed consent; the impact on the client in reading the case report; and the impact on the therapist in writing about the client. Allannah Furlong (2006) observed that some clients could be highly positive on reading the case study whilst others became negative, even hostile. She concluded that no universal ethical guidelines on obtaining informed consent would meet every eventuality, and suggested that therapist researchers consult a colleague to assess the impact of any unconscious processes involved in seeking consent and writing the results. William West (2002) also noted the limitations of an ethical framework for counselling research and, like Bond (2000, p. 243), suggested that the

way forward is ethical mindfulness (West, 2002, p. 267). One way of remaining ethically mindful is suggested by Pirkko Graves (1996, p. 78), who writes of the professional integrity needed in writing the case study, which she maintained by ‘keeping the patient as my audience’.

The author is ethically mindful of the dual relationships in this research. That the counsellor providing bereavement support is also the researcher, inevitably colours the nature of the counselling dyad positively or negatively. The client may feel obligated to continue with research participation even if he/she becomes uncomfortable with the arrangement. For the researcher there may be a temptation (or an unconscious motivation) to put research ends before the needs of the client; for example by holding on to clients way past the normal span of counselling. The researcher may feel obligated to the research clients, giving them more personal attention than clients who are not the subjects of investigation. Indeed, even though the practitioner may be mindful of this possibility and attempts to avoid unfair advantage, the additional note-taking and re-visiting of recordings and transcripts will unavoidably afford the research subjects more time in the mind of the practitioner/researcher than will be devoted to other clients. In order to address some of these caveats, the author made the decision not to listen to the recordings until the client’s counselling was complete. Other concerns from the dual relationship are addressed at the end of Chapter 6 on page 92.

The logic of theory building case studies

Whereas the purpose of a *clinical case study* is to acquire a deep understanding of the case through the application of theory or theories, in contrast, the purpose of a *theory building case study* is to apply the case to the construction of the theory (Stiles 2009).

Research is a comparison of ideas with observations in the process of which ideas are changed. Theories communicate ideas between theorist and audience. Truth emerges from the fit between theory and observed events. Writing of theory building in psychotherapy Stiles (2003) states:

“A good theory can help practitioners understand their clients and how to be effective in helping them” (ibid, p 7).

Theories built from counselling and psychotherapy case studies will be broader than the material found in each single case. The good theory helps the practitioner to understand the uniqueness of detail in each case. Conversely, the detail of each case highlights a growing point of the theory (Stiles, 2007).

The logical operations behind building theory with a case study

Whereas quantitative research, for example a randomised controlled trial, usually tests one hypothetical statement (Stiles 2007), there are limitations. In particular, much of the richness of individual subjects is likely to be lost in the data. In comparison, the theory building case study ‘compares many theoretically based statements with correspondingly many observations’ (Stiles, 2009b, p. 11). Whilst the confidence that the researcher can have, either in individual events or in theoretical statements derived from them, will be small, it is the accumulation of many observations and many statements that add confidence to the theory.

The three logical operations pertinent to theory building are deduction, induction, and abduction. (Stiles, 2009b). Together they can be used to address the limitations of the case study as a scientific method. Deduction ensures logical consistency, induction is concerned with the likely plausibility of results, and abduction allows a theory to be logically modified in the light of unexpected results. The logic behind each operation is described below.

Deduction

For deductive statements to have logical truth there must be a consistent interconnection between them. This is epitomised in the Aristotelean logic: All men are mortal. Socrates is a man. Therefore Socrates is mortal (Stiles 2009b). In addition, Stiles draws attention to a second important component of deductive logic: the necessity of what he calls ‘consistent sign meanings’ (ibid, p 13). In Aristotle’s example for the statement to always be true the word ‘mortal’ must retain a consistent meaning. Though in popular culture we may regularly refer to individuals who have attained immortality, this use of language in no way detracts from the logical truth of Aristotle's original statement. However, such an example demonstrates that in this research methodology it is important to pay particular attention to this aspect of logical consistency.

Induction – Affirming the consequent

In a theory building case study the researcher makes observations which may go some way to confirming the theory. Proof can never be claimed since any theory concerns events that have not yet happened (Stiles 2009b). For example the fact that deciduous trees in a temperate climate are observed to shed their leaves in autumn does not prove that all deciduous trees will always shed their leaves in autumn.

In deductive logic, if all A have quality B and C is an A, then C has quality B

In inductive logic, if C is both A and B then all A are B. Hence Socrates died, which by inductive logic proves that all men are mortal. This is, in deductive terms, a logical fallacy. However, the fact that all men throughout history have eventually died lends weight to a

theory of inevitable mortality. Thus inductive logic is concerned with probability and plausibility rather than proof. Scientific progress is made through observation and weight of numbers (ibid).

Abduction

Although scientific theories can never be proven it was Karl Popper (1959) who said that the mark of a scientific theory is that it can be falsified. When an observation does not fit the theory, and this remains the case with repeated observation, then the theory may have to be abandoned. Alternatively the theory may be modified. Using abduction, the response to an unexpected observation, is to propose a tenet such that if this tenet is true then the observation would be expected (Stiles, 2009b). Thus if an oak tree was observed to still have all its leaves in December that tenet might be that a sharp frost is necessary for the leaves to fall. If there had been no sharp frost preceding the observation then the tenet has plausibility and the theory can be modified. Increased confidence in the modified theory comes from repeated observations in the same circumstances.

‘Abduction thus starts with a meaningful account and modifies it. The modifications may include corrections of previous errors, elaborations of previously unappreciated aspects, or extensions to domains not previously encompassed’ (ibid, p 19).

Stiles (2007, 2009b) sees this process is one of permeation. Observations ‘permeate the theory’ (2007, p123). The metaphor Stiles employs is one of observations as particles diffusing through ‘theoretical interstices’ as opposed to a metaphor in which scientific ideas are accumulated as in the building of a brick wall. Thus, “understanding grows not by stacking fact upon fact but by diffusing observations that expand the theory” (2007 p 123).

Why APES?

On page 8 the author introduced the Assimilation of Problematic Experiences Scale (APES), as a means of monitoring a client’s process of psychological change. Table 5.1 on page 72 illustrates the model. The decision to incorporate APES into the methodology was easy to make. It was clear that Stiles shared the author’s position that therapeutic change come from the assimilation of new schemas. From the point of view of the organisation hosting the research, using APES to observe psychological change is not intrude on the counselling sessions as a clinical measure would do. Rather than assess therapeutic change through questionnaires, APES uses transcripts of the counselling sessions to detect instances in which the client assimilates a problematic experience (Stiles, 2006; Brinegar, Salvi, & Stiles, 2008; Honos-Webb, Surko, Stiles, & Greenberg, 1999; Stiles, 2001; Stiles & Brinegar, 2007; Stiles, 1999). The therapist identifies each problematic experience, assesses the degree to which the problem has been

assimilated by the client, and uses this as the starting point to help the client move to the next level. Thus a fearful client is enabled to move from a situation where a problematic experience is warded off to a point where the experience is recognised and understood (Stiles, 2001). Further levels in successful therapy enable the client to work with the experience and eventually integrate it into healthy functioning.

This assimilation model has been used in qualitative research, although not generally with bereavement counselling; although the model has been used to track psychological change in the therapy of a refugee who had fled political persecution and whose torture whilst pregnant was followed by the death of the child she gave birth to (Varvin & Stiles, 1999). Henry (2006) interviewed seven immigrants to assess their continuing bond with their native culture and used APES to link this to the Continuing Bond model of bereavement (Klass et al., 1996). In another study, Henry et al (2005) used three broadcast interviews from the Al-Jazeera network to assess Arab immigrants' continuing bond with their native culture. Most published research using APES has involved a case study approach using transcribed recordings of therapy sessions (Honos-Webb et al., 1999; Brinegar et al., 2008; Varvin & Stiles, 1999).

APES has been used widely, as an assimilation model of psychological change, in other areas of counselling and psychotherapy. Shepherd (2015) used this assimilation model to devise a questionnaire to assess therapeutic change in adults with a learning disability. Newman and Beail (2002) have also applied the scale to monitor change in clients with an intellectual disability. Osatuke and Stiles (2010) have used the model to chart change in clients with post traumatic stress disorder. The scale has been used with clients following a diagnosis of dementia (see for example, Lishman, Cheston, & Smithson, 2016; Watkins, Cheston, Jones, & Gilliard, 2006). Osatuke and colleagues (2007) noted that in depressed clients, this model of assimilation was a useful framework for observing submissive voices which dominated the client's narrative.

The individual as a community of voices

The APES sequence is predicated on a metaphor of the individual as a community of voices (Brinegar, Salvi, & Stiles, 2008; Honos-Webb, Surko, Stiles, & Greenberg, 1999; Osatuke et al., 2005; Stiles, 1999). Each voice has its genesis in past experience (Osatuke et al., 2005). These voices allow the individual to conduct an internal dialogue with the self. This dialogue may foster change and adaptation or it may 'represent fragmentation or dissociation' (Stiles, 1999, p. 3). Many schools of psychology and counselling recognise the concept of the multivoiced individual (Honos-Webb, Surko, Stiles, & Greenberg, 1999). For example, many counsellors, including the author, make use of the phenomenon in encouraging clients to talk to different aspects of themselves, a technique originating in Gestalt therapy (Paivio &

Greenberg, 1995). Counsellors are aware of these voices in their clients, and the cross case comparisons in Chapter 7 illustrate examples. The APES sequence makes use of the active, dynamic aspect of the community of voices as the client moves from dissociation from the problematic voices, through to allowing them to speak, and in time, bringing the voices together in the construction of a 'meaning bridge' (Stiles 2001. P. 463).

Summary

Chapter 4 concluded with the construction of a theory of grief, which recognises both the distress of broken attachment and the disruption of a client's life narrative. Chapter 5 began with the author seeking a methodology appropriate to counselling research but which recognised the contribution that could be made by observational biology. Historical tensions between a positivist and a relativist approach to counselling research were reviewed. The author, with others (Wilson et al., 2014), devised a philosophical approach which addressed this tension, and this was incorporated into the methodology. Precedents for observational studies on bereaved people were discussed. The author outlined an ethological approach which frames the theory within Tinbergen's (1963) Four Questions. The limitations imposed by Popper's (1954) criterion of falsifiability were addressed. The strengths and limitations of the case study as a research tool were discussed; and the literature of case studies in grief was reviewed. Both the limitations and the ethics of grief case studies were addressed. The author concluded that a rigorous way of addressing these limitations was to adopt a theory building methodology (McLeod, 2010; Stiles, 2007).

Stage		
0	Warded off, dissociated	Client has no awareness of having a problem. Problematic voices do not emerge. Client will quickly avoid problematic issues raised by the therapist, though not in awareness. Clients will seldom self-refer for counselling at this stage. Anxiety increases as client moves towards stage 1.
1	Unwanted thoughts	Problematic voices begin to emerge but often only in response to the therapist's interventions. Client will still avoid problematic issues and troublesome voices; though with more intention and deliberation than at stage 0. Clients feel that something is wrong but cannot clearly articulate their difficulties.
2	Vague awareness	Client recognizes that something is wrong and begins to articulate the problem. Voices, often confused and frequently in opposition to each other, emerge more strongly than at stage 1 and give rise to powerful, negative and distressing feelings. Clients will often self-refer for counselling at this stage.
3	Problem Statement/ clarification	Opposing voices begin to work together to formulate the nature of the problem. Confusing and distressing emotions begin to be manageable. Client can begin to focus on the nature of the problem and on the tasks ahead.
4	Understanding/ insight	The problem is constructed into a schema which can be understood and articulated. Voices come together to form a "meaning bridge" (Stiles 2001, p. 463). Emotions can still be distressing but there can also be times of excitement and discovery.
5	Application/ working through	Problems are now articulated clearly enough to be worked on. Client will begin to make choices and formulate courses of action, some of which will result in therapeutically helpful outcomes. This is very much a stage of trying out ideas and ways of being.
6	Problem solution	Client arrives at a successful solution to an identified problem. Voices which bring about the solution are used to generalize solutions to other problems. Negative emotions recede. Affect becomes positive
7	Mastery	The process of generalizing to produce solutions to new situations becomes automatic rather than a conscious effort. There may be a positive affect if past problems are mentioned, but generally, affect is neutral since emotions are no longer heightened by past events.

**Table 5.1 The Assimilation of Problematic Experiences Scale (APES)
(c.f. Varvin and Stiles 1999 p 384)**

Chapter 6: Method

This chapter is divided into two sections. Section 1 outlines a method that was conceived at the planning stage of the thesis. It includes the organisational context of the research, theory building case study design, and the intention to invite each client to participate in exploring the outcomes of his or her case study. However, it transpired that for a number of reasons, client participation was only possible in one instance. As a result, new methods needed to be employed in order to triangulate the findings. This involved the use of iterative protocols which enhanced the reliability of the data. These methodological revisions and outcomes form section 2 of this chapter. Cross case comparisons in Chapter 7 begin with a detailed overview of each client.

Clients recruited for the study

The first five clients in the table below are listed in the order in which the author first began working with them. They each became the author's clients. The second group of five are listed in the order that they were assessed by the author. Neither Ted nor Fiona had any further counselling. Caitlin, Sue and Maureen went on to work with other counsellors (see page 128). Figure 6.1 on page 75 presents a timeline of data collection.

Pseudonym	Bereaved of:	Cause of death	Time since loss	No. of sessions	Duration of counselling
Tony	brother	road traffic crash	34 years	39	21 months
Sam	son	organ failure	16 months	10	4 months
Amanda	grandfather	pneumonia	7 months	9	6 months
Jacqui	father	alcohol-related	2 years	3	4 weeks
Sophie	husband	cancer	16 weeks	44	21 months
Ted	son	suicide	3 months	assessment only*	
Fiona	husband	cancer	14 months	assessment only*	
Caitlin	mother	dementia	5 months	5**	9 weeks
Sue	husband	cancer	5 months	1**	1 week
Maureen	daughter	stillbirth	16 years	6**	6 weeks

*assessments carried out by the author. **assessments by the author but further sessions with other practitioners.

Table 6.1 Summary of the ten case studies

Section 1: Planning the research method

The organisational context of the research: Saint Catherine's Hospice

Bereavement Support Service

Saint Catherine's Hospice Bereavement Support Service (SCHBSS) is community based and serves the needs of a population of 240,000. An Adult Service and a Children and Young People's Service come under the umbrella of SCHBSS. The Adult Service consists of a British Association for Counselling and Psychotherapy (BACP) Accredited Manager and two BACP Accredited counsellors. SCHBSS has a team of 30 volunteer practitioners who are trained in-house (initial and on-going training). The service also takes Counselling Diploma students on placement, with a 15 hour induction course in bereavement theory. Footnote 4 on page 8 explains the decision to be transparent about the identity of the research setting.

One half of SCHBSS volunteer practitioners are qualified counsellors. Until 2009 volunteers received an initial training of 50 contact hours in bereavement theory and counselling skills with a requirement of a minimum 20 hours per year ongoing professional development. From 2009 new volunteers were required to complete a minimum of 200 study-hours, delivered as an assessed module in bereavement theory and counselling skills. This module, originally validated by York St John University, is taught by SCHBSS staff. On completion of this module, volunteer supporters are inducted into the service and are required to maintain at least 20 hours of continuous professional development. In-house training opportunities are provided by SCHBSS on a monthly basis throughout the year, with the exception of August and December.

The social setting of the project

Grief is manifested in a social context. Isolation, age, unemployment and poverty can all have a role to play and must be considered in data collection. The SCHBSS catchment area of Whitby, Scarborough and Ryedale is both urban and rural, with significant areas of urban deprivation as well as a significantly affluent population. Geographical and social isolation is a factor, especially for many of the older bereaved population. According to the Ryedale 2011 census there were 29% of single households, of whom 16% were pensioners living alone. The percentage of people aged 60 and over was 31.6%. In 2011 almost 99% of the Ryedale population was white, and 72% of people described themselves as Christian. People of all other religions totalled less than 1% (Ryedale, 2011).

Client referral and assessment protocols

The majority of clients (65%) come to SCHBSS via their General Practitioner. Experience has taught the counselling team to be clear with clients that they present for

counselling with ownership of their grief rather than in acquiescence to their doctor's diagnosis. Many of the clients seen have for a variety of reasons, relocated from other parts of the country including the large conurbations in West Yorkshire. In these instances, loss of roots and geographical isolation from extended family support may exacerbate the grief

All clients referred to the adult service are initially assessed by one of a team of five counsellors, three of whom are volunteers. Clients are assessed using in-house written guidelines which have evolved and which continue to change in response to need (Appendix 1). The information collected attempts to ensure that each client receives the appropriate level of support. Risk assessment and any other action needed, is determined from this information. Neither grief inventories nor other standardised measures for social and psychological health were routinely used by SCHBSS during the period of data collection for this thesis.

Approach: Original intentions of the project

The proposed sample group was adults aged 18 or over, bereaved of a close friend or family member either self-referred or referred by a General Practitioner to SCHBSS. Three years of the project had been allocated for data collection and this proved to be realistic. Recruitment to the project was more difficult than had been anticipated although of those clients who did give informed consent, no person dropped out of the project, and all remained positively engaged throughout the support they received from SCHBSS. Ten clients were recruited. Five of these received between 4 or more sessions of counselling from the author. All five of the rest were assessed by the author. Two found the assessment session adequate to meet their needs and three went on to be supported by other practitioners. Figure 6.1 illustrates the timeline for data collection from 2012 to 2015.

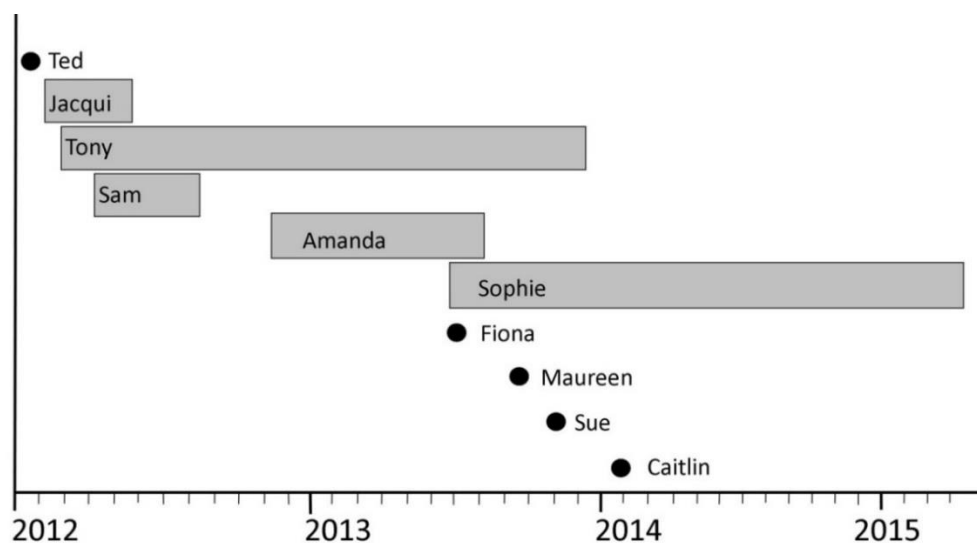


Figure 6.1 Timeline of data collection. The black dots represent single sessions
 Note: pseudonyms have been used to preserve anonymity

As described in the previous chapter, a theory building case study approach (Stiles, 2007) was used to chart the grief journeys of clients who agreed to participate in the project. Clients chosen for the study were, in common with all clients referred to the service, assessed as to the appropriateness of bereavement support before counselling began in order to establish a base line, and the assessment session was included in the data collection. Each counselling session was audio-recorded, transcribed verbatim and analysed to chart changes in the grieving process. In the final session of counselling, each client was invited to say what part counselling has played in effecting any changes.

Exclusions from the study

There were exclusions from the study; specifically clients referred by a mental health professional, those under the care of a mental health service, and any client with a diagnosed condition; including dementia; obsessive compulsive disorder; chronic depression; bipolar disorder; post-traumatic stress disorder; and borderline personality disorder. Also specifically excluded were clients with a learning disability. There were several reasons for these exclusions. Experience has taught the staff of SCHBSS that clients in these categories frequently have a range of psychological needs in addition to the bereavement. In many instances, in the mind of the client, these needs take priority over the bereavement work. There would also be significant ethical difficulties in working with these groups. Clients with certain diagnosed disorders and clients with learning disabilities may be unable to give adequate informed consent. It is also arguable that clients in this group may be at an increased risk of being adversely affected by such research tools as recording devices: for example paranoid clients who may have an anxiety about record keeping and may worry about how audio recordings may be used. Gelso (1972, 1973) has researched the inhibitory effects of recording devices on clients with certain specific difficulties. In some states of psychosis, clients would be unable to give informed consent to participate.

Involvement of participants

Bereaved clients who were part of the sample group were all assessed by the author and five went on to receive client-centred bereavement counselling from the author in exactly the same way as other clients in his caseload who were not part of the study. All that was different from the clients' point of view was that with the client's knowledge and consent, each session, including the initial assessment session was digitally recorded in its entirety.

Obtaining informed consent

Bereaved people who self-refer or are referred to Saint Catherine's Hospice Bereavement Support Service are sent a letter from the Service Coordinator which asks them to telephone her to make an appointment for an initial assessment. Clients who responded (and who were not, from the referral information available, seen to be in the exclusion categories above) were advised by the Service Coordinator that a research project was taking place and they were asked if they were willing to take part. Those who expressed an interest were sent a leaflet (Appendix 2) explaining the project, including details of how to contact the researcher if they had further questions. An informed consent form (Appendix 4) was sent with the leaflet. Those clients were allocated to the author for an initial assessment. At the beginning of the assessment clients were asked if they were still willing to give their consent and were asked to complete the consent form if they had not already done so. Only after this was completed was digital recording begun. Clients were made aware that they could change their minds about recording at any time.

Potential risks to research subjects

It is impossible to design ethically neutral research (McLeod, 1994, p. 166). The author carefully monitored the sessions for any signs that the recording had on the participants; both during the recording and when the sessions were played back for transcription. From the client's perspective, the counselling sessions appeared to be little different than would be experienced by any client, except for the presence of a recording device and the knowledge that what is said is being recorded. Whilst it would have been naive not to anticipate that recording might have affected what was said, at least until participants got used to the recording, no difficulties arose. The digital recorder was small and operated without any noise, and because of this was inconspicuous. Although it was made clear to clients that at any time recording could stop, there was no situation in which a client invoked this right. It was made clear to all clients who went on to work with the author that they would be given access to their transcripts and the case studies written from the transcripts. As is reported in Section 2 of this chapter, only one client wanted to see her case study. Two clients perceived a risk of becoming distressed if they revisited the material by reading the case study.

Effect of the practitioner-researcher relationship

In the previous chapter the ethics of the dual practitioner/researcher relationship, were explored. In order to minimise any effect on the counselling outcomes, a decision was made to not listen back to any of the recordings until after each research subject had completed their counselling. This is because the author identified a perceived risk that listening to the

counselling sessions could unconsciously influence the direction of the counselling; by making interventions based on the content of previous sessions. The author noted with interest just how much content of the counselling sessions was missed until the recordings were played back and transcribed. It was observed that some opportunities for therapeutic interventions were missed and that some interventions were clumsy or inappropriate in hindsight. This would suggest that the decision to file the recordings until after counselling ended was the right one: there would have been a very real risk on the part of the counsellor, of consciously or unconsciously revisiting previous sessions. In spite of these precautions, the risk remained that the researcher/practitioner worked harder with these clients during the sessions than with those clients not part of the research, and also more likely to think about them between sessions. If an unconscious bias of this nature existed, then by definition it could not be detected. The author was aware of his gratitude that these clients had volunteered to be part of the project and very possibly each research client felt 'special' from the close interest being taken in their welfare.

Another consideration discussed in the previous chapter was a likelihood that the practitioner researcher would be tempted to extend the duration of the counselling relationship. The author feels confident in saying no client was encouraged to stay in counselling for longer than they wanted to be there. All endings were mutually agreed.

Clinical supervision played an important part in the research. Good supervision can bring unconscious processes into awareness. The author's counselling supervisor, who has published qualitative research, was kept informed about the nature of the dual practitioner/researcher relationships as part of clinical supervision.

Risks associated with completion and publication

A slight theoretical risk was identified that in the final counselling session, the process of reviewing and recalling the counselling experience may have reawakened thoughts and feelings that supposedly had been resolved. Although the contingency plans discussed below were in place, they were not needed.

In spite of the best efforts of researcher and research subject to be clear about disguising identity in publication, there remains the possibility that a friend or neighbour may identify the client through the details of the case study. This may raise difficulties for the client and others affected by the bereavement: for example if information about the family not previously known outside of a small group of confidants gets into a wider domain. Research subjects were also invited to read what has been written about them, agree that this was an accurate record and asked for consent to publish. Again this carried a risk that, like the review in the final counselling session, it might bring supposedly resolved issues to the surface. It was

also possible that the client could introduce new material at this point. The outcomes of this procedure are discussed in Section 2 of this chapter.

Contingency planning for the protection of client wellbeing

In case a client felt that, despite best efforts, he or she had been adversely affected by participation in the project; contingency plans for the client's emotional wellbeing were in place. A new assessment of the subject's needs would have been carried out by another counsellor within SCHBSS and it was recognised that it would be ethical to minimise any delay to this process. For this reason, a member of staff not involved in the research project had "emergency" assessment spaces put aside in the departmental diary should such a need have arisen. In the event, contingency plans were not needed.

Maintaining the anonymity and confidentiality of clients

i) Security of original sound files

Counselling sessions were recorded on an Olympus WS-311M digital recorder. Each sound file was named automatically with a sequential number by the filing system on the digital device. Some sessions took place within the Hospice and some in the community: usually in surgeries and health centres. Where recordings were made in the field they were transferred to a password-protected laptop for transport back to the Hospice. Audio files were renamed with a client code number and session date, negating any need to append client names to the sound files. All SCHBSS clients have a departmental code, meaning that the client's name and other identifying details never needed to be recorded outside of the Hospice secure system. This anonymous code; unique for each client was used in the research record, and each client was given a pseudonym.

ii) Backup copies and transcriptions

Copies of the entire recording file catalogue were copied onto CD ROM, discs which were filed as backup copies in a locked cabinet within the SCHBSS department. Whenever the raw data sound files needed to be used on computers in order to be transcribed, sound files were transported; either on a password protected laptop computer or a password protected memory stick.

Written transcripts had the name of the client and the names of others talked about, changed to pseudonyms at the point of transcription. Completed transcripts were stored securely at the Hospice as hard copies, electronically on Saint Catherine's Hospice server, on the hard drive of the author's password protected laptop or on a password protected memory stick. When hard copies of completed transcripts were transported outside of the Hospice they

were kept in a locked briefcase. Electronic copies in the process of being edited were kept either on a password protected memory stick or password protected laptop computer.

iii) Contingency planning in the event of the death of the researcher/practitioner

With the cooperation of SCHBSS, plans were put in place to safeguard the raw data collected in the form of digital recordings. The secure passwords used to protect the raw data on the author's laptop and on encrypted memory sticks, were known only to the author. Only two filing cabinet keys existed to access the backup of raw data kept on compact discs. One was in the hands of the author and stored under lock and key at SCHBSS, and the other was in the possession of the SCHBSS manager. Stored alongside the discs was a sealed envelope containing the passwords needed to access stored data on the author's laptop and memory sticks.

Replaying of sound file excerpts to others

The research methods adopted by this project involved the use of iterative protocols to improve the validity and reliability of the results. This involved the playing of anonymous sections of the original sound recordings to counselling colleagues at SCHBSS who had expressed an interest in the research project. Their role in the project was to provide a conceptual consensus in the interpretation of data (Schielke, Fishman, Osatuke, & Stiles, 2009). Sections that were replayed to others were edited by the researcher using Wavepad Sound Editor (NCH Software) so that any identifying names used either by the counsellor or the client could be 'beeped out'. The same software was also used to disguise the voice of the client before recordings were played back.

Analysis of transcripts

Transcripts were analysed using The Assimilation of Problematic Experiences Sequence (Stiles, 2001) as discussed in Chapter 5. The use of APES (Table 5.1) was consistent with the lightness of touch on the client (Wilson, 2011) that this project strove to maintain.

Triangulation of case studies

The original intention was for each client to participate in the research. They were to be invited to read the completed case study and be instrumental in modifying the draft including discussion of the APES scores with the researcher. Figure 6.2 opposite illustrates this.

Organisational approval

Ethical approval for the project was granted from the hosting Hospice Research Committee and from York St John Research Ethics Sub Committee. The Research proposal appears as Appendix 3, page 241.

Communications with colleagues and line managers

A project such as this, over a period of six years, involved winning and retaining the trust of all the staff and volunteers in the bereavement support service. The key to this was open and honest communication. A research forum was established for those staff and volunteers interested in the development of evidenced based practice in the department. Monthly training meetings afforded an opportunity to provide updates on the developing project, and staff meetings for the service's core team were the forum for any anticipated issues arising from the research which could have affected the day to day running of the department. Regular updates on the research were circulated via an email network which included those independent practitioners who provide clinical supervision for the service.

It was considered important both by the author and other members of the bereavement support service that the research be implemented alongside the bereavement service's normal daily practice. This required careful preparation and good communication throughout the organisation in order to obtain full cooperation from staff and volunteers. The establishment of the research forum for staff and volunteers was the key to identifying those who were willing to assist in data analysis. This was in addition to regular opportunities designed to keep all practitioners up to date with wider developments in bereavement research and practice.

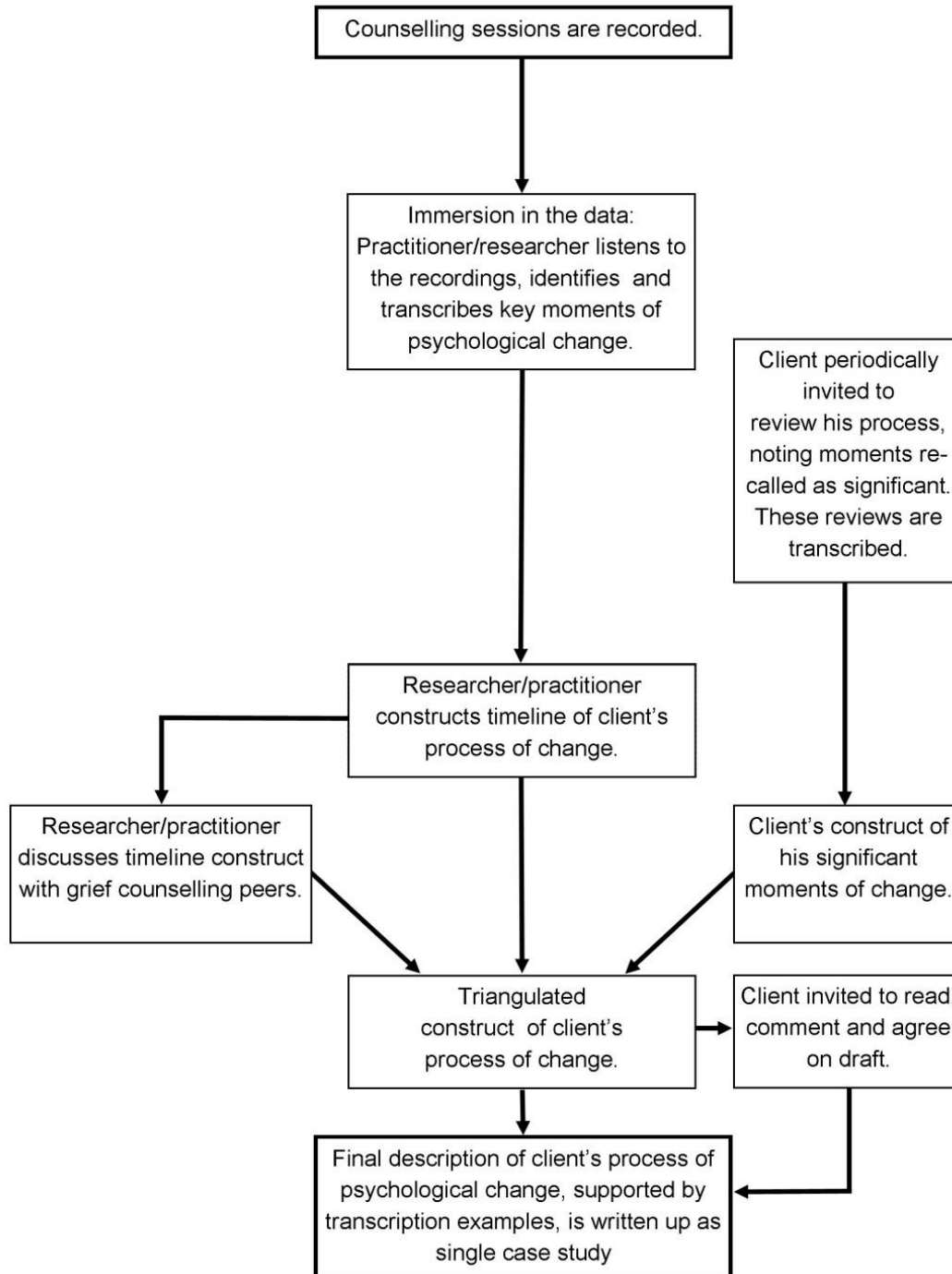


Figure 6.2 Triangulation method involving client participation

Transcription notation

Case studies were transcribed for assimilation analysis (Honos-Webb et al., 2006; Honos-Webb et al., 1999; Varvin & Stiles, 1999). This differs from conversational analysis (Gordon, Ellis-Hill, & Ashburn, 2009; Jefferson, 1978). The following transcription notation was used. The number in square brackets indicates the time into the session, [hour:minutes:seconds]. Descriptions of behaviour appear in brackets (). Brief pauses are

marked (pause) and longer pauses with the number of seconds. Interruptions to the speech of the other interlocutor are marked ‘.’ at the point of interruption and again at the beginning if the sentence is continued. An emphasis spoken by client or counsellor is written in italics. Most of the counsellor’s verbal encouragements: ‘hmm’, ‘mm’ etc. have been omitted for clarity. Words and brief phrases used by the client are written in double inverted commas within the text. All names and family names are replaced by pseudonyms. Phrases in square brackets [] are used to disguise names, occupations and places. Each syllable of unintelligible words and phrases is marked with a forward slash thus ///.

Section 2: Methodological revisions and outcomes

Identifying meaning making moments

Jacqui's sessions had been the first to be transcribed. The sessions were transcribed in their entirety and totalled 26,000 words. The first task had been to identify those moments where Jacqui exhibited meaning making as she assimilated new schemas which would help her make sense of her loss and grief. Table 6.1 gives examples of the criteria used for identifying Jacqui's moments of assimilation when analysing her transcript.

	Transcribed text without meaning making
1	My dad was an alcoholic. He was still in a family life but that's all we'd grown up with so did spend most of our childhood. He wasn't married to my mum, he married again and all we've all known is just it was always in and out of hospital and things.
2	I don't have the kids at the weekend so sometimes we might go for a meal and sometimes we might just to end up there. If there's entertainment on, we don't have to pay taxis; we just walk and walk home.
3	My dad used to go and get drunk and get into fights and then appear at the house with a black eye. Drove the car home from the nightclub and overturned it on the Odeon roundabout when that used to be there. Wrote the car off (laughs). All stuff like that you know.
4	In (area of town) there is a little courtyard. There's a unit it's got a downstairs area and an upstairs so you could have the beauty upstairs and hairdressing downstairs or you could have it just as beauty. And I thought "there's nothing in (this area)". You can park there, it's a real nice courtyard you could have it all very nice, but you pay rent for them. I think £800. That was a couple of years ago. It's keeping the business going, the customers coming back and everybody happy.
	Transcribed text with explicit meaning-making
5	My partner doesn't know how to support me because he's never lost anybody.
6	I think that's why people are concerned about me because I have been drinking more than I would normally do.
7	I need to be focused now and turn into a professional woman that I think I am (laughs) start getting focused and just change a few things.
8	As much as I've come out the other side that sadness will always be there but I just feel stronger about me.
	Transcription with implicit meaning-making (text in red)
9	I took a part-time job at (workplace). I worked there on a morning while I built the business up and I finished that last year, I did that for a year. <u>I think I just focused on that.</u>
10	And that's another thing. This morning he knew I was coming but never said anything I said, "Ooh I'm setting off at ten" cos he went out with the dog and "Okay I'll be back by then" and then that was it, It wasn't like er "Hope it goes well" or "hope you know". <u>But I think that's just his way.</u>
11	At my dad's funeral she came and she was like, turned into sort of a little bit of a different person. But it doesn't last long. There were no, you know, no hugs or anything like that or anything but she was a bit deep in her words and.. And she thought it was really, <u>I think she was that gutted that, 'cos she said he was a big part of her life,</u> you know and I mean?

Table 6.2 Identification of Jacqui's meaning making moment

Sections of transcription where there was no meaning making (Figure 6.3 examples 1 to 4) were easy to identify. They consisted of narrative descriptions of events without any interpretation on Jacqui's part. Those phrases which contain an element of reflection or interpretation, for example a clause followed by "because" (examples 5 and 6) were construed by the author as having an element of narrative construction. In example 5 Jacqui is trying to make sense of why her partner was finding it difficult to support her. In example 6 she tries to understand people's concern for her drinking. In example 7 Jacqui is constructing a narrative to make sense of what she needs to do in the future and in example 8 she is reflecting on her grief journey to date. In examples 9 to 11, Jacqui narrates three events with an implicit interpretation tagged onto the end of each. In example 9 there is a beginning of awareness that she had been focusing on other activities to avoid her grief. In example 10, where she has been giving example of her husband's lack of support, to make sense of this by attributing it to his nature rather than to any sense that he did not care about her. In example 11 she is trying to make sense of her mother's reaction to her father's death.

Transcribing Jacqui's sessions highlighted the process of her narrative construction. Some schemas were not fully assimilated, though they showed stages in her meaning making, consistent with the APES sequence which is shown in Chapter 5 page 72. In other sections it was possible to identify moments of assimilation, but it was clear that Jacqui was not making helpful connections for herself. For example, in the passage which appears below, transcribed from five minutes into the second session, Jacqui describes the effect that her father's drinking had on those who loved him, yet does not relate this to family concerns about her own drinking. Moments of assimilation are highlighted in yellow:

Jacqui: He was in and out of hospital all the time and he was very lucky to be honest to last as long as he did given what he was doing and my dad's wife, this was years ago and he disappeared. We knew he was drinking somewhere we just didn't know where he was and she said I had to drive round town and try and find him and she said "You are the only person he will listen to". She went "Will you try and get through to him". But he listened but it just went straight (pause) through and at the end he'd say "I love you loads". He just didn't see what he was doing to everybody else.

Counsellor: Mm.

Jacqui: So sometimes I got annoyed but then I just um (pause) It was the way he was. Nobody was going to change him.

Counsellor: So you were accepting?

Jacqui: I accepted it yes.

Counsellor: Knowing that it might limit his life?

- Jacqui: Yes, I knew it would (pause) he would go, that's the point, I was always sort of prepared.
- Counsellor: Right
- Jacqui: .. for him going but when they actually go it's like a, like a big emptiness isn't it? And he isn't there too. I mean he was absolutely useless with his phone but he used to text me and ring me up and um want to meet up um and obviously that's. I can't do that anymore. But yeah, I mean. I. He just taught me not to be like him, as much as yes I might go out and socialise a bit too much, and it's you know it was me mum saying that I was drinking too much and am going to end up on the same road as him. But I thought I don't really know how she knows what I'm drinking because it's not that she's (pause) I think she knows that I meet. 'Ladies who lunch' we call it and she knows that I go out on a weekend with (husband) I don't know. So it was, and I thought she doesn't really know really.

When the analysis of Jacqui's transcription was completed it was found that just over 1000 words (4%) were concerned with meaning. These moments of narrative construction were embedded in Jacqui's stories, reflections and narratives, in which she told the story of her father's life and death, described the relationships with her mother and her partner, discussed the stresses and uncertainty of her self-employment, and voiced her concerns about her alcohol intake. Over 50% of the sessions were taken up with other narrative accounts of her life. The rest was administrative conversation including reviewing the final outcomes of her counselling, (See figure 6.3).

Jacqui's case study was completed using transcriptions of all the relevant meaning making passages in context. This came to just 6,300 words of the original 26,000 transcribed words. Because so little of each session contained moments of meaning making in the form of assimilated schemas, it became clear that to transcribe whole sessions of subsequent clients would serve no useful purpose. A way was sought to identify and transcribe only those sections which included moments of assimilation and the context in which such meaning making occurred. Even if other clients exhibited a higher percentage of meaning making dialogue, it was still unlikely that it would be necessary to transcribe complete sessions. The transcription method was adapted accordingly.

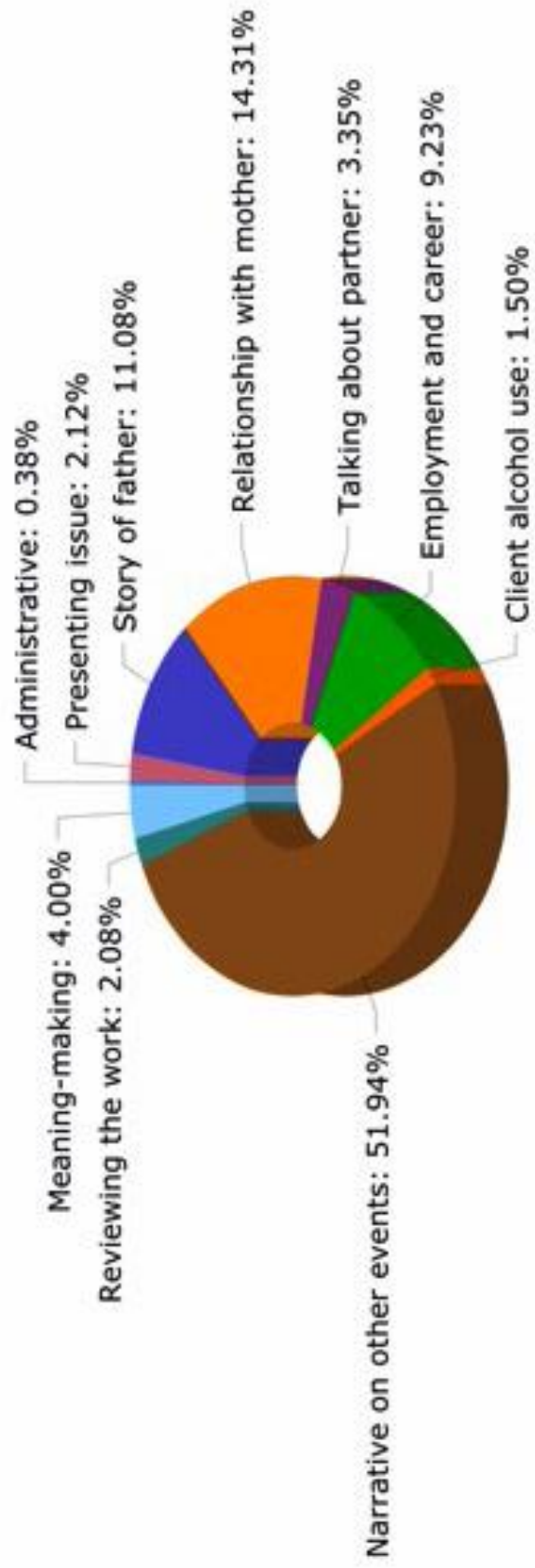


Figure 6.3 Analysis of Jacqui's sessions

Refining the transcription process

A grid was produced which divided an A4 sheet into five 3 minute segments, so that notes on a one-hour counselling session could be handwritten in four pages. (See figure 6.4). This made it possible to make handwritten notes whilst listening to the session recording, and to identify moments of assimilation in real time. The digitally recorded sessions were played back on a laptop computer using WavePad Sound Editor (NCH Software). The programme displays a wave form of the recording and a running counter in hours minutes and seconds. Notes were made which put the client's meaning making dialogue in context. A client speech that could be accurately captured in the moment was written in double speech marks, and paraphrased moments in single speech marks. The time elapsed was recorded. The division of the notes into three minute segments ensured that if the author wished to revisit segments of the recording they could quickly be found. This way of working greatly speeded up the transcription process. It meant that time was not spend accurately transcribing irrelevant passages, allowing more time to become immersed in the data, and to replay and accurately transcribe moments in which assimilation occurred.

Detailed notes were only made where the client's speech could be construed as containing elements of meaning making. Social exchanges between client and counsellor, and administrative events, such as arranging appointment times, were excluded from the analysis. Narrative accounts, for example where a client describes an aspect of her life, such as her occupation, were excluded. Passages where a client is describing the life, illness and death of the person they have lost were not included except for moments of interpretation and reflection. These sections of narrative did, however, provide the context for meaning making, and handwritten notes on these passages were entered on the analysis grid. Also included in the notes were narratives on the stressors complicating the client's grief, with an emphasis on the client's interpretation and reflection on the nature of those stressors¹⁸.

¹⁸ Table 3.1, page 23, refers to identified stressors which complicate grief.

Client code	File number	Date of session
343		27/2/2012
30.00	Thought he would be able to work through difficulties once he stopped work - glad he has been at home - even though not right - but working away had no home life. Saw no way out 31:50 32:15 (Big yawn) 'Brother hiding away' (32:50) Brother in Leicester	
33.00	Talked about CBT female practitioner 'very busy' - Felt it didn't work - not in a place to question it. Latest therapist could but methodology not right. But discovered "More my dad" (than work/home stress)	
36.00	36:30 "Came out with tears" "Quite angry with it all" 37:30 Weary expression 'oh dear - I don't know' Me: If we could join up the dots, then you'll know. Client "Feel like I'm dragging something along"	
39.00	40:20 (Yawn) "Just feels too much to drag along" - Don't care - "Don't give a bloody toss" (40:46) "Hate that complete coldness inside me" Arguing, internal voices	

Figure 6.4 Analysis grid used in identifying moments of assimilation/accommodation

Scoring the data using APES

The value of APES for analysing Jacqui's counselling sessions validated its use. Her counselling revealed a sequence of awareness of the nature of her difficulties which could be scored against the APES scale. The APES descriptor of opposing voices was demonstrated in Jacqui, illustrated in the section above, where Jacqui has a voice for her father's problematic drinking, but an opposing voice for her own alcohol use. The decision was made to continue using the APES scale for subsequent clients.

Data collected from Tony's counselling sessions was the next to be analysed. The unusual nature of Tony's delayed grief and the complex effect that this had, both on his mental state and on his behaviour, meant that it was possible to ascribe different APES scores for each problematic experience under a number of headings, each with many subheadings. Every topic and issue Tony discussed in his counselling was catalogued (Table 6.3). Each time an item in the catalogue was discussed by Tony it was scored against the APES scale. The results of this process appear in Appendix 5. This became cumbersome, and when Tony's case study was reduced from the initial 44,000 words, a decision was made to abandon attempts to follow the

APES sequence for each of his issues¹⁹. In its place a single APES score was determined for each session which reflected just his changing pattern of grief. This protocol was used for subsequent case studies.

Revision of the triangulation method

When the project was planned, the original intention had been to triangulate the data against each client's observations of his or her case study. The plan had been to allow the client time to read the text, and then interview them to record their reflections on the counselling and comments on the case study. Only in one case this was this possible. At the conclusion of her counselling Jacqui expressed great interest in reading her case study. Sadly, in the process of contacting her to say that the case study was complete, a National Health Service database indicated that she had died. The cause of death is not known. Tony's completed case study, including transcribed extracts, totalled 44,200 words. This was sent to him with his agreement. However, in the event, he did not feel able to revisit the sessions, and decided against reading any of the completed case study. At the end of her counselling Amanda agreed that she would like to read the 7,800 word case study. When this was completed she was sent a letter offering the chance to read a copy. However she did not respond to the invitation. Sophie's case study came to 11,600 words and she was very clear at the conclusion of her counselling that she did not wish to read it, although she remained happy for it to be used in the thesis. Sam was the only client who read her case study (6,600 words). Having read it she agreed to be interviewed. An account of this interview appears below.

Of the remaining clients, neither Ted nor Fiona needed any intervention after the initial assessment sessions. The coordinator of the bereavement support service which was hosting the research, allocated Caitlin, Sue and Maureen to other counsellors rather than to the author, since volunteers were available to see these clients and it was deemed unfair to keep these clients on a waiting list in the interests of research²⁰. Although the author retained access to the notes made by others, it was not possible to make any further digital recordings. In the light of the observation that nearly all of the longer term research subjects had chosen not to revisit their sessions, the author made the decision on ethical grounds, not to re-contact any of this cohort. The data extracted from the assessment session recordings remained useful.

¹⁹ This was essentially a pragmatic decision, since to continue with an assimilation analysis in this detail, would have increased the word count of the thesis, and would have limited the time available to interpret the data from other case studies.

²⁰ This loss of valuable data was an outcome of the agreement that the effect of the research on the running of the service would be kept to a minimum.

Focus: Awareness & understanding of behaviour:
Contacting emotions is a key component of change
Work stress not the main cause of behaviour
Part played by antidepressants in blocking emotions
Significance of bereavements in relation to behaviour
Narrative:
Brother's death
Father's death
Disrupted childhood security
Mother's mental health following the crash
Parents' relationship after the crash
Childhood obsessive activities & magical thinking
Childhood denial/pretence around brother's death
Client's difficult relationship with mother after the crash
Client's bond with mother since the crash
Father's deteriorating condition
Tension between work pressure and caring for dad
Mother's cancer diagnosis and treatment.
Had instigated previously unspoken conversation with mum
Period in his teens, post-accident, when he 'didn't give a toss'
Caring about life again related to parenthood
Metaphors, tensions & dilemmas
Behaviour redolent of recalcitrant teenager
Making sense of his anger
Childhood belief he caused the crash by his wishes
Belief he could not 'fall apart' until parents were safe.
Hiding from both deaths: resonance between the two
Sons, granddad & uncle, will never enjoy each other's company
Possibility of continuing bonds through reminiscences
Game spoilt, so wait for it to end, then start again
Metaphor of thread to brother getting thinner
Metaphor of flawed computer operating system
Lost child, squashed between the anger of others
Saying goodbye to his brother
Metaphors: Meaning in the here-and-now
Emotions like: waves of nausea: build up, be sick, feel better
Compares opposing voices with a background computer program
Waiting for the train, fearful it won't reach destination
Issues stuffed into metaphorical cupboard
Tensions and dilemmas (expressed as voices)
Letting go versus feelings of betrayal
Impossible dilemma: wishing either father or brother still alive
Would not have had this wife & these children without the crash
Dominant voices: client to self
"I get so frustrated and angry with your behaviour"
Understanding of his inner child
"You use past events unreasonably to excuse your behaviour"
"What's the point?"
Becoming kinder and more understanding of self

Table 6.3 Catalogue of all issues discussed in Tony's counselling

APES scoring of the remaining clients' transcripts

The transcripts of clients Sam, Amanda and Sophie were scored using the APES scale (Stiles, 2001), as were the assessment sessions of Ted, Fiona, Caitlin, Sue and Maureen. The assessment session clients were not invited to look at their case studies. It was deemed unethical to involve either Ted or Fiona in further contact with the Bereavement Support Service after they had opted not to receive counselling. Caitlin, Sue and Maureen went on to work with other counsellors, and although the author had access to their notes, it did not feel appropriate to contact three people who had effectively become other counsellors' clients. In Chapter 7 all ten cases are compared using APES. In Chapter 8 the case studies are used to build a theory of post bereavement narrative reconstruction through the assimilation and accommodation of grief complications.

Ethical concerns of the dual relationship

In Chapter 5, page 67 the author discussed any possible ethical issues which could arise from the practitioner/researcher dual relationship. A principal concern was the temptation to treat these clients with more attention, including offering more sessions than would be normal practice. There was also a concern that the client, once recruited, might feel obligated to continue. The author's ethical mindfulness (West, 2002) as a researcher was central to the project. No sessions recordings were played back until the client's counselling was complete. Only then were sessions transcribed. To the author's conscious awareness, counselling endings were negotiated, and agreed with clients, no differently than clients who were not part of the study. The fact that Tony, Amanda and Sophie exercised their right not to view their case study, nor to be interviewed, suggested that they felt no exaggerated sense of obligation to the researcher.

Limitations of the method

There are a number of possible limitations in the method, some of which have been, to some extent, overcome. These are revisited in the final chapter. Originally the intention had been to record and transcribe the counselling sessions of colleagues. Understandably there was resistance to this, at which point the author decided to obtain informed consent to research some of his own clients. This presented a potential role conflict, for example the risk that the special interest and immersion in each client's case would affect the result, and that there might be a temptation to retain clients for the sake of the research after the need for counselling had come to an end, even if this was not in the best interest of the client. Awareness of this possibility, and discussion in counselling supervision, addressed this risk. As is discussed on page 67, in order to mitigate this risk, a decision was made neither to listen to recordings nor to transcribe sessions until counselling for the client had ended. Working so

closely with clients who were also research subjects also risked introducing subjective bias on the part of the researcher. This limitation to objectivity was addressed on page 65.

As with any multiple case study research, the number of case studies completed is directly related to the weight of evidence. Thus any conclusions drawn are limited in both validity and reliability, by the number of case studies completed. Theory building case study methodology acknowledges this limitation and tests the initial theory with each new case study, in order to confirm or modify the theory. Thus it holds true that the degree of confidence in the theory increases incrementally with the number of completed case studies. In the current research, best practice in applying the theory building method would have been to complete the theory building cycle, including challenges, confirmations and modifications (pages 150 and 175) after each case study was completed, transcribed and analysed. Time constraints (see page 75) prevented this from being possible, although a way was found to use each case study independently to build the theory (see pages 151 to 174). This expedient change to the theory building method inevitably introduced a limitation.

The original plan was to triangulate each case by asking the client to read through his or her case study and reflect on the content. This was to be done with an interview, which sought to assess whether researcher and client recognised the same process and outcomes in the case study text (see Figure 6.2). As is reported on page 90, this only proved possible with one client. It had also been the intention of the author to work with all ten clients to completion of their counselling. As is discussed on page 90 this did not happen in three cases, where other counsellors were used following the initial assessments. A lack of counselling transcriptions for these clients limits the weight of evidence available for building the theory.

An important limitation in the project, and one which it was not possible to address, was the absence of a standardised measure of psychological change, such as CORE (Barkham et al., 1998)²¹. This would have provided additional evidence of psychological change in each client. However, getting consent for the research included an agreement not to introduce any clinical material into the hosting service, outside of standard organisational practice.

²¹ CORE is the Clinical Outcomes in Routine Evaluation (Barkham et al., 1998). It is in common use in counselling services to measure psychological, social and behavioural change in clients.

Chapter 7: Cross case comparisons

This chapter describes the outcomes of assimilation analysis of the transcripts of clients who took part in the study using APES (Stiles, 1999, 2001) as described in Chapter 6. Tony, Sam, Amanda, Jacqui and Sophie were assessed and counselled by the author through to the conclusion of their counselling. Ted and Fiona elected not to receive counselling. After their assessments Caitlin, Sue and Maureen went on to work with other counsellors.

Case study synopses

The first five clients below are listed in the order in which the author first began working with them. The second group of five are listed in the order that they were assessed by the author. Table 6.1 on page 73 presents a summary of each client, and Figure 6.1 on page 75 presents a timeline of data collection.

Tony

Tony, aged 45, had been referred for bereavement counselling by a CBT practitioner he had been seeing for stress and depression. This practitioner suspected that the real issue was about his father's mental deterioration at the end of his life, rather than the presenting issues. The client had until recently worked away from home during the week and had come home at weekends tired, stressed, and irritable with his family. He had eventually given up work due to the stress levels, and the effect it was having both on him and his family: a wife and two sons. To his great disappointment, his behaviour had continued. In bereavement counselling it was quickly established that Tony's difficulties stemmed from the death of his eldest brother when Tony was 11 years old. Although he had received counselling following a suicide attempt in his twenties, many issues around the bereavement had remained unresolved. Tony's counselling was marked by a series of emotionally cathartic events followed by long periods of little change. Tony was able to use these plateaus to observe, reflect and to learn to control his depression and his moody outbursts towards his family. Over the course of counselling his mood lifted and change appeared to be long lasting. One year after his counselling ended, Tony reported that he continued to manage his moods well and was not depressed. Tony had 39 sessions of counselling for a period of 21 months.

Sam

Sam had been bereaved of her adult son Mark 16 months earlier. Mark had weight-related type II diabetes and diabetic neuropathy. His surgeon had suggested a gastric bypass for weight loss and Sam's son was keen to take up this option. However it appeared to Sam

that Mark's surgeon may have underestimated the severity of the condition. After his first operation Mark had suffered a stroke. After his second operation he had a second stroke and went into a terminal coma.

At the time of Mark's death, Sam was pursuing a counselling degree. The process of becoming more self-aware and keeping a journal had alerted Sam to the emotional feelings that she was finding hard to contain, and she sought counselling for her grief. In counselling Sam learnt to face the reality of her loss and discovered that it was safe to relax into her grief rather than always being busy as a means of avoiding her emotions. Sam had 10 sessions of counselling spread over 4 months.

Amanda

Amanda's maternal grandfather had died seven months before counselling began, from pneumonia complicated by asbestosis. For a time Amanda had tried to manage without help. However the stress of doing so had resulted in a chronic loss of appetite and mouth ulcers.

During his last days in hospital, she looked after her grandfather's personal care, so felt neither regrets nor a sense of unfinished business. Something however, kept pulling Amanda back to her grandfather's last days. This left her with a sense of confusion and she was keen to explore what was causing this feeling. During and between counselling sessions, Amanda came to make sense of his illness and death. She was also about to find ways of being symbolically close to him without a need for searching behaviour. Amanda had 9 sessions of counselling spread over 6 months.

Jacqui

Jacqui, a self-employed woman aged 42, was self-referred for counselling two years after the death of her father from alcohol-related organ failure. Her father, who she described as an alcoholic, had died suddenly, aged 61. He had collapsed and died during the night in the home he shared with his second wife. Jacqui said that she was still getting the vision of his body as it was found in his home. For two years she attempted to cope by keeping busy, but by the time she presented for counselling at her family's entreaty, she was struggling to keep going. In her brief contact with counselling, Jacqui established a continuing bond with her father through discussing a picture he had painted for her. Jacqui had 3 sessions of counselling spread over 4 weeks.

Sophie

Sophie presented for assessment 16 weeks after the death of her husband David from a rare form of cancer. She said that she just wanted "somebody to make it better"; for her and her children, Emily aged 18, Andrew 15 and Michael 6. Sophie also wanted to understand the

nature of David's cancer and the suddenness of his death. He had begun to feel unwell in the summer before he died but had not been in pain. By the autumn his abdomen had begun to swell and he was losing weight. Sophie said she had "nagged" David to see a doctor, which he did in October. By Christmas it was very clear from the symptoms of swelling and weight loss, that cancer was a strong possibility. However with the Christmas holidays intervening, David did not get an appointment to see an oncologist until February. By this stage he was uncomfortable but not in pain. Following confirmation that this was cancer, David was started on chemotherapy. Two weeks after the beginning of the treatment, when resting at home, David suffered a fatal embolism. His family heard him fall and rushed upstairs. Paramedics were called but David could not be saved.

Over the course of her counselling, Sophie was for most of the time, able to grasp the reality of David's death and accept that he could never come back. She acquired strategies which allowed her to begin the process of re-learning her world (Attig, 2001, 2011) and she accepted that her grief would be long lasting. Sophie had 44 sessions of counselling spread over 21 months.

Five further cases studies

Of the remaining five, Ted, bereaved of a son, and Fiona, bereaved of her husband, elected not to receive counselling following the assessment. Caitlin, who had lost her mother, and Sue who had recently been bereaved of her mother followed soon afterwards by her husband, were assessed by the author before each was supported for a short time by other counsellors. Maureen self-referred because of unresolved grief following the still birth of a daughter seventeen years earlier. She was assessed by the author before going on to work with another counsellor for a small number of sessions.

Case study comparisons by APES stage: Tony, Sam, Amanda, Jacqui and Sophie

The very nature of bereavement counselling and the organisational structure in which it takes place, means that most clients do not present for counselling at Stage 0 of APES because by definition they are not aware that they have a problem for which counselling may help. In the author's experience, neither do many clients seek counselling during the stage of unwanted thoughts described by APES 1. The author finds that, for most clients, counselling begins at the stage of vague awareness; APES 2. This is not surprising because, by Stiles' descriptors of the APES sequence, at APES 0 there is no negative affect (Stiles, 1999). Evidence for Stage 0 is collected as clients talk retrospectively about their experience of warding off their grief. Evidence for Stage I can be collected as clients talk about how they have coped until they presented for counselling. However at all stages in these case studies, it

was found that clients revisited earlier stages. Moments of assimilation were either observed during the counselling session or were self-reported to have taken place between sessions.

Assimilation from APES Stage 0 to Stage 1

APES Stage 0 is described as ‘Warded off’. At the beginning of bereavement counselling, each client demonstrated and/or reported on aspects of warding off grief. Tony, Sam and Sophie had reached a point where they were warding off grief in awareness, perhaps as a means of gaining temporary respite. At times this afforded all three a degree of disassociation; both from negative affect and the reality of the death. Tony was aware that he warded off his grief and suspected that his prescribed antidepressants had become an unhelpful means of perpetuating this behaviour. He said,

“Instead of focusing on things, it allowed me to look away” [Tony, session 1, 0:04:36].

Sam’s dissociation from the death of her son Mark 17 months earlier had become a habit.

“I won’t allow myself to think about it” [Sam, session 2, 0:45:00].

Sophie was aware of her grief and was well into distressing negative affect by the time her counselling assessment took place. However, there were times when she was still able to ward off her grief by avoiding the reality:

“When I think about it in my head it’s like it’s a film and it’s not really real.” [Sophie, assessment session, 0:18.50].

Sophie continued to find ways of warding off her grief; strategies she was still using well past the first anniversary of her husband David’s death. This is discussed later in the chapter.

Whilst Tony, Sam, and Sophie were able to recognise strategies they had used to ward off their grief, this was not the case for either Amanda or Jacqui. Immediately after the death of her grandfather, Amanda began to experience a number of physical symptoms which she and her doctor attributed to the stress of her grief. These included a loss of appetite, acute weight loss and mouth ulcers. Clinical tests revealed that the ulcers were the result of poor nutrition, as Amanda had pined for her grandfather. During her counselling she described her difficulties in accepting the reality of her grandfather’s death. She recalled sitting outside the

hospital mortuary, not wanting to leave him. Although eventually she was persuaded to leave, two days later she felt a strong compulsion to return.

“Even two days after he died we went down to [name of hospital] and I said to my mum, ‘I’ve got to go back. I’ve got to do it.’” (Amanda, session 7, 0:25:33).

It was clear from the opening comments in Jacqui’s assessment that she had presented for counselling more to appease her family than to address problems she had clarified for herself. The extract which appears below, taken from the opening moments of the first assessment session, illustrates Jacqui’s use of impersonal language which effectively distances her from her own emotions:

Counsellor: How can I help?

Jacqui: Um (pause) I don't know (nervous laugh). I went to the doctors and erm (pause) I just thought erm (pause) My dad died two years ago and um I’ve dealt with it but (pause) cos I just like deal with things on my own, and erm (pause) just over the past few weeks erm my mum my sister, my partner are showing concerns.

Counsellor: For you?

Jacqui: Regarding me.

Assimilation from APES Stage 1 to Stage 2

At APES Stage 1 ‘Unwanted thoughts’ begin to intrude into the awareness of the client. In grief work at this stage, although the loss is an unavoidable fact, the client avoids the reality, the grief and the emotional pain associated with it. If asked to talk about the loss during a counselling assessment, the account offered is brief and lacking in detail, a phenomenon noted by Machin (2013, p. 107) and frequently observed by the current author. The story of the loss may be confused and related out of temporal sequence. This was a feature of Jacqui’s assessment session.

Tony had struggled with a delayed grief reaction for many years. In session 1 he described hiding away to avoid his grief. He spoke of the pretend world he had created for himself as an 11 year old. In this world his brother was still alive and would one day return. It transpired during his counselling that he had never completely stopped believing this. He drew parallels between the alternative world he had created as a child, and his adult behaviour, which had consisted of working away from home and living in bed and breakfast accommodation. In hindsight he saw this as a form of hiding from reality:

Tony: It was, it was escape, I was escaping, and I sort of knew that but perhaps I forgot it (pause) and, because there wasn't reminders of my brother and things like that and I didn't perhaps have to look at my mum and dad (pause) I was (pause) I wanted to be able to work out what I was doing. Er (pause) I suppose when I was away working there was another (pause), I haven't got a (pause) I don't have a world where I can go and escape to any more, do I?

Counsellor: No, that's right.

Tony: I had school, I used to go to school. College, I used to (pause) had college. Then there was sort of that where I went sort of thing for [brother] but even then I'd still sort of go (pause) well when I went to London, I lived in London. [Tony, session 1, 0:34:19]

Tony was not alone in pretending that the deceased was still alive and could return. Sam reflected:

"Maybe I'm playing a waiting game thinking he hasn't gone" [Sam, session 5, 0:08:15].

The pretences that form part of APES 1 are helped along if reminders such as places, photographs and music can be avoided:

"You can easily avoid um grieving for people by the fact that you keep away from where they've been." [Sam, session 4, 0:18:53].

Clients at this APES stage may become stressed and exhausted by keeping busy in order to control their grief. Personal relationships frequently suffer at this stage. Some clients are unable to recognise Stage 1 until they are well past it, at which point they can talk about it in hindsight. In her final session Amanda described how the relationship with her partner had reached a crisis, at which point she had briefly entertained some suicidal thoughts. It was at this point that she telephoned her mother and it was agreed that Amanda should seek counselling. In comparison, Sam was aware that she had developed effective strategies for avoiding her grief; not just avoiding places which reminded her of Mark but also by keeping

busy as a means of distraction. Sam described this as her “running on adrenaline stage”. [Sam, session 6, 0:18:00].

When compared to Sam, who had an awareness of her avoidant strategies, Jacqui had a far more limited awareness. It was at the suggestion of her family, who had been concerned about her, that Jacqui had made an appointment with her doctor. Jacqui said she had admitted to her doctor that her alcohol consumption was the above clinically accepted safe limits:

Counsellor: I just wondered if you have checked your (pause), the effect that your alcohol is having on you.

Jacqui: Oh no, I just talked to her first, to the doctor I said that they've got issues regarding (pause) And she said that she thinks because I have maybe need to speak to someone regarding everything, er my dad and things, the (pause) the other little things around would get better.

Counsellor: Yeah. I guess (pause). I guess a lot of it depends whether or not you drink to cope or drink to socialise and they're two different things aren't they?

Jacqui: Yeah (pause) it's a socialize (pause) It's definitely socialise. [Jacqui, assessment session, 0:43:50]

Jacqui said that she had not cried at her father's funeral, “no tears; no nothing.” She kept busy by returning to work immediately after the funeral.

Counsellor: You said you were fine at the funeral but then did you get straight back to work? Did you have any time off?

Jacqui: No because I work, I've got a [small business] in my house

Counsellor: Right

Jacqui: So I'd just set that up so it was up-and-coming..

Counsellor: So you're self-employed

Jacqui: Yes (pause) and then um it wasn't very long after (pause). I think I just focused on my work. [Jacqui, assessment session, 0:14:47].

When invited by her counsellor to consider if she kept busy as a means of avoiding her grief, Jacqui replied,

“Yes um, I’m always busy. I’m always doing something. I can’t sit down. I’m always doing something.” (Jacqui, session 1, 0:04:25)

There was, however, no further exploration on Jacqui’s part.

At APES stage 1, clients will sometimes employ magical thinking in order to hold the deceased close to them. In session 4, Sophie described how she had found herself comforted by finding a white feather in the room where David died. She said that she had noticed how white feathers kept appearing although she recognised the irrationality of her behaviour. She talked of sometimes finding herself searching for signs of David. She had entered his name into a Google search and had gone over hospital letters which discussed his diagnosis and prognosis. This searching behaviour has frequently been observed by the author in his client work; particularly in the early stages of loss and grief.

Assimilation from APES Stage 2 to Stage 3

It is at APES Stage 2; ‘Vague awareness’, that clients become aware of their distress and can begin to describe how it affects them (Stiles, 1999). Tony had long been aware of his depressive symptoms and his irritability with his close family and had sought professional help. It was a mental health practitioner who had identified the possibility that his long-standing difficulties were due to delayed grief following the death of his father and had referred him for bereavement counselling. Sophie’s employer had noticed how she was struggling to cope in the first few weeks that followed her bereavement and suggested that she self-refer for counselling. Right from the start of her counselling, Sophie found no difficulty telling the story of David’s diagnosis, prognosis and death. She was aware of her guilt at talking to a friend about the stress of looking after him and in conversation had wondered, with some resentment, how long this phase of her life might last. The following day he died suddenly.

Sophie: Then I felt awful saying that cos the next day he died (sobs). I feel bad saying that. It’s almost like somebody heard me say that and then though ‘Oh well we’ll just take him away then’..

Counsellor: As if you made it happen

Sophie: ..Yes (sobs). Sometimes I think things like that happen when I think things. [Sophie, assessment session, 0:12:11].

Early in her counselling Sophie proffered another example of magical thinking. She interpreted an inexplicably opened wardrobe door as a sign of his presence, and spent a lot of time in that room talking to him.

Sam's move into APES Stage 2 had first been sparked during her counselling course when she had been required to keep a journal. This had alerted her to feelings she was finding it hard to contain. She described herself as like a ship in a bottle; isolated and insulated from emotional contact. She was aware that she had learnt to bottle up her feelings during her childhood and recognised that she could "theorise until the cows come home" [Sam, Session 1, 0:18:30].

Amanda, who had come for counselling with the encouragement of her family, was aware of something that kept pulling her back to her grandfather's last days. This left her with a sense of confusion that she was keen to explore.

Although Jacqui showed the least awareness of the five clients, she was beginning to see that her avoidance strategies sometimes failed her:

"And then every so often I might, you know, end up in a little state with myself and what have you." [Jacqui, assessment session, 0:08:02]

Assimilation from APES Stage 3 to Stage 4

APES Stage 3; 'Problem statement' is the point at which the client can state what it is they wish to work on (Stiles, 1999). It involves the client having a clear picture of their difficulties and an ability to identify what they want to achieve. When Sophie presented for counselling 16 weeks after the death of her husband it was very clear that she wanted "somebody to make it better" (Assessment, 0:00:25), not just for herself but for her children. Although such a generalised statement is limited in its helpfulness, the essence of an idea was there. Sophie recognised that she needed help in adapting to bringing up her family and all that this entailed without her husband by her side. In session 14 she explored the effect that David's death might have on Michael, aged 6. She reflected that the older two; Emily aged 18 and Andrew, 15 had had longer with their father whereas Michael has missed out. She wondered to what extent she could fill his father's role, and thought about future homework.

"I always used to say to Emily, 'Go and ask your dad, he'll know. They used to say 'Daddy knows everything' (laughs), and he generally did. Yes, you know I just feel like I won't be able to fill those boots. And he's going to miss out on that" [Sophie, session 14, 0:52:18].

She said that she worried that as a result, Michael might become a difficult teenager, compared to Andrew and Emily.

“I worry about is this going to affect Michael? Is he going to be a troublesome teen because he hasn’t got a dad there to keep on straight and narrow?” (Sophie, session 14, 0:54:00).

Trying to meet her children’s needs remained a theme for Sophie throughout her counselling. She also identified that she needed to understand David’s illness and death and she wanted to develop helpful coping strategies.

At his first assessment session, Tony believed that his problems stemmed from his father’s physical and cognitive deterioration which eventually led to his death. He acknowledged his guilt that because he worked away he was not always there to support his mother through this difficult time. In the second assessment session he described his difficulties in terms of his confusion at taking retirement from his self-employment and then finding to his disappointment that his mood did not change. Although in time it became clear that Tony’s difficulties stemmed more from the death of his brother than his father, his focus remained firmly on finding the cause of his mood swings and depressive episodes.

From the beginning of her counselling Sam had a vague awareness that avoidance of her grief was unhelpful. In session 1 she spoke about recognising the effect that suppressed emotion was having on her health. Between sessions 4 and 6 Sam had discussed with her doctor the possibility that her immune system was weakened by suppression of her grief. Although Sam realised that there were complex reasons for avoiding her grief which went right back to her childhood, avoidance was compounded by guilt for her absence at Mark’s death. She also expressed a need to explore whether his choice for surgery had been the right course and whether she could have done anything to prevent him making the choices he did. Sam also wanted to recognise the reality of Mark’s death.

“Obviously I find it difficult to believe. There’s still denial that he’s dead, because up until 2007 I’d been three years up here and he’d been three years in Sheffield, so there’s distance. So am I being unreal and thinking he’s going to come round the corner one day?” [Sam, session 1, 0:47:53]

Seen as a whole, Sam was seeking a balance between controlling her grief and being overwhelmed by it. She wanted to accept the reality of her son’s death, explore the choices he had made and seek a new symbolic continuing bond.

The problematic experience that Amanda wished to work on in her grief was not at any point clearly stated or clarified. Nevertheless it was implicit in what she said that she needed to use her counselling time to make sense of her grandfather's death and sense of her reaction to it. Most of all she needed to accept the painful reality of her experience. On several occasions she talked about this being the first death of a family member she had experienced.

"I think to myself, 'you've just lost a (pause). Something's actually happened. For the first time in your life you've actually lost somebody.'" [Amanda, session 3, 0: 31:45].

Amanda described herself as having been in a "childlike state" since her grandfather's death; hoping that her parents could make it better.

"Your mum and dad always make it right don't they? And this one thing can't be changed. That hurts because I know it can't be changed. So it's trying to make it real and not wanting it to be real at the same time." [Amanda, session 3, 0:35:00].

There was no point in Jacqui's counselling sessions where a clear problem statement could be identified. Difficulties were, however, implied. Although she recognised her sources of emotional vulnerability; grief for her father, the stress of self-employment and the sometimes difficult relationship with her mother, her solution appeared to be to maintain her well-developed defences:

Counsellor: So you have to be quite emotionally self-sufficient?

Jacqui: Yes.

Counsellor: And you've always had to be?

Jacqui: Independent. On your own. I mean [husband's name] will say I've got brick walls (pause) but they're not on bricks they're on hydraulics, just and (pause) they'll go up and down just to protect myself, come down just to protect myself, they'll go up. They'll come talking to you.

Counsellor: So if you imagine a box and it's got sides and they'll get, they can get flat to the floor. It's a bit like a clam shell isn't it?

Jacqui: Yes but I've always been like that, I've always had that sort of (speech tails off). (Jacqui, assessment session, 0:18:57).

Counsellor: It seems like it's a two-way box. It keeps people out but it shuts things in.

Jacqui: Yes (pause. Yes. [Jacqui, assessment session 0: 20:25].

During session 1, Jacqui described in great detail how her father had promised her a black and white picture to hang on the wall of the freshly decorated room where she treated her clients:

Jacqui: Two days later I got a phone call "Your picture's here, it's ready so that's in there as well.

Counsellor: I see

Jacqui: So it's like got a little bit of (pause). You know what I mean?

Counsellor: Yes

Jacqui: I mean (pause) I wouldn't say it was necessarily the room it's the things that are in there (pause) the vibe. It just (pause). And sometimes when I go in there to do some work it's like (pause) I might talk to it sometimes, the picture (pause) you (pause) not in a (pause) you know, just in a (pause) positive way.

By implication Jacqui was framing the nature of her problem with her father's death. She had missed their social meeting and the support she had felt from him, which she compared with what she viewed as a lack of support from her mother. This picture now became a symbol of a lasting connection, a continuing bond with her father.

Voices in opposition

Stiles' (1999) metaphor of the multivoiced individual is outlined on page 70. Until APES Stage 4 is reached, each client can be seen as a community of confused voices. In grief work it is not difficult to find evidence to support this description. A reoccurring theme for Tony was the voice which cautioned him not to be too happy or optimistic.

"There's a bit of that 'Oh God I don't want to say it too loud if I'm happy', because I'd feel like, 'Jesus you'll really get it then.' You know something really bad had happened." [Tony, Session 4, 0:07:27]

At other times Tony conducted a dialogue with himself in which chastisement and censure could be observed. For example, Tony sometimes experienced episodes of crippling

depression that prevented him doing anything. At times like this, opposing voices would conduct arguments with each other:

“Like ‘Go and go and kick the ball about. Sort of try and just do it’, and it’s like I’ll find something. It’ll just start annoying me and it’s like ‘Well what else do you want to do?’ ‘Nothing really nothing’, you know, even if you say, ‘Well there’s always one million things to do.’ But (pause) you (pause). I don’t know. [Tony, session 8, 0:13:18].

Early in her grief, Sophie experienced opposing voices of guilt if she did anything to enjoy herself or allowed herself moments of happiness. In Session 22 she reported that she had been out with some girlfriends. It had been an enjoyable evening but when she got home she felt guilty at having enjoyed herself.

“I felt so guilty, I felt really guilty and horrible and it made me cry.” [Sophie, session 22, 0:05:27].

However, Sophie said that as bad as the “meltdown” had been, it allowed her to vent pent-up emotions. She questioned whether she had been ready to go out with friends, but answered her own question with opposing voices that showed signs of coming together.

“I think, ‘Maybe I wasn’t ready for going out, but then I think ‘If I wasn’t I wouldn’t have gone.’ [Sophie, session 22, 0:14:16].

Sam’s opposing voices concerned breaking old habits of keeping busy in order to avoid difficult emotions.

“I was quite happy doing nothing yesterday, but then the other voice comes in and says, ‘You’re not going to get anywhere if you spend the day doing nothing’.” [Sam, session 5, 0:35.15].

Amanda’s opposing voices were concerned with acceptance versus denial of the reality of her grandfather’s death. Related to this was the voice that wanted to move forward with her life, rather than staying emotionally close to the point of her grandfather’s death. In session 3 she talked of not wanting the first anniversary of grandfather’s death to arrive. She said that felt guilty about not feeling as bad as she had at first and began to cry.

"I always think that I'm doing so well and I move you know, dealing with it. But then I seem to go straight back." [Amanda, session 3, 0:13:26].

"Sometimes I think it's real and then sometimes it's not. Dreams about him (pause). And then when I wake up it's like (sighs) he has gone." [Amanda, session 3, 0:14:17].

Jacqui's opposing voices were implicit in her tension between emotional avoidance and the recognition of the price she paid for this.

"It's best to go forward and everything, I think. But just sometimes I find myself running out of um energy or power trying to keep myself going, and then I need some support and then I don't know how to do it." [Jacqui, assessment session, 0:07:45]

Assimilation from APES Stage 4 to Stage 5

At APES stage 4; 'Understanding/ insight', the client becomes more aware of the nature of his or her grief (Stiles, 1999). The opposing voices illustrated above begin to come together. Tony began to be less self-critical and was able to forgive his own negative moods and behaviour. In this extract he recalls recently being unpleasant with his family. He was able to forgive himself and move on, rather than ruminate on the incident and feel shamed:

"I was proper crap. Mmm (pause) I was. It is (pause) just (sighs). It (pause) it does knock you back a bit. It comes out of nowhere and you don't quite realise it creeps up on you and suddenly you *are* being a shit and it's like 'Oh God' and then you (pause) it all (pause) coming out the other side of it you still feel a bit reeled back from it like a bit like you've had a punch-up with someone in the fact that you think 'Oh flipping heck'. And you stagger back and you think 'Oh God!' You got to sort of pick yourself up, keep going 'No no, keep calm', you know what I mean? 'Move on. 'Alright, it's been upsetting for the lads and (wife) and you'd been a knob again', and, and it's like, 'But don't throw baby out with bathwater, Just keep calm, don't (pause). Get over it or whatever. It's happened. You didn't want it to happen'. Instead of going down the route of 'Oh God, you know I cocked it'." [Tony, session 17, 0:13:27].

At APES stage 3 Sophie had identified three areas to work on; bringing up her children alone, understanding her husband's illness and death and acquiring restorative strategies. In almost every session Sophie continued to address her struggle as a widowed

mother. By session 30, although this remained true, she was beginning to question her sense of identity as a person in her own right. With Andrew beginning to plan for university, and Emily already there, she reflected how empty the house would be with just her youngest child. Although eventually she planned to sell the family house, she wondered about her life until then.

“I know I’m a mum and everything, but what’s the other bit of me doing? Do you know what I mean? Where do I go from here? (sobs). Don’t know, don’t know. I can’t see a plan. People that I don’t really know, you know, they see a wedding ring and they you know, assume you’re married.”

Recently in conversation at the school gate she had been labelled as a single mum.

“I don’t think of myself as being single parent. Do you know what I mean? I’m not divorced and I find that a bit annoying. But she lumped me in as a single parent. I don’t feel like that. Yes. Is that weird?”

Her counsellor said that he understood.

“I don’t like being lumped as a single parent. Then I realise I don’t like being thought of as a widow either.”

She said that ticking the ‘widow’ box on forms was horrible.

“That’s the sort of box I should be ticking when I’m in my seventies. I feel I’m just, I’m not just a mum but I’m a mum and then there’s the other box; What else am I? I just feel like is every week just going to feel like this now?”

[Sophie, session 30, 0:10:15 to 0:30:40].

It took many more weeks before Sophie was able to report that she could now to go out with her friends without feeling guilty. [Sophie, session 40, 0:22:00].

Sam allowed herself periods of relaxation. In session 9 she reported that she had put a post-it note in her kitchen reminding herself that it was okay to do nothing and relax. By not

feeling that she constantly had to keep busy, she felt as though she was “climbing out of the abyss a bit” [Sam, session 9, 0:02:55].

Amanda gradually accepted the reality of her grandfather’s death, although it was sometimes a struggle.

“I’m thinking yes I’m doing okay. I’ve accepted it but then tomorrow I can turn round and say, I could be here tomorrow and be in a completely different way like I can’t believe he’s gone, do you know? But most of the time I *have* accepted he’s died. Yes I can say it now, I know he’s died. I used to find it really hard to say that, but I know he’s died. And most of the days I’ve accepted it.” [Amanda, session 6, 0:36:23]

Jacqui was, in her own limited way, able to accept the help of counselling, although she continued to keep very busy and chose to end counselling after just three sessions. At the end of session 1 she reflected that she had accepted the physical reality of her father’s death, but felt his continued presence in a spiritual connection:

Counsellor: What do you think you (pause) still need to do (pause) In terms of grieving for your dad that I can help with? Or that we can do together?

Jacqui: Yes. I don’t know. Cos I think um (pause). Like I say I do feel um better. I do feel um stronger towards him going. I feel um that he’s still around me..

Counsellor: Yes

Jacqui: .. Obviously not in a physical way he’s still there and I don’t know, I just think that um (pause) maybe come to terms and dealing with it and I’m `just focusing on the fact that, you know, he’s around. I don’t think about him all the time. Um I don’t sit at the back door anymore and feel sorry for myself and put music on and you know, have my moments. I was doing that a lot.

Counsellor: Were you?

Jacqui: Yes. I’m not doing that any more. I can go to the back door, let my you know (pause). I will look up (pause). I don’t know why (pause) I don’t know (pause). Everything’s just making me smile. And he’s just there to smile. (Jacqui, session 2, 0:38:46).

Jacqui ended her counselling in the session which followed this, believing that she had got what she needed from it. Her counsellor reminded her that she had initially harboured doubts about counselling:

- Counsellor: But you were a bit sceptical weren't you?
- Jacqui: Yes I was yes 'cos it's not like (pause) very cos I thought 'Oh my God!' (pause). I thought, 'this isn't me to do this'. That's where you realise who you are isn't it? And coming out the other side's so a very very good feeling coming out of the dark into the light. Cos I just convinced everyone I was okay. I'm quite good at acting (laughs) so everybody thinks that I'm fine. Nobody knows what goes on inside and that's how I felt. I don't feel like that now.

Jacqui talked briefly about how her husband had noticed changes in her and added:

"It's been really really good. I don't want it to end really. I enjoy it, you know? But I am (pause). You sort of think 'I don't know what I'm gonna say today' (pause) cos I feel (pause) I feel that I'm in a good place." [Jacqui, session 3, 0:13:30].

By this point Jacqui had gained some insight into the various issues which compounded or complicated the grief for her father: the pressures of self-employment, the effect her alcohol use had on her relationships and the relationship with her mother. Jacqui had left home at 17 and said that "I was moving to escape" [Jacqui, session 2, 0:11:00] Jacqui's relationship with her mother had been discussed in every session. By the last session she had resolved many of the practical issues in her small business. A decision had been made to cease working in another person's salon and go it alone by setting up a dedicated space in her home:

- Jacqui: So I'll have a new place at home separate to the house and even if I don't stay there it will still be a room that we will be able to use for whatever.
- Counsellor: Without putting words into your mouth, can you see your dad's part in this? Because I can see..
- Jacqui: Yes he's coming with me. He's coming in that (pause). Yes and yes yes definitely
- Counsellor: So that picture he did was really..

Jacqui: Yes. And he's with me there. It wasn't with me at the salon cos it wasn't mine but yes he's coming. [Jacqui, session 3, 0:01:15].

She said she had reached a new place in how she viewed the relationship with her mother:

Jacqui: For years and years and years I've always thought it was me and she's got a problem but I've done well in my life workwise and everything and still am. I've got two great kids, my life's good and if she doesn't want to be part of that and enjoy it with us, then that's her (pause)

Counsellor: Her loss
[Jacqui, session 3, 0:05:50].

Jacqui compared the relationship with her mother with the continuing bond with her father. Whilst she had admitted that she did sometime drink more than was healthy for her, she continued to see her alcohol use as a social activity. Although some blind spots remained which perhaps could have been addressed in a longer counselling relationship, Jacqui was well towards APES 5 when the work finished.

Assimilation from APES Stage 5 to Stage 6

At APES stage 5; 'Application/ working through' is the stage at which clients complete most of the work on narrative reconstruction. Having stated their problem (Stage 3) and gained an insight into its complexity and ramifications (Stage 4), they are ready to apply their efforts to reaching a solution. Many clients do not get further than stage 5 in the course of their bereavement counselling and some may make a conscious decision to stop at this stage. They may feel, in some cases quite justifiably, that they now have the resilience and resourcefulness to work without a counsellor. Sam was an example of this, as will be described below. Jacqui, as we have seen above, also chose to end without working through her grief.

For Tony, who had identified his problem as a need to understand his low moods and link this to unresolved grief, the work proceeded in long periods of inertia punctuated by significant moments of dramatic change. The resulting moments of tears and elation which followed such moments offered him helpful insights into his behaviour. Of particular significance was a link between an event in session 20 and Tony's explanation for that event in session 24. In session 20, Tony had brought an album of childhood family photographs, including pictures of him taken before and after the crash in which his brother was killed. A

photograph of him taken a few months after the crash, particularly puzzled him. He could neither remember being the child in the picture, nor recognise himself:

- Tony: It's weird how quick it all was isn't it? (4 second pause) All them imperceptible little bits that just get lodged inside here. (Looking at picture of himself) (22 second silence) Can't (pause) just can't see myself there as me, other pictures I can sort of see me or recognise me if you like.
- Counsellor: Mmm. Which one's that Tony?
- Tony: This one. I can't quite (laughs) remember that at all. I remember that, I remember my clothes, if you like. I don't remember him, (pause) I really don't. I don't remember my hair being (pause). And yet in that picture which isn't that before (pause) much before (the crash) if you like, to this (8 second pause). I remember him, I remember him yeah, and I must remember like that one from school I remember him an' all (comparing pictures of self) (sighs, 43 second silence) yeah I really didn't understand any of it (pause). I really didn't. I can vaguely remember at school, I can sort of remember bits there (3 second pause) when I was in the first and second year. I don't know what the hell was going on at home really (70 second silence). I suppose I really don't recognise myself as him.
- Counsellor: But you weren't the same person after [name of brother] died were you?
- Tony: No (pause). No. [Tony, session 20, 0:36:03].

In session 24, all became clear to Tony:

"You know when we were looking at those pictures before I couldn't (pause), I couldn't see that lad. That's why couldn't see him because he wasn't bloody there was he? Bless him! He was just, he was (pause). There was a sham of a person, and it was squashed up tight in the bloody middle of it, stopping anything coming out. That's why couldn't remember anything (begins to cry). Is that it? I couldn't figure it out (pause), couldn't figure it out. Couldn't figure out cos I looked inside picture and couldn't see anything (pause), couldn't remember it. Bloody hell (pause), waffling on and it comes out. Suddenly makes sense. You see you're not just grieving for people,

you're grieving for yourself aren't you? For the things (pause) you grief for this time".
[Tony, session 24, 0:52:24].

Tony reflected how mad he was as a child, but paradoxically neither the people around him nor Tony himself realised because he didn't let it out.

Tony: Times maybe when I was too scared to let it go. And it was wrong (pause) wrong. It wasn't the right thing to do it was wrong and it was and it was this and it was that, just absolutely nowhere, trying to think (pause) and there wasn't (pause). That was it isn't it? Trapped in there (pause). Little bit right in the bloody middle (pause) (laughs). Soaking it all up (pause). Soaking it all up getting madder and madder and madder and madder and madder.

Counsellor: It was compressed by everybody else's um (pause) rage.

Tony: All these bloody bastards around me (pause). People and things and stuff and all the, all the usual crap of school maybe (pause). But it's just compressed the whole bloody block. [Tony, session 24, 0:56:15]

Now Tony had assimilated an understanding of his suppressed anger and its effect on his behaviour that originated in his childhood and continued to affect him thirty years on. The consensus between the author and the iterative group who also rated Tony's transcripts, was that this was the point that Tony moved from APES stage 5 to stage 6.

For Sophie, working through her problem statement was a long and protracted process. She had tried to make sense of her husband's diagnosis, prognosis and death by arranging to meet the oncologist who had cared for him. In session 5 she said that she needed to know whether the embolism from which he died was caused by his cancer or by the chemotherapy. In the event, meeting the oncologist with her questions was in Sophie's view unhelpful. In session 20 Sophie said that she had experienced him as defensive and she had not got the answers she needed. She did not feel he had listened to her. During the meeting she said that she could hear David's voice asking her why she was doing this. However she concluded that it was something that had to be done. As early as session 10, Sophie was able to reflect that as traumatic as David's death had been for the family, to die suddenly, rather from a long debilitating illness, was the end he would have chosen for himself.

“He wouldn’t have liked to have lingered but he wouldn’t have wanted us to go through any of it really. But definitely that way for him.” [Sophie, session 10, 0:54:50].

In the same session Sophie talked about her sense of responsibility for her children’s grief and the burden of lone decision-making. However she noticed that recently she had successfully purchased a new car without help and she reflected on her progress.

“I do feel like I’m getting somewhere.” [Sophie, session 10, 0:34:47].

Although there were many times in her first year of spousal bereavement when Sophie felt positive, there were regular periods of intense grief. She did, however, become adept at identifying the triggers for her low mood and she acquired restorative strategies (Stroebe & Schut, 1999, 2010).

Amanda’s time at this stage was spent making sense of her grandfather’s death and of her reactions to it, including coming to terms with reality. When the counsellor met her for session 9, three months had passed from session 8. The anniversary of Grandfather’s death had been easier than Amanda had expected. Her grandmother had recently had surgery for cancer, and had reflected that she was glad her husband was not there to see it. Amanda agreed with this and commented on grandmother’s positivity.

“He would have been in bits, so that is a blessing really. If she can be like that we all can really.” (Amanda, session 9, 0:07:39)

Amanda said that she still thought about her grandfather every day but she did not cry like she used to. She said that the counselling had taught her that it was okay to feel like she did, and to grieve like she needed to. Although certain things would still “set me off”, if she went down in mood now, she knew how to get back up. She said it was her grandfather’s birthday next month. “We talk about him and we laugh.” (Amanda, session 9, 0:06:30). She had learnt that oscillating between facing her grief and living her life (Stroebe & Schut, 1999) was both possible and helpful. She had found meaning in the timing of her grandfather’s death because to her it meant that he avoided the pain of seeing his wife with cancer. In the sense that she was still actively grieving, she could not be said to have reached APES 6, but she appeared to be working well into APES 5.

Sam made a conscious decision to end her counselling at APES stage 5 moving towards 6. In her penultimate, ninth session she reported feeling more positive. She said she

was taking more care of her health and was no longer in physical pain. She felt able to consider new courses of action, including marking her son's life symbolically, perhaps with a donation in his name to a charity he favoured. She brought his journal to the session, and noted that this was something she would not have been possible at the beginning of her counselling. She could read the journal and talk about the choice Mark had made knowing the risks of surgery and being realistic about the chance that he could die as a result. Although Sam had not yet achieved a successful solution to her difficulties, solutions were being planned.

After an interval of four weeks and on the second anniversary of Mark slipping into a coma, Sam met her counsellor for her final session. She said that she realised now that she was grieving but that she was not hiding anything. For this reason she believed that she did not need any further counselling. Her counsellor concurred with this decision. It could be argued that if for Sam, her APES 3 problem statement was to face the reality of her son's death, understand the choices he had made about surgery and learn to oscillate between grief and restoration, then inasmuch that she had now chosen to spend time oriented towards the loss, rather than avoiding grief by keeping busy, she had reached APES 6; Problem solution. Yet in other ways Sam had only just begun to stop warding off her grief. In session 9 using an APES for grief scale (Wilson, 2011) Sam had assessed herself as being between APES stages 4 and 5. In contrast, by using the criteria above, the author had assessed her as being at around 5-7.

Assimilation from APES Stage 6 to Stage 7

At APES stage 6; 'Problem solution', a client could be expected to have fully accepted the reality of the loss and made sense of the death and events leading up to it. Sad memories would begin to be tempered by recalling happier times and the bereaved person could be expected to find a new identity to re-engage with life. The case studies discussed here have shown two things. Firstly, most clients do not need to reach this stage before they feel ready to manage without counselling. Secondly, that even within the extended timescale for counselling after spousal bereavement; typically two years or more, clients frequently revisit earlier stages. For example 14 months after David's death, Sophie was still making use of a ritual for symbolically keeping him alive, perhaps as a means of getting respite. She said that she felt close to him in the bedroom where he died but that she still could not sleep in that room. Each time she left the bedroom she always shouted back upstairs,

“‘See you later’ sort of thing. And I don't shut the door, cos he hated being shut in. So I kind of feel like he's there.” [Sophie, session 31, 0:41:36].

It may be that the enormity of fully accepting the reality of a lost partner gone forever must be mitigated by taking time out from dwelling on the loss, by deliberately avoiding the full reality through engagement in distracting activities²². After the significant events in sessions 20 and 24 of Tony's counselling, there was very little further change until session 33. In Sessions 30 and 31 Tony was beginning to contact a disquieting feeling that some unidentified and unfinished business still remained. In Session 30 he said "I feel I'm struggling with something, and I don't quite know what it is". (Tony, session 30, 1:04:00). In Session 31 he spoke of, "That bloody feeling of like there's something I've forgot to do, or forgot to think about (pause) something nagging me or something or (pause). I should be something to do or something I forgot to do or something (pause). I don't know. (Tony, session 31, 0:05:40).

For Tony, session 33 proved to be the final piece of the puzzle. He had been on holiday with his family. Before they went he had got into a state that he described as "catatonic". He had got to the point where he had reasoned that the only way out would be to take his own life. It was a fleeting thought, but he found it frightening. He managed to work through the feeling and the holiday was enjoyable. He had arranged for his siblings to take care of mother during his absence and had not been stressed. All he could conclude was that he was punishing himself for something. Together, counsellor and client began to explore what this might be:

- Counsellor: Could be, although what you're still punishing yourself for.
- Tony: I don't know. Maybe it was. Maybe it was going away without my mum
- Counsellor: Mmm that's a possibility
- Tony: You see I (laughs) find she's had a really good time went she's been away (pause) yeah maybe there was I think (fills with tears) (pause). That's what I do to myself isn't it? (pause). I think that's what starts these damn things (pause)
- Counsellor: That feeling's touched you
- Tony: It has hasn't it? I didn't think it would be about that. And when I think it's like (pause). It's like er (pause) after our [name of brother] died. Enjoying yourself, having fun (pause). Go and have fun, and when my dad died (pause). It is isn't it? It's like me going (pause).
- Counsellor: Not allowed to have fun.

²² This was considered in Chapter 4 and is revisited in Chapter 9.

- Tony: Yeah maybe. Or, 'Look at you being all (pause). Someone else can look after your mum. Oh going to enjoy yourself are you? Not bothered about her are you? Your brother is dead now, forget about him. Oh forgotten about him have you? Enjoying yourself are you? He can't enjoy' (pause). You know, it's that isn't it? I think maybe that's it isn't it? There's me thinking it was like (pause). Bugger me I never thought that.
- Counsellor: What's that?
- Tony: ..Guilty
- Counsellor: Feeling guilty touched at your emotions didn't it?
- Tony: Yeah it bloody did. Flippin' did. Could have cried for a week then I think (laughs) Bloody hell. Cos that's what it feels like. Did feel like I'm punishing myself, just didn't know why.
- Counsellor: Sort of sabotaging yourself.
- Tony: Yeah 'tis, and that's what it feels like ..
- Counsellor: Just when I'm doing well, and I got to put a stop to that.
- Tony: ..Yeah, put a bomb under it. Self-destruction.'
- [Tony, session 34, 0:50:46].

Now Tony had assimilated an understanding of the self-punishing behaviour that had for so long been a feature of his life, and he could place this alongside the pieces of the puzzle which earlier had explained his suppressed anger, movingly revealed in the unrecognised grieving child he contacted in Session 24. The author and the iterative group rated the client as being well into APES 6 at this point.

There were three more sessions after this. Session 34 took place two weeks later. Tony said that he was doing well. He recalled the revelation of Session 33 and described it as "the final click". He had talked to his wife and his mum and concluded that had he not been coming to therapy, these discoveries "were never going to happen". He said he hadn't felt guilty or thought of himself as guilty but it was obviously "in the back there". Since Session 30 he had just been able to "[do] stuff" and was even confident enough to say that this didn't seem like a "false high". Since assimilating the meaning behind self-punishment, he had been able to engage in dialogue with his opposing voices.

“And there’s been little bits of moments when stuff I could feel a tiny bit coming on, ‘It’s you, feeling guilty about. Don’t feel guilty about that. Stop it!’ [Tony, session 34, 0:07:09].

He said it was not always as conscious as that and that “just knowing” that it had been found out, stops it happening. He said it felt like he had “all bases covered”. He summarised his new-found understanding.

“It’s only ever been me in the room, by myself, doing that to myself. [Tony, session 34, 0:07:54].

Tony was explicit that it did feel there was nothing left for us to do together. He said he felt so much calmer about doing things. He said that where there were little blips, and he got “a bit wobbly” he could now cope with it. Counsellor and client met 5 weeks later (Session 36) and the change was lasting. The final session was 7 weeks after this. Change had been maintained. Tony’s final words in the closing seconds of the last session were “Fantastic! Bloody fantastic!”

Sophie continued to work through her grief. At APES stage 3, she had identified three areas of work; adapting to raising her children on her own, making sense of her husband’s illness and death and developing helpful coping strategies. By the time her counselling had ended, Sophie was aware of the triggers to her low mood; usually the quietness of the house after the children had returned to the school on a Monday. This was made worse on the occasions when her daughter had been home from university for the weekend. She had restorative activities in place during the absence of her children, in particular swimming and yoga classes. At the end of her counselling she announced that she had joined the WAY Foundation²³ so as to make social contacts with other widows. It is also significant that she was far more accepting of the low points of her grief and she realised that change would be slow. Sophie’s penultimate session was the day after the second anniversary of David’s death. She reflected as on past occasions the build-up had been worse than the actual day. Although others in the family had been tearful she found that she was not, and worried that others might think she did not care. Six weeks later she met her counsellor for the final session. She described her mood as “A little bit up and down but not too bad.” [Sophie, session 44, 0:04:21]. She had reached the point of understanding that future change would be slow.

²³ The WAY Foundation is a British charity offering mutual support for spouses bereaved of a partner before reaching the age of 50. ‘WAY’ stands for ‘Widowed And Young’.

“I just feel like I’m in this (pause) plateau of nothingness really. And then sometimes I think I miss David *more* now than, (pause) obviously I miss him all the time but I feel like I’m missing him more now because I want to be able to do things, everyday things with him and things like that. It’s weird really, but I feel I’ve just got to get on with it, can’t do anything about it. [Sophie, session 44, 0:33:47].

However although her grief would continue, she now had an understanding of its nature and felt that she had the emotional resources to cope without further professional support.

APES Stage 7: Mastery

Stiles (1999, p. 11) describes APES stage 7 as ‘Mastery’. By this stage clients generalise solutions to the problematic experience and can apply the solution to new situations. Clients would be unlikely to reach this final stage within a typical timescale of receiving bereavement counselling. As has been shown, Sophie; who was still receiving counselling two years after the death of her husband, came nowhere close to mastery over her grief. Indeed some bereaved people may not reach this stage for many years, if ever. Examples would be people bereaved of a spouse (Parkes, 1998), and a parent’s grief for a child (Wilson, 2014, pp. 117-119). However, using Stiles’ (1999) original Stage 7 descriptors, we can extrapolate what APES 7 for grief resolution would look like. The bereaved person would be able to use the experience of grief and the strategies are acquired to better cope with future losses. The loss would become integrated into a past which could be talked about reflectively with minimal negative affect. Any search for meaning would cease; either because meaning has been found or because the person has accepted that no meaning can ever be found. A continuing bond with the deceased would be integrated into the life of the person and he or she would be open to new close relationships.

Could Tony be said to have reached stage 7? Inasmuch as he now recognised the origins of his destructive behaviour and had far more control over his mood, perhaps he had. However, what could not be known was how Tony would cope with future losses. If he was resilient in his grief this would be a test of his mastery. At the time his counselling finished, Tony’s mother, at this point in her ninth decade, was receiving palliative care for advanced cancer. It was very clear to Tony that he could return for further support at any time if he needed it.

Triangulation protocols

In Chapter 6, page 80 and in figure 6.2 the author described his intention to triangulate the data by inviting each client to read their completed case study to assess whether their view of the experience matched that of the author. As has been mentioned, only Sam agreed to be interviewed. A summary of this interview appears below, and the full transcript forms Appendix 6.

Tony declined an invitation to interview and another means of triangulation, involving an iterative process, was devised. This follows the summary of Sam's interview, below.

Sam's follow-up interview for triangulation

Sam met the author three years after her counselling had finished. A detailed record of the interview appears as Appendix 6. The session, which was digitally recorded, lasted an hour and was unstructured. Two themes emerged. The first was Sam's tendency to avoid her emotions by intellectualising situations. The second involved her struggle to accept her son's decision to have bariatric surgery for weight loss, knowing the high risks involved because of a pre-existing condition. The author took Sam through the case study page by page. Seven extracts were discussed. These extracts were chosen by Sam. Her reason for the choices was not discussed, but implicitly there was a sense that these were passages with emotional salience, and which reflected the significant moments in the counselling²⁴. Sam agreed that the case study formed an accurate record of events, although with the wisdom of hindsight she recognised that there were times during the counselling that she had not been entirely honest; either with herself or her counsellor. For example, she could now admit to feeling far angrier towards her son about his choices, than she was able to express three years earlier.

Sam was able to understand and explain her decision to end counselling at the height of her grief. The therapeutic relationship had opened cracks in her defences. While she did not want to end counselling, and valued the support it gave her, she said,

“To get any further in counselling, I would have had to unpick the rest of my life before [Mark's death] to find out how it was affecting me.” She did not feel that at the time this was necessary. “It was enough to grieve at the time without.”

She regarded the counselling that she had received as helpful in identifying strategies to cope with her grief, and she had successfully attained the goals she had set herself in

²⁴ Sam had recently completed a degree in counselling and had gone to some lengths to understand the APES scale.

adapting to the loss of her son. These included buying a car and revisiting places that held special memories; and which she had avoided following Mark's death.

Iterative protocols used in triangulating Tony's Case study

In reading the long case study of Tony, which included large sections of transcript, a pattern was noticed. Early in the work there were moments which Tony perceived as being dramatic and elucidating, but these were followed by long periods of little change. A pattern of sudden changes and plateaus emerged. Ten sound clips were chosen by the author because they were illustrative of this pattern of change. Each clip was supported by the following transcript extracts. The recordings were played to seven experienced²⁵ bereavement counsellors at Saint Catherine's Hospice Bereavement Support Service. Digital software was used to disguise Tony's voice to preserve his anonymity. Each clip was played alongside a transcript of the clip, set in context as it appears here. Each counsellor had a copy of the APES scale. After each clip a discussion followed to arrive at a consensus of where to score Tony on the scale at that point. Each member of the group rated the clip and gave his or her reasons, and from this a consensus was reached on which the group agreed. The author was careful to allow the group to reach their decision without revealing his own scoring of the sound clips.

Clip 1

Assessment session [0:04:36]

Tony said he had been prescribed antidepressants, but that he felt that:

"Instead of focusing on things, it allowed me to look away."

Although he believed, tablets had helped for a time,

"I know it's not the answer, look away".

The counsellor asked "Almost like avoiding?"

Tony replied, "Yes, almost like avoiding, but I could see it does help,

definitely, but it's not, it's not to say it masks it, it just it doesn't, I haven't got to the root of it, if you see what I mean".

Clip2

Session 2 [0:52:20]

Tony volunteered that counselling felt rather indulgent.

²⁵ Counsellors in this bereavement support service, most of whom are volunteers, are required to complete a 200 study hour module on bereavement theory and supportive skills before being inducted into the service. Each counsellor is expected to complete 20 continuous professional development hours annually, and training opportunities are provided in-house. All seven of the counsellors in this iterative exercise had followed this research project from the start. Each counsellor had at least five years of experience with the service.

“This process as well, sometimes I feel a bit silly, talking to someone, feeling indulgent doing this. I feel you know, you’ve got your life and your things and I know you’re doing a job and things and (sighs) but you just feel a bit, feel a bit silly, all ‘you look at me, I’ve got these problems, derrr! I don’t know (sighs twice through tears)

Clip3

Session 4 [0:04:40]

Tony reiterated that he just keeps coming back to ‘What’s the point?’ I asked the client if this was also related to the loss of his brother and father. He agreed it was and added,

“I want there to be a point. You know it’s like with the kids again it’s sort of (pause. There’s so much, you know they have so much joy in front of them, I think ‘so did I, I want them to have that and I want to join in with it’”.

Clip 4

Session 5 [0:07:27]

Tony said that between this session and the previous one he have been thinking about not wanting to tempt fate by being too happy.

“There is a bit of that of, ‘Oh God I don’t want to say it too loud if I’m happy’ because I’d feel like, ‘Jesus, you’ll really get it then, you know, when something really bad had happened’, know what I mean? I don’t wanna be (pause). And I know it doesn’t make any sense. There is a bit of that, (laughs) as illogical as it (pause). You know I don’t know.”

Clip 5

Session 9 [0:09:54]

The counsellor pointed out to Tony that it was not going to be a massive sudden change after 30 years that he alluded to the big breakthrough in an earlier session when for a moment:

“It all went (laughs), It really did! It sounds dramatic and a bit over the top but it just felt like ‘bloody hell’ It was such a moment, as much as it was good it sort of knocked me back because I felt like bloody hell I was going to get it and then it felt silly and stupid and it felt a long way away and cos I just, it snapped shut again and it was just like I don’t know (pause) and it’s learning to be patient I suppose.”

Clip 6**Session 10 [0:07:46]**

Tony arrived for the session in low mood; saying that even if he won the lottery, he could still imagine feeling, 'So what?' He shared passing suicidal thoughts.

"When I feel like this it's just there's nothing really. There's nothing (pause). If I get a (pause). Don't know (pause). Wave a magic wand. Not even sure but I feel like this, even if it suddenly won the bloody lottery took the family to go and see something, I could still imagine myself bloody stood there going (pause) 'God (pause) Well so what?' Oh God. Just a thing, a place (pause) Oh God, and all I could think to myself (sighs) I know (sighs) and it's not like there is a. (pause) Oh I don't know (sighs). I really was thinking the other day about (pause) Not massively seriously, but bloody thinking, 'God, I'll just do myself in', I just thought, 'bloody hell' and I thought (pause), or just walking off somewhere, just you know, really thinking about. 'How do I go about this?' I don't want to, and it's the crappiest thing in the world to do, for everybody and I just thought, 'God, just (pause) just so fed up of just being in this nothing bloody world of nothing, feeling nothing '. You can go round and you can pretend you can act like you're feeling something: say the right thing, do the right thing so people don't get on your back (pause). But it was (pause). Yes, haven't thought like that for a long time.

Clip 7**Session 11 [0:02:47]**

After a row with his wife which had upset his children, Tony resolved that he would talk to them. He said he sat them down and told them about the accident.

"So I sat them down I sort of went through it, like 'Our [name of brother] got killed in an accident', and dad and stuff and I sort of went through it with them, and how it affected me, or *is* affecting me, and 'your daddy sort of, you know it seems to something still going wrong and I said I was coming to see you and we're trying to do something about it."

I asked the client if this was the first thing they knew about the counselling. He said it was but that it is coming to the point that he wanted to tell them. He felt that the effect he was having on the children was bothering him as

much as his behaviour related to the accident, so he wanted to explain to the children why he was like he was and why mummy and daddy argued:

[0:04:0] "So I explained, 'And that's why your mummy gets frustrated and I get frustrated 'cos I'm not helping her enough and then this and that (pause). But I just went through it and said to them how much a (pause) um (pauses and sighs, becoming emotional) 'bloody hell (pause) um (pause) That the, about (sighs twice) That (pause) that I'm upset that my dad can't (pause) and my brother can't meet them (pause) (now in tears), and they can't meet them and how much (pause) joy they would have had from my dad and Our [name of brother] but like me dad, he would have had the (pause) He's just bang up their street both ways with like being able to go and do things and build things and, and it just, and it would have just been you know, so nice um. And saying that to them and just, and crying a bit, and I haven't bloody cried for ages and er it was very sort of cathartic it was all sorts and I (pause) That was the day after I'd been upset the night before and that day leading up to that I'd sort of (pause) I'd sort of gone 'right' I'd sort of got control a bit, I felt like I'd got control a bit, and thought, 'Right I'm. (pause) right I'm going to do that, I'm going to talk to the lads' and I felt a bit happier about just come into that decision and you don't (pause), you don't know what's cocking you up don't you? These (pause). You don't (pause). It's not particularly a secret, but it was just I don't know (pause). It didn't seem a resolution to (pause) I don't know but by coming to that conclusion, 'Right that's what we're going to do', that's what I did and (pause). And I asked them how they were and if they wanted to say anything and you know, talk to grandma or mummy or me and you know um (pause) but they were pretty good and we had a bit of a cry together."

Clip 8

Session 23 [0:41:0]

Tony began to talk about the idea of letting go of his brother.

"Maybe that's why I get a bit mad with family and stuff like that, because I've had to let him (pause) I had to let him go. Because them conscious thoughts are not what they were. And there's maybe a bit of resentment towards people. There's this loyalty whatever to people, friends and family and people like just can't piss me off enough for me to abandon them, just can't. Maybe

that's it maybe that's some of it, that, that thread though's got thinner, further away. And every now and again I see it, and it's happened because I have got a family, a little bit that's (pause). And I don't think of him as much and I don't hold that same thoughts and beliefs or something."

The counsellor asked, "So the thread connecting you to (brother) gets thinner?"

Tony replied, "Thinner and further away, maybe yes. Like I say because I've got my children probably subconsciously that's it. Maybe as much as that's what I want, I resent them in the fact that they obviously there's something (client breaks down in sobs) upsetting me (sobs and sighs). Oh God!"

Clip 9

Session 27 [0:16:30]

This session was characterised by the exploration of 'letting go', and at the same time facing up to reality. Tony said,

"That tiny thought of like our (brother) is alive somewhere. You sort of knew it wasn't but it was there and that germ of it to accept that that is going to happen and that isn't going to happen, these finites, these definites, as opposed to always thinking, "Well it could." And realising that "No, the things of what's happened, that *is your life*. It isn't going to be another life where you get it better, that *is your life* and that's how it's been, and it's, you've got to accept. You sort of knew it before, but you didn't, don't know. It's that tiny subtlety of them little grains what are, from a different brain if you like, which are still holding true in your (pause) affects your other thoughts; how you look at things um. I suppose it comes to that thing of (pause) that tiny bit of that growing up (pause). Cos there's a lot of that isn't there? There's a lot of that being trapped with so many of that little lad's thoughts."

Tony said that he was approaching problems differently; less pessimistically. He said he was beginning to look into the future. He remained confused about how to recognise redundant ways of doing things, but things were different, were changing.

Clip 10

Session 34 [0:03:42]

The counsellor asked Tony how he was feeling. He replied,

“I’ll tell you what I’m doing, I’m doing all right. I am doing bloody (pause). Tell you what, after that last thing it didn’t half feel like a bloody er. It felt like the final click for me. All the stuff we’ve been doing, it was all good, all that was right, but in a way that, and it’s, but that, so glad that that happened, because. And at the time it sort of depressed to be in the (pause). Well it didn’t really depr (pause). I sort of got in and got out of it quick (pause). But put it behind me which was all good, you know, I couldn’t even bloody remember it really, it was all good but it was still that bloody thing, that the damn thing had happened, and you think, ‘God’ It was all that was until it? When I was here before and it’s like, ‘Do I have to put up (pause). Is this it?’ And then that (pause) there was that (pause) there’s been so many little moments. Moments of revelation and, er, um, enlightenment to things, but that, I think that was the one last thing, and quite a big background running thing.

The result of the iterative exercise is as follows (Table 7.1). The Intraclass Correlation Coefficient (ICC) (McGraw & Wong, 1996) was calculated using SPSS Software (IBM Corporation) (See also, p. 186).

Session	Group consensus	Author
Assessment	APES 2.5	APES 3.0
Session 2	APES 2.0	APES 3.0
Session 4	APES 3.0	APES 3.5
Session 5	APES 3.7	APES 4.0
Session 9	APES 4.0	APES 4.5
Session 10	APES 4.0	APES 4.5
Session 11	APES 4.5	APES 4.5
Session 23	APES 5.7	APES 6.5
Session 24	APES 5.9	APES 6.7
Session 34	APES 6.7	APES 7.0

Intraclass Correlation Coefficient

	Intraclass Correlation	95% Confidence Interval	
		Lower Bound	Upper Bound
Single Measures	.927	.749	.981
Average Measures	.962	.856	.990

Table 7.1 Tony’s APES scores determined by a consensus of 8 raters

It can be seen that there was broad agreement between the author's scores and those determined by the iterative protocol of the seven colleagues: ICC = .962. The author had tended to be slightly more optimistic in scoring these ten clips, but the excellent reliability compared with the iterative group consensus provided the confidence for the author to score the rest of Tony's moments of assimilation.

Building confidence in a theory of grief resolution through assimilation

Pages 94 to 120 have examined and compared the case studies of Tony, Sam, Amanda, Jacqui and Sophie. Each successive case contributes to building a theory of grief resolution. To recap, the theory is that since the state of psychological confusion which follows a loss exacerbates grief, the process of assimilation and accommodation during and between counselling sessions allows the grieving client to make sense of his or her world which in turn reduces negative affect.

Each of the five case studies has its own unique aspect. Tony's story was one of chronic grief unrecognised for many years. The chosen focus of his therapeutic work; to uncover the cause of his depression and irritability, had a successful outcome which may be more easily charted using Stiles' original scale than a version of APES adapted for grief work. Nevertheless, amongst the complexity of this case was a need to accept the reality of his brother's death, make sense of the events surrounding the fatal crash and revisit his childhood response to the loss of a brother. Sam's progress can also be matched with the original APES sequence (Stiles, 1999), since evidence suggested that although she was approaching APES 6 at the elected conclusion of her counselling, she was only just beginning a healthy process of grieving, which she recognised could be a long process. In her journey from APES 0 to APES 5.7 over the course of ten counselling sessions, Sam stopped dissociating from the reality of her loss, and could begin to memorialise her son's life. With this came the ability to oscillate between loss and restoration orientation (Stroebe & Schut, 1999). Once she was able to accept the reality of the loss she could begin to make sense of her son's death. Sam had assimilated the construct that Mark had been unhappy living with his disability and the surgery was a way out. It appeared from what he had written that he understood the risk he was taking in seeking a gastric bypass. Sam also understood that had he survived the second stroke he would have suffered even greater disability. In comparison with Tony and to some extent Sam, Amanda presented for counselling with issues solely focused on her grandfather's death. In the course of her nine sessions she accepted the reality of events and made sense of the death. She had also begun to find ways of fostering a continuing bond (Klass, 2006; Klass et al., 1996) with her grandfather which did not involve ruminating on painful memories. Jacqui's appearance in the counselling room was prompted by the concerns of others. On the APES scale Jacqui was

no longer able to ward off her grief; something she had been attempting with the use of alcohol. She was able to acquire some, albeit limited, insight into her grief and develop a symbolic continuing relationship with father. However, she chose to end counselling at APES 4 without working through either her grief or her problematic relationship with alcohol.

Of the five case studies, only Sophie's story unambiguously follows a classic, stereotypical grief trajectory (Bonanno et al., 2008). After an initial period of numbness, a prolonged period of grieving began. Over the course of two years she learnt to accept the reality of her husband's death and even find some meaning in its sudden nature; which although it was traumatic for the family, it was in her view preferable to a long lingering and possibly painful end to David's life. Her relationship with David continued through the children they had borne together and through shared family memories. She was beginning to build a new life for herself and establish an identity in a world without her husband present. A trajectory such as this is familiar territory to the researcher in his work with many other clients outside of this project. It has similarities with the findings of Marris (1958) and Parkes (1970, 1972) and to the current theories and models discussed in the literature review (Chapter 4); notably Stroebe and Schut (1999), Attig (2001, 2004, 2011), Klass et al (1996), and Neimeyer (2006c, 2001b). It is important to recognise that Sophie's grief did not end with the cessation of her counselling. Sophie recognised that adapting to losing a partner involves an acceptance that the sadness of grief is enduring and that its painful aspects will at times continue to surface for many years; perhaps for life.

At this point we can reach a tentative conclusion that there is validity in a theory that grief involves a process of assimilation and accommodation towards the construction of new meaning. Each of the five case studies supports a small incremental confidence in the theory. The case studies also contribute to modification and development of the APES for grief scale originally proposed by Wilson (2011). This is pursued in Chapter 8.

The remaining five case studies

Five more clients were assessed. Of these five, Ted and Fiona felt that no further support was needed following the assessment session, a decision which is explored in the next paragraph. Due to an administrative decision made within the bereavement service (see page 92) three were not counselled by the author. Caitlin, Sue and Maureen were allocated to other counsellors. However, the assessment sessions were recorded and transcribed and assimilation analysis (Honos-Webb et al., 2003; Honos-Webb et al., 2006; Varvin & Stiles, 1999) was carried out on all five transcripts.

Clients who elect not to receive counselling

Of any set of clients referred for bereavement counselling by health professionals, there will be a subset of potential clients who elect not to attend. There is another subset of those who do present, but only for the initial assessment session. Of these subsets it is entirely possible that some individuals are warding off their grief. Indeed it is the experience of the researcher that some clients who do not initially take up the offer of bereavement counselling will sometimes do so at a later date. However, it is also recognised that most bereaved people make a satisfactory adjustment without the need for professional intervention (Bonanno, 2004; Ott, 2003; Silverman et al., 2000). Might it be that in their period of adjustment to loss, some individuals have the resilience to move autonomously through the sequence described in table 5.1 (page 72). It may be possible to go some way to answering this question through an assimilation analysis (Honos-Webb et al., 2003; Honos-Webb et al., 2006; Varvin & Stiles, 1999) of clients who found the initial assessment session sufficient to meet their needs. Two such clients, Ted and Fiona, are considered.

Ted and Fiona

Ted, a retired police officer aged 72 had been bereaved of both of his adult children. Three years earlier Ted's daughter had died after a "brave fight" with cancer. Three months before Ted presented for assessment, his son Jimmy had hanged himself following the breakup of his marriage. Fiona, aged 74 had been bereaved of her husband Charles following a cancer diagnosis 14 months earlier. Both clients had been referred for counselling by their doctors. It was nine weeks since Fiona's husband had died.

In spite of different relationships to the deceased and very different circumstances, Ted and Fiona had much in common in the way that they had responded to their loss. Both were able to make sense of the deaths. They told their stories clearly and concisely. There was little if any confusion over the events leading up to the loss. Ted related that at the inquest he discovered that Jimmy had been receiving professional psychological support where he had disclosed suicide ideation, including his plan. After Jimmy's wife had ended the marriage, she had agreed to accompany Jimmy to a long-standing wedding invitation.

"He and his wife went to a wedding of a mutual friend some distance away and we knew that he was hoping for a reconciliation. In fact he came to see us the weekend before and was his usual self. We never suspected that he had any mental problem."
[Ted, assessment, 0:01:25].

Ted believed that discovering that there was no chance of getting back together precipitated the suicide.

“All he wanted was for her to go back and live with him, and she, ‘No. I’m (pause) it’s over, I can’t deal with this.’ So we have no idea what was going on in the house. That’s normal. Yes it was a complete mystery to us.” [Ted, assessment, 0:09:23].

Ted could now make sense of the nature of Jimmy’s death. He said that he had professional experience of attending suicide scenes and after a conversation with the coroner’s officer he had concluded to his satisfaction that Jimmy’s actions had been deliberate.

“I was in the police force and I’ve dealt with a hanging. I’ve dealt with sudden deaths but you’re on a different side of the story when it’s your family.” [Ted, assessment, 0:11:53]

“Another thing that came out of the inquest was that he’d hung himself but when the policeman found him his feet were on the floor, and they wanted to make sure that he intended killing himself as opposed to an accident, when he said he’d tried it on before. And anyway I queried that and the coroner said ‘Oh it’s quite normal’. He said ‘I would think it’s probably a safety’ (pause), the fact that he could touch the floor, if he decided half way through the procedure and he didn’t want to die, he could release himself. But I can remember finding a man hanging and he was way up in the air. I never realised what was going on now but the coroner said this was happening quite regularly.” [Ted, assessment, 0:17:02].

Fiona said that it had helped her to have a medic in the family, which had helped her understand her husband’s diagnosis and prognosis.

“I sort of knew that it would be nasty and my son is a surgeon so he was quite concerned, so obviously we went through that and the diagnosis right from the start wasn’t particularly good. They put him on a drug tested for a tumour and thought that it might work and for a while it did, but um (pause) so I suppose we lived with it really.” [Fiona, assessment, 0:04:00].

Fiona appeared to be comfortable with Charles' apparent choice to die without her being present, in that she could calmly tell the story.

"I went into the hospital. My oldest son was there and one of the home nurses who had popped in to see him. And he even took my newspaper that morning. I'd stayed all night. About eleven o'clock I said I would go home to have a bath. We're 40 minutes from the hospital. Somehow when I got home I had the bath but I couldn't relax. I went straight back and when I went into his room, I don't know if he was alive or not; his eyes were sort of fixed on the window and this had happened from the nurse checking on him to /// and I called my son and he put his hand to his mouth and said 'he's died'. So I wasn't (pause) but when I left him he gave me a kiss. To say he looked at the paper which is very strange isn't it?" [Fiona, assessment, 0:15:09]

It is important to recognise the emotional pain that these two clients had felt immediately after the loss. Fiona said "I cried a lot before he died so I've certainly cried a lot since". [Fiona, assessment, 0:03:25].

She asked the counsellor, "Do you get a lot of us older people who are really broken hearted?" [Fiona, assessment, 0:05:10].

Ted reported,

I found that I was crying and crying and crying and crying until I was actually, on one or two occasions I almost passed out. [Ted, assessment. 0:06:24].

Both continued to experience the pain, could describe the nature of their grief and to some extent were already accepting of how they felt. Fiona reported,

I think I'm scared. Well there's personal (pause) self-pity, I don't know if that's the right word, but sort of (whispers /) and I don't suppose I have any real reason to be scared but I just miss him, and there's no cure for that really. [Fiona, assessment, 06:34].

Ted said,

Early hours of the morning you wake up and immediately straight into thinking about Jimmy, 'cos I don't sleep very well now. But I've accepted that and it's decreasing as the time (pause) I'll tell you what, you have a funny feeling sometimes, that it isn't real. It's just all a horror (pause), it's a dream and he'll walk round the corner in a minute. [Ted, assessment, 0:20:04].

Both Ted and Fiona's coping strategies included emotional avoidance. For a time, Ted avoided going to his chapel.

I cry at hymns. Hymns make me cry (pause) or poetry. It's touchy for it. You can't say when it's going to happen. There was a time when I thought 'I can't go to Sunday chapel, I'll cry. And when I start singing hymns I'll cry'. But it's subsided now. [Ted, assessment, 0:35:55].

Fiona was avoiding playing the jazz that her husband had played at home.

When I'm out of the house I'm probably better at my daughter in-laws, I probably am. But then I think 'I should be back (home). It's when I open the door. It's all quiet. He used to play his music a lot. I think 'You play it', but I don't want to play his music. I'm being very difficult I know. [Fiona, assessment, 0:27:07].

Later in the session, she talked about avoiding photographs of Charles "I can't look at photographs, no" [Fiona, assessment, 0:31:44].

Both had other coping strategies. Ted said that he had played golf twice in the past week.

Ted: I've had two games of golf, and it's quite right, if you can keep talking to people, keep in company, and (pause) on the whole I find that they all know what we are going through.

Counsellor: You feel they are supportive?

Ted: Oh without a doubt.

[Ted, assessment, 0:23:20].

He reflected how grateful he was that his wife had cultured and maintained friendships which had now become so valuable.

The counsellor asked Fiona how she had coped with her loss immediately afterwards.

I just did it. My son came over from Italy, and um the whole family came round. Things just went from (sentence tails off). [Fiona, assessment, 0:18:37].

She described planning the funeral and described how well it had gone. However, the worst time followed, and she had made an appointment with her doctor who had prescribed antidepressants. Since then she had found it helpful to avoid being at home,

I've sort of gone at the house for a walk /// so that happens quite a lot. [Fiona, assessment, 0:22:12].

She was also spending time with her daughter-in-law, because her son was currently working away from home. "I sleep better when I'm there" [0:23:01]. She valued her "super neighbours" [0:24:02]

They're all elderly, and they obviously have problems of their own but they're a real go-getting lot and we've always done things since we moved there six years ago, and Charles and I had talked out this bit, but I don't want to do it at the moment, that's the problem. [Fiona, assessment, 0:24:10].

Fiona wanted to know if her behaviour was normal and the counsellor was able to reassure her that had witnessed this pattern many times.

My friend said yesterday, 'Let's just go out for a coffee', and you know, years gone by I'd have been in the car, and the inclination's not there to do anything. [Fiona, assessment, 0:24:51].

In spite of these difficulties, she found it helpful to spend time in the company of family and friends; including a friendship group, she had joined where people "took me under their wing" [Fiona, assessment, 0:37:39].

Ted had found meaning in his daughter's death three years earlier, and drew comparisons with the more recent loss of Jimmy.

At the end of the day you're relieved. You *know* it's going to happen. She was gradually getting worse; weaker and you know that one day (pause) It was Sunday morning when she passed away and this with Jimmy is just (pause) well just out of the blue. [Ted, assessment, 0:14:35].

Fiona found a tenuous meaning in her husband's death.

Do you know what helps? And it's an awful thing to say but it helps but Charles used to nearly always come to the supermarket with two trolleys. I fought against going but I was running out of freezer because I'm not eating very well. But I made myself go the other day and it was full of the elderly and there was a lot of people where there was no one obviously in charge and you know, they were frail and I thought 'Well I don't have to go through that again'²⁶. [Fiona, assessment, 0:44:31].

Ted appeared to be helped by a belief in an afterlife.

Ted: It would be nice when we meet up again

Counsellor: To tell him off

Ted: To tell him off. 'Hey what were you doing all those years ago, leaving us?

[Ted, assessment, 0:37:02].

Both clients had managed to find meaning in their post-bereavement life: Ted as a husband and Fiona as a mother and grandmother, although she had briefly lost interest in life, even briefly contemplating suicide. Yet she reflected, "But you can't switch off. You have to go on, and my father would say 'Wait until you are called.'" [Fiona, assessment, 0:44:04].

Both had an awareness of their own resilience. Ted was able to say "I've dealt with things, mishaps, and I'm not one to panic." [Ted, assessment, 0:30:00]. Fiona recognised her resilience although for now she suggested that it temporarily eluded her, "I was a very well-regulated person, I've been told by one of my friends that [Fiona, assessment, 0:18:55].

However later in the session she said that her adult life had "always been an up and down

²⁶ The author is unclear about the significance to the client of the 'two trolleys'. It seems likely that this was simply a memory of how they shopped together, although maybe the trolley served as a walking aid for her increasingly frail husband. The significant construct in this sentence is no longer having to support this frailty.

person” following post-natal depression and again after her husband had a stroke. [Fiona, assessment, 0:28:38].

Ted and Fiona: summary and conclusions

In spite of the emotional pain that Ted and Fiona were experiencing, each was on a grief trajectory that would progress through the APES stages without professional intervention. In fact both clients had already moved some way through the APES sequence, and from assimilation analysis (Honos-Webb et al., 2003; Honos-Webb et al., 2006; Varvin & Stiles, 1999) of the transcripts, it was possible for the author to arrive at a score for each of them. They were both able to tell their story in an unhurried, temporal sequence, in a way that made sense to them. As distressing as it was for him to hear it, Ted had been helped by what was revealed that the inquest, including the circumstances leading to Jimmy’s suicide. Helped by her son’s professional knowledge, Fiona understood the prognosis of her husband’s condition. Whilst both clients expressed some regret in relation to the circumstances of their bereavement, neither Ted nor Fiona exhibited any guilt, remorse or other unfinished business. Both clients were able to get some respite from their grief. One way was to avoid triggers to a grief response; in Ted’s case, hymns at chapel, and for Fiona, not playing her husband’s music nor looking at photographs of him. Both clients had begun to be more accepting of their grief, recognising early signs of it becoming easier to manage. By spending time with friends and family each of them was learning to oscillate between grief and restorative day-to-day activities. Although both were at an early stage of learning to live without the deceased, Fiona was beginning to see the possibilities of a life without a frail partner. Ted knew that life had continued after his daughter’s death, and he valued time spent with his wife. In APES terms, it appeared to some extent, that Ted had attained some degree of mastery (Stiles, 1999) over the grief for his daughter and was using this as a resource for coping with his current loss, with the mutual support of his wife.

As bereaved clients move successfully through APES, there are moments of revisiting earlier stages. Like Sophie, who even after 18 months could hear a car outside and think her husband had come home, Ted recounted moments of thinking that Jimmy still might return. Experience has taught the author that such thoughts are common in the early stages of grief. In time they happen less often and in Sophie’s words they become a “fleeting second” [Sophie, session 41 0:49:00]. Likewise the community of voices which come together at APES 4 will still on occasions appear in opposition. For example, during the assessment Fiona criticised herself for “being very difficult” [0:27:07]. In contrast, she reported that having briefly flirted with suicide ideation, opposing voices had come together in encouraging her to go on [0:44:04]. Overall, both Ted and Fiona were assessed by the researcher as being at APES 3,

possibly with some of the understanding and insight which characterises APES 4. The counsellor supported the clients' respective decisions not to receive counselling, and concluded that each of them had the resilience and personal resources to successfully work through their grief without any professional intervention. The retrospective assimilation analysis (Honos-Webb et al., 2003; Honos-Webb et al., 2006; Varvin & Stiles, 1999) of the transcripts supports this view. From an APES perspective, these two case studies suggest that in the absence of other complicating factors, once a resilient client can state his/her problem with clarity they can, with understanding and insight, manage their grief without professional intervention.

Case studies in which the grief may have additional complicating factors

Although bereavement from a sudden unexpected death is a potential risk factor for complicated grief, and the death of a child is a confirmed risk factor (Burke & Neimeyer, 2013), neither of these appear to complicate Ted's grief to the extent that he needed ongoing professional help. Spousal bereavement is also a confirmed complicating factor (ibid), yet Fiona's grief did not appear to be complicated beyond her own managing strategies. However, evidence suggests that concurrent problematic experiences alongside the grief can be complicating factors. For example, in spite of being bereaved of her husband, Sophie's grief appeared to be normal in the circumstances but complicated by the reality of bringing up three children without her partner. What of those clients who are generally resilient but whose bereavement is accompanied by other stressful situations? Sometimes a situation, not directly related to the bereavement, tips a client over the limit of their resilience. In an audit conducted by the researcher of bereaved clients on a waiting list for counselling (n=58), 57% (33/58) had concurrent situations which were complicating their grief, including two or more bereavements close together, family disputes, financial difficulties, other losses, long term depression and lifestyles that involved substance abuse, including alcohol use. Of the remaining 43% (25/58), all but two clients presented with at least one complicating issue. Examples included: trying to find existential meaning, both in the nature of the death and the circumstances leading up to it; perceived deterioration of physical and/or mental health following the bereavement; and the use of alcohol in order to cope. Two clients were re-referrals from previously unresolved losses.

If a theory of grief adaptation through assimilation and accommodation holds true, one can predict that resilient clients who present at APES 3 (Problem statement) or APES 4 (Understanding/insight), but who, unlike Ted and Fiona, have concurrent life stressors, could find professional support helpful until they have acquired sufficient insight into their situation to then self-manage their grief and concomitant stress. Likewise, clients nursing feelings such

as regret and injustice may benefit from the opportunity to find meaning in what has happened. Naturally resilient clients in either or both of these categories may only need a brief intervention. Two clients, Caitlin and Sue had bereavements compounded by many factors.

Caitlin and Sue

Caitlin presented for counselling assessment five months after the death of her mother from dementia following a stroke. Caitlin had been having palpitations, breathlessness and overwhelming feelings of panic. Her doctor had diagnosed panic attacks, anxiety and depression. Sue's assessment session took place five months after her husband Gary's death. She had been referred for counselling by Gary's Macmillan nurse, who suspected that Sue was bottling up her grief, and she began to cry as soon as the assessment began. Gary had a protracted battle with cancer but then died so suddenly and unexpectedly that police officers became involved.

Both Caitlin and Sue had difficult life histories. Caitlin's father had been physically and psychologically abusive to his wife and three daughters. She acknowledged his abuse as a mental illness akin to the behaviour of the husband in the film "Sleeping with the Enemy" (Ruben, 1991). Caitlin described as a young child being awoken and dragged out of bed by her ear to be shown by her father that she had replaced a toilet roll in its holder incorrectly. Sue had married Gary in 1996 but had previously been in an abusive marriage for twenty five years. When Gary became ill, Sue was already caring for her mother who died with dementia. She recognised how difficult her life had been.

I said to my son last night, 'The only thing that has not happened in my life is somebody's been murdered'. [Sue, assessment, 0:24:14]

Each client had complex stories to tell of the events leading up to the deaths. Caitlin's mother had waited until her daughters had grown up before she chose to leave her violent husband. Not long after this her daughters began to notice that she would forget things and they shared in her care for about fourteen years. When her mother finally had to go into residential care Caitlin, her husband and her children moved from the South of England to be nearby. Establishing decent care had been difficult. Caitlin felt that the social worker who dealt with her mum's case had been "unfeeling and horrific" [0:08:10]. Initially, her mother had been placed in a care home where she had been attacked by a resident and had broken her hip which failed to heal. Caitlin had experienced panic attacks at the sound of an ambulance following what she viewed as mother's poor hospital care. This included insensitive ambulance staff and hearing the terrified screams after a radiographer refused to let her stay

with her mother during an x-ray procedure. Caitlin's situation had not been helped by an early miscarriage shortly after her mother's death.

"It didn't help. When we found out that I was pregnant it was a really nice positive focus for the future. So I think that was a massive setback. It was very early and I'm actually okay with it. I trust nature and I just think it was not viable and I'm cool with that. I've got three very healthy children. So I wouldn't say was devastated by it, I just think it happened at a really bad time in that it was a nice positive focus and think that bears on my mind. I'm thinking 'That was in our plans', you know, around this time. We always said we would have four. It plays on my mind that time is ticking on. I'm thirty eight. It's just adds to the mix." [Caitlin, assessment, 0:27:00]

Gary's illness had spanned almost four years. Sue recalled Gary crying at the diagnosis. After a risky but successful operation Gary had received no chemotherapy. When the cancer reappeared Gary was put on steroids while they had a "lovely holiday" [Sue, assessment, 0:12:20]. On their return Gary began a course of chemotherapy which made him very ill. The chemotherapy continued at least twice weekly up until Gary's death and it continued to make him very ill; something Sue very much regretted.

Sue: If he could have had a break, he just could have time to himself. He said 'No no, they want me to have the treatment'. He was due to have the treatment on the Tuesday but he was too ill. And then he died on the Friday. I just feel there's a time where, (sobs) he could have been happy.

Counsellor: Time that was taken away from you

Sue: Yes. He could have been happy, if only for a month if he didn't have his last treatment. [Sue, assessment, 0:13:55].

Caitlin talked very little about the day of her mother's death in the care home, as it had been expected and was peaceful. Neither Caitlin nor her three sisters had any regrets about their mother's welfare once they had found quality care for her. They worked together in planning the funeral within four days of her death. The funeral had been very difficult for the sisters and Caitlin suspected that this was a culmination of so many difficult years caring for their mother. She and her sisters had taken a month off work and had cared for each other. In

contrast, Sue talked at great length about Gary's death. She described trying to give him cardiopulmonary resuscitation until paramedics arrived.

"I was trying to give him CPR on his recliner. When the paramedic arrived I said, 'I can't get him on the floor!' I was absolutely panic stricken. He couldn't either until the two ambulance men arrived. Three of them got him on the floor. And it was such an impossible situation. I couldn't do anything. I was shouting, 'Gary don't do this to me!' I was really getting cross. Never did I think he wouldn't start breathing again, I just thought he was choking." [Sue, assessment, 0:35:00].

Both clients were able to state the nature of their problematic experiences clearly. Sue expressed her regrets about Gary's treatment.

Sue: He had an operation and they said they had taken it all away. They said there was a 75% chance of it not coming back so they thought he wouldn't have to have chemo. So he didn't have chemo and he went back for his yearly check-up and they said it had gone to his liver.

Counsellor: How did you two as a couple deal with it?

Sue: I was a little bit matter of fact to be honest. I was a bit annoyed that he did not have the chemo [Sue, assessment, 0:10:05].

She talked about Gary's reluctance to ask questions about his prognosis during his course of chemotherapy.

Sue: He still wouldn't ask the question [Sue, assessment, 0:13:26].

Sue: And he wouldn't ask *that* question. And he asked the Macmillan nurse once because I kind of twisted his arm. She said she would answer it but she didn't come back to us. [Sue, assessment, 0:33:32].

Sue talked about her anger.

Sue: I was angry at my ex-husband; at what happened, but I'm more angry that Gary died.

Counsellor: Are you angry with Gary for leaving you?

- Sue: No because he'd never have done it. I know I can't do anything about it.
- Counsellor: Angry with yourself; that you could have done better?
- Sue: Oh yes, I should have rung on the Thursday not the Friday (cries) I said that to the ambulance man 'I should have rang yesterday I got the ambulance'. He said, 'if you'd have thought you needed to you would have done.' [Sue, assessment, 0:27:0].

Caitlin was very aware of potential stressors caused by juggling self-employment with family responsibilities. However she did have self-care strategies.

"I'm self-employed so I work from home. I can juggle that it's not a problem. Sometimes I sit at my desk and I think 'I can't do this' and I just stop and watch TV. We were doing too many school clubs and we've given some up. I do feel a bit guilty about that, but they're young and it's fine." [Caitlin, assessment, 0:15:00].

She also acknowledged her traumatisation as a result of those times when her mother received poor care. She summed up her stress by saying,

"There's just too many things going on, like just overwhelming it (pause). I want it to stop. All I would like to do, and I say this to my confidants, is to go to a hotel room on my own, and just lock the door and be alone. [Caitlin, assessment, 0:24:42]."

Both clients were aware of their resilience, even though it had been sorely tested.

Caitlin: We are super strong. Mum made us [Caitlin, assessment, 0:02:34].

Sue: Normally I'm quite a strong person [Sue, assessment, 0:27:14].

Both were aware of their effective coping strategies. Caitlin described how supportive her husband was being. Friends gave her permission to be tearful, even though they did not know what to say. She had also resumed exercising by running. Having children kept her busy, and when with them she described herself as "like a machine" [Caitlin, assessment, 0:15:02]: the children did not see her upset. Sue described the support she received from her daughter-

in-law, who cajoled her into going out and doing things. Most of all she appreciated the value of her dog.

I talk to the dog more than I talk to him (Gary). I talk to the dog *about* him. And if I cry she comes up and licks my face, which gets me out of it quite quickly. [Sue, assessment, 0:47:56].

Both were aware that there were sometimes elements of avoidance in their coping strategies which were not always helpful.

Caitlin: I think I can just keep going, but I think that's probably to my detriment. [Caitlin, assessment, 0:15:11]

Sue: I don't face it in front of people. I cry on my own. [Sue, assessment, 0:42:26]

Both clients reported a pervading sense of the unfairness of life in general. Caitlin expressed regret for her mother; that having endured an abusive marriage for so many years, the time spent finally free of her husband had been blighted by dementia. Sue felt a sense of unfairness for herself; that having found happiness in her second marriage it should end like this "We had everything and it just got taken away (cries) and I feel so cross" [Sue, assessment, 0:07:00]. This sense of unfairness was compounded by a belief that her husband's chemotherapy took away her husband's quality of life in his final weeks.

Assessment outcomes

When asked if she wanted ongoing support, Sue expressed an initial reluctance. "I don't know if there's anything that can help me really. I think I've got to get through it myself" [Sue, assessment, 0:49:09]. The assessing counsellor suggested that counselling might be a good place to make sense of her complex issues. Sue said that her son was urging her to have counselling because it had helped him in the past. She agreed to have counselling "if you think it will do me good" [Sue, assessment, 1:00:47]. She met with a different counsellor five weeks later. In her first session she said that she had been coping better after the assessment, although she was still angry over her husband's end of life care, in particular the timing of his chemotherapy. Because her daughter-in-law was being so supportive she did not feel that she needed further counselling. Her counsellor contacted her after two weeks to check that this had

been the right decision. Sue confirmed that she was managing without support and that she would contact the bereavement service should she need further help.

Caitlin agreed to counselling and was very clear what she wanted from it.

“I just want to stop reliving and thinking about things. Let the past be the past and just come to terms with it and be fine.” [Caitlin, assessment, 0:39:23].

She also expressed her optimism.

“I know that I’ll be okay. I can’t imagine that I’ll like lose it.” [Caitlin, assessment, 0:43:09].

It was 13 weeks before Caitlin’s counselling began and she had five sessions spread over nine weeks. In her first session she reported feeling out of control and tearful much of the time. The next time she was seen by her counsellor she had been on a three weeks holiday where she had felt very “fragile”. At her third session, two weeks later she announced that she was pregnant. Although her husband had been working away, she valued her support network. Two weeks later in her fourth session, Caitlin said that she had employed an au pair to relieve the domestic pressure and felt better as a result. In the fifth and final session her counsellor reported that she looked really well and it was mutually agreed to end her counselling.

Caitlin and Sue: summary and conclusions

Neither client had any difficulty in telling their story in detail, although for both, the events were painful to relate. Caitlin talked about feeling “overwhelmed” [Caitlin, assessment, 0:17:50] whilst recognising her need to be in control. She was not tearful during the assessment whereas Sue cried many times. In contrast to Caitlin’s coherent account, Sue moved around events and emotions and the timeline of her story was out of temporal sequence.

Each client had clearly assimilated the nature of their processes in the face of grief. They both regarded themselves as “strong” which they credited to surviving difficult lives. Strength however, is not necessarily resilience, defined as the ability of a material ‘to absorb strain energy without fracturing’ (Atkins & Escudier, 2013, p. 391). A strong material such as cast iron can be fractured by stress; a helpful simile from materials science to illustrate the effects of stress on human well-being. Resilience on the other hand, is used in the physical and human sciences to describe bouncing back from stressors without permanent damage. Although it may be possible to glean some sense of Caitlin and Sue’s respective mental constructs of “strong” from the transcripts, the case studies would have benefited from a

counselling exploration of how each client regards the nature of emotional strength. Caitlin expressed her optimism when she said that she knew she would be “okay” in time. Optimism is a recognised characteristic of resilient people (Cooper et al., 2013 pp. 102-106) yet Caitlin’s choice to “keep going” to her admitted “detriment”, suggested a stoicism that was not always helpful. It did seem however, that she had the potential to be resilient. Sue on the other hand, talked of keeping busy to avoid her grief and of hiding her grief from family members. When asked by her counsellor if this amounted to “bottling up” her grief she agreed. Through tears, towards the end of the assessment, Sue said “I can’t look forward” [Sue, assessment, 0:52:26]. This contrasted with Caitlin’s positive outlook.

The presentation of these two clients brings into question the nature of ‘warded off’: stage 0 on the APES scale (Stiles, 2001). Although both clients were sometimes avoiding their grief, they were not dissociated from it, in the form of narrative dissociation described by Currier and Neimeyer (2007, p. 94). Like Ted and Fiona, they were each able to use avoidance as part of an oscillation between grief orientation and restoration (Stroebe & Schut, 1999). This recognition that there are benefits in taking time out from grief, coupled with evidence that expressing distress is not universally essential for grief resolution (Wortman & Silver, 1989, 2001), suggests that Caitlin’s and Sue’s avoidance may have a healthy dimension. On the other hand, grief avoidance has, in some situations, been identified as a feature of complicated grief (Shear et al., 2011b). Experience has taught the author that warded off, dissociation from grief involves obsessive avoidance of reminders of the deceased; including places, music and photographs. Talking about the deceased is avoided if at all possible. This behaviour described neither Caitlin nor Sue.

Unlike Ted and Fiona, both Caitlin and Sue had issues to explore which were complicating what was already intense, though normal grief. For Sue it was the perceived unfairness of her situation and the sudden turn of events which had taken Gary away; the Coroner’s involvement and Gary’s post mortem which meant that “He wasn’t mine for four days” [Sue, assessment, 0:39:00]. For Caitlin it was a sense of injustice for her mother after a lifetime of struggle, additionally complicated by some of the poor care her mother received. Caitlin was also struggling to balance her own needs with those of work and family. Yet in spite of these complicating factors, both women were able to assimilate the nature of their problematic experiences and were beginning to gain a degree of insight. Like Ted and Fiona they were assessed as being at APES 4, working towards 5. The prediction held true. Just a minimal amount of counselling appeared to give Caitlin and Sue sufficient insight to continue to work through their grief.

What though, of a client who does not appear to gain a high level of insight, with or without professional intervention? Could APES be used to identify clients at risk, and could it explain why some clients experience enduring grief. The case of Maureen is considered next.

Maureen

Maureen had self-referred for a return to bereavement counselling after a gap of sixteen years, for unresolved grief over the death of her second daughter who had been stillborn. A post-mortem revealed a heart defect. Maureen said that she had tried to tell midwives and doctors something was wrong but she did not feel they had listened. When she was eventually rushed into surgery for a Caesarean section, the baby was dead. She said that it transpired that the foetal heart monitor had been picking up her heart rather than that of the baby. After the surgery she was moved into the labour ward and she begged the hospital to move her. In spite of the seventeen years that had past, Maureen was tearful as she told this story. She recalled being left on her own a lot of the time. On leaving hospital she recalled spending a lot of her time experiencing unreality.

“I can just remember I was just like in a dream. I just kept thinking ‘This can’t be real, I’m going to wake up in a minute’”. [Maureen, assessment, 0:12:50].

The Caesarean section had caused complications which were remedied after a second stay in hospital. Maureen decided to go back to work after two months, at around the same time she began bereavement counselling with the same service in which the current research was situated.

Counsellor: Do you think it helped at the time?

Maureen: (Pauses before answering) Yes I do, but I don’t really know what helped, but, and I don’t know if everybody else is like this, but I find it easier to get to talk to about my situation to people I don’t know than people I do know, and I think that’s what I found probably more helpful than anything, to talk about it to somebody I didn’t know. And we kind of got quite close, well I think we did, quite close bond.

Counsellor: Did you have a partner at the time?

Maureen, No I didn’t have a partner at the time.

Counsellor: That’s quite isolating, isn’t it?

Maureen: Mmm, but in the hindsight, I think I was probably best not having a partner to be honest (sobs). [Maureen, assessment, 0:16:10].

Maureen reflected on the choices she made.

“I can remember thinking ‘I’ve got two options here. I can either push myself out and get back to normality, or just like waste away and just crack up completely’. I just decided to get back to normality. I went back to work after nine or ten weeks because I knew that if I didn’t push myself, I never would. I can remember all the time it was like (pause) whenever you see somebody I used to feel guilty for them. It seems really strange but if I saw somebody coming towards me I knew they would feel awful and they wouldn’t know what to say. And they would cross over the road and I used to feel so bad for them that I used to hate going out because I hated to have to see somebody, because I knew what sort of reaction I was going to get from them.”
 [Maureen, assessment, 0:14:00].

Maureen went on to have a son. Sometimes she wondered if she would have had the third child had she not lost the second. The lost baby had continued to play a part in family life, with photographs displayed, her birthday being marked every year, regular visits to her final resting place and a visit to the crematorium to view the book of remembrance on every anniversary of her funeral. This daughter would now be approaching seventeen. Maureen said that her grief had returned.

Over this last year, I’m more like (pause) I’ve always been able to talk to anyone and I would say nine times out of ten I’ve not got upset. It’s just like a normal conversation. But this last year I can’t really talk about it without being tearful (begins to cry). I just think ‘If it’s going to get worse than this, what is the point that it’s going to stop getting worse?’ Is it going to get worse over the next few months and years, and if it is going to get worse, how much worse is it going to get? That’s my main worry.
 [Maureen, assessment, 0:20:00]

Maureen wondered why this was happening. She said that she was not upset by her elder daughter, now 18 and about to go to university. She was not aware of any other current stressors in her life but remained puzzled as to why her grief should surface after all this time. She was aware that she had never really talked about the stillbirth. She reflected “Maybe it’s because I’ve been so busy with my life (0:18:57) and also because “mother is one of those old school people. ‘It’s happened and that’s it’”. (0:21:00)

Maureen was able to tell the story of the stillbirth. The counsellor wanted to know if Maureen had made any sense of the death.

- Counsellor: Have you ever explored the reason?
- Maureen: Of why it happened?
- Counsellor: Yes
- Maureen: I know what the cause was. It was an infection she got to her heart, but obviously I haven't gone into it. I've had all the reports back from the hospital and stuff and obviously, um (pause) the hospital did apologise for different things they did and didn't do. They can apologise as much as they like, it won't bring her back will it?
- Counsellor: I wish they'd listen to mothers, because mothers do know when something is amiss.
- Maureen: Then afterwards. I said to them, 'How many times did I tell you that there was something wrong and you wouldn't listen to me?' And it was about four or five hours all this was going on, and I got to the point where I was begging them. I said 'Please will you just get a doctor to me? Please, there's something not right', and they went, 'No no no everything's fine'. And it makes you feel like you were being stupid. And I knew I was right and in a way you feel like saying, 'I told you so', but that's not the right way to go.
- Counsellor: Have you ever felt guilty that you weren't even more insistent?
- Maureen: No because I don't think I could have been more.
- Counsellor: That's good. [Maureen, assessment, 0:23:00].

She also attempted to make some meaning of the death.

"I've always thought well, if she'd been born alive and she had to have a heart transplant, and if for some reason she didn't get a heart, or it hadn't worked and she'd died like a week later, I probably had (pause), sounds really obvious, but I think I had the best option of her dying when she was born than having her for a week and then dying, and then I think, if she'd lived for a year and she'd died then, that would have been even worse than her dying when she was born. I do think of things like that, I think 'I probably had it the best way, because I didn't get to know her properly.'" [Maureen, assessment, 0:34:00]

Maureen's counselling began six weeks after the assessment, with a different counsellor. In the first session she repeated her story. In the second session she talked about

her work and her children. In the third session she related how as an only child neither parent had shown her a great deal of affection. In the fourth session she talked about the strength and independence. She described the pangs of grief and said that this made her feel low. In the fifth session, although she had been on holiday with her son, her low mood had continued as she anticipated her lost child's birthday in ten days. Her sixth session was three days before this anniversary but she was experiencing quite positive emotions and asked if the next week's session could be her last. The counsellor postponed the next session and left messages asking her to rearrange. In spite of this, Maureen never responded again.

Maureen: Summary and conclusions

It seems likely that Maureen's surgical complications which involved a return to hospital interrupted her grief and exacerbated her stress. This may have contributed to the dissociation from her grief which she described as "like in a dream". Her view of grief in black and white terms, resulted in an either/or choice, "normality or just waste way". This is a classic example of Machin's (2013) observation that clients overwhelmed by their grief who choose to rigidly control their emotions, risk a state of vulnerability. It was from here that Maureen originally began counselling; where she developed a "close bond" Maureen, assessment, 0:15:00] with a male counsellor. Her reference to her mother in the assessment session, coupled with her memory of an upbringing which lacked parental affection discussed in counselling, suggests a strong possibility of an insecure attachment style; a factor known to complicate grief (Parkes, 2009). Adding to her vulnerability was a strong maternal injunction to get on with life and avoid her grief. There appeared to be an additional injunction to put the needs of others before her own, even at the height of her grief, encapsulated in her moving recollection and her guilt at how her grief affected others, with no expectation of getting her own needs met. Maureen's reported behaviour suggests a preoccupied attachment style (Bartholomew & Horowitz, 1991).

Although Maureen had spent seventeen years attempting to ward off and dissociate from the emotions of her grief, the events surrounding her daughter's stillbirth were still very real and quite possibly traumatising. By the display of her photographs in the house and the frequent crematorium visits, this daughter had remained an important member of the family. This paradox of emotional avoidance coupled with "excessive proximity seeking" has been recognised as a component of complicated grief (Shear et al., 2011b p.109), From Maureen's description of her situation it was clear that her grief had never been far from the surface. Even before the previous 12 months that she had described, she was still being tearful when telling her story at least 10% of the time 15 years after her loss. Maureen's repetition of ideas and phrases which appear in sections of her transcript; notably the passage where she worries about

her grief continuing to worsen, have a ruminative style. Rumination has been recognised as a grief-complicating factor (Stroebe et al., 2007a; van der Houwen, Stroebe, Schut, Stroebe, & Van den Bout, 2010).

The circumstances in which Maureen's previous counselling ended are not known. However, in her more recent counselling she spoke of her continuing pangs of grief, but as soon as she began to feel better, ended the work following a session postponed by her counsellor. This suggests a 'flight into health' and a denial of her emotional needs (See for example Beisser, 1979).

Maureen's narrative has a style reminiscent of Amanda's early sessions (see pages 97-102) in that the account records events accurately but lacks sufficient personal reflection to indicate an understanding of the nature of her problematic experiences. Although it was apparent that she was puzzled by the re-emergence of intense grief, she offered no clear reflection that could be construed as APES 3: problem statement/clarification. This, coupled with aspects of chosen avoidance and warded off grief, suggests that Maureen was between APES 1: unwanted thoughts, and APES 2: vague awareness.

Chapter summary and conclusions

In this chapter, moments of assimilation in each of the case studies were compared. A theory of assimilation and accommodation was supported by the findings. Each client demonstrated that grief can be addressed by constructing meaning from events following the death of a loved one. For each client, meaning construction was observed as a process of assimilation and accommodation analogous to that described by Piaget (1952, 1954). Furthermore, the sequence of assimilation and accommodation matched that described by Stiles in the Assimilation of Problematic Experiences Scale (APES) (Stiles, 1999, 2001) (Chapter 5, Table 5.1).

Developing the assimilation and accommodation of new schemas with each client required the creation of a safe therapeutic space²⁷ and a collaborative endeavour which sought to put the client firmly in control. Three-way trust between client, counsellor and process was central to the therapeutic alliance. Major changes were fostered by empathic intervention. Clients who moved successfully through the assimilatory sequence did so alongside the counsellor on a journey of mutual, creative curiosity.

²⁷ A safe therapeutic space in this context is one in which i) boundaries are in place to secure the client's confidentiality, ii) the room used feels comfortable to client and counsellor, and iii) the counsellor makes effective use of empathy, congruence and unconditional positive regard (Rogers, 1957). For a detailed account of a safe space for bereavement counselling, see Wilson, Gabriel and James (2016)

Chapter 8: Theory building from the case studies

Theory building method

Figure 8.1 illustrates the theory building method utilised in this research. As each case study was completed, including the triangulation protocols employed, comparisons were made between them. Any conclusions drawn have the potential either to add weight, or to modify the original theory. Thus, as was introduced in Chapter 1, Table 1.1, a cyclic dynamic process exists such that theory, outcomes and conclusions remain inextricably mixed and subject to ongoing revision.

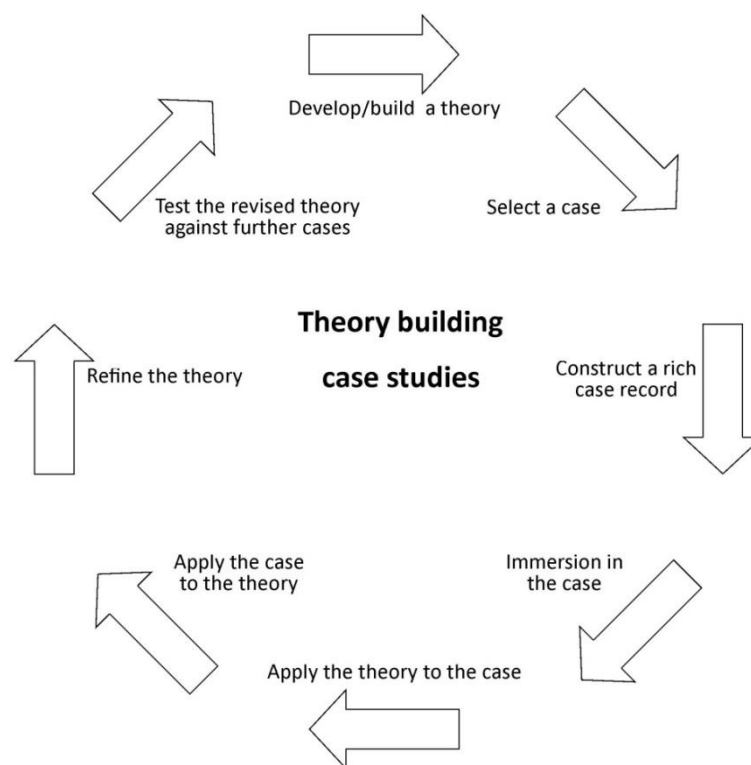


Figure 8.1 Method for theory building from multiple case-studies (Stiles, 2007)

Towards the end of Chapter 4, pages 51-52, the author's theory of grief was adumbrated. It stated that the protest features of grief were linked to separation distress as an evolved survival mechanism which disrupts the bereaved person's personal narrative and results in homeostatic disequilibrium. The greater the number of complicating factors, the greater the extent of the narrative disruption. In the process of recovery an individual seeks to reconstruct a new narrative and adapt to a world without the deceased. Bereavement counselling can facilitate this process.

In theory building case study logic, weight is added to this theory if, in the initial phases of counselling, the case study shows evidence of the distress of broken attachment, (for example maintaining close connection to the deceased) and of disrupted personal narrative (reported by the client in the counselling sessions). For the theory to have validity then, as counselling progresses there should be evidence of the client reconstructing a new personal narrative. There would be further confidence in the theory if the role of the counsellor in facilitating adaptation and narrative reconstruction can be demonstrated.

In order to build this theory using each case study, a working checklist was devised. This appears below (table 8.1), which describes those clients who choose to engage in counselling, and who make effective use of it. The therapeutic alliance essential for an effective counselling process is discussed on pages 195-198. It is important to stress that theory outlined here for the purpose of the theory building, had its genesis before the planning and execution of this project (illustrated in Figure 4.1, page 28). The author became a bereavement counsellor in 2000, and the ideas presented in this theory including a theory of assimilation, have developed from reflective practice and experience over 16 years.

For clients who engage effectively in the counselling process:	
8.1.1	Initial phases of bereavement counselling show evidence of the distress of broken attachment (see pages 51-52).
8.1.2	These initial phases of bereavement counselling also show evidence of disrupted personal narrative (see pages 51-52). These may be directly observed in the counselling sessions, or reported by the client to the counsellor.
8.1.3	The number of complicating factors is proportional to the extent of the narrative disruption (see page 52).
8.1.4	The extent of narrative disruption is related to the time the client remains in counselling.
8.1.5	The grieving process reveals examples of narrative reconstruction (see page 52).
8.1.6	This narrative reconstruction follows the sequential stages described by the Assimilation of Problematic Experiences Scale APES (see page 72).
8.1.7	Counselling sessions show the client adapting to a world without the deceased (see page 52).

Table 8.1 Working checklist used to test the theory against each case study

The theory outlined in Table 8.1, based on the author's observations discussed on pages 51-52, was tested using the theory building methodology illustrated in Figure 8.1 at the beginning of this chapter. Evidence from applying the theory to each case either adds confidence to the theory, or modifies it. This is explored on pages 151-169. Then each case is in turn applied to the theory outlined in Table 8.1. This exercise appears on pages 169-174.

Applying the theory to each case

Applying the theory to Tony's case study

Tony did not in the first instance consider bereavement counselling as a solution to his emotional difficulties. He was originally referred for psychological support because of his depression and mood swings. From Tony's point of view he wanted things to change because of the effect this was having on his family. Both he and his first counsellor considered it likely that the significant changes he had made to his life, giving up his business and choosing to become a house husband, was the primary factor affecting his low mood. Although this was shown to be a significant part of his difficulty, this was a small part of the larger constellation of problematic experiences²⁸ impinging on Tony's well-being. Importantly, Tony's narrative reconstruction did follow the APES sequence, although this was a complex process. In terms of clarifying and stating his problematic experiences, he became aware that it was his delayed grief rather than his current life changes that caused his difficulties. It became clear to him that contacting his emotions was going to be central to any changes he might make. His belief that antidepressants were blocking this contact led to his decision to cease taking them, which in turn led to a problem solution: a cathartic and liberating release of feelings. Once he reached this point he was able to discover, much to his surprise, that it was delayed grief for his brother, rather than the more recent loss of his father, that was to be the focus of the bereavement aspect of his counselling. Yet his story was so much more complex than grieving for his brother or his father. Much of his focus remained on changing his own behaviour as a husband and father. In addition he was coping with an elderly mother in palliative care, and an assumptive world changed by his recent career choices. These factors, plus the delayed nature of his grief, made Tony an atypical bereavement client and an equally atypical case study. If however, Tony's complex circumstances are viewed as complications to his grief, this would explain the extent of his narrative disruption and hence the number of sessions Tony received before he felt able to end counselling.

It was three decades since Tony's brother had died, and the initial distress of broken attachment had become a memory which Tony was able to report. In spite of the time elapsed his grief once contacted, remained very raw.

²⁸ Table 6.3 on page 91 Shows the complete range of Tony's problematic experiences.

- Counsellor: You don't want to lose either of them why should you
- Client: No I don't . That's what you can't work out. You can't work it out on your own
- Counsellor: But you're working it out with my help
- Client: Yes it is I can feel it (cries loudly) it feels good I can (pause). Oh blimey (sighs twice) even let myself believe a tiny bit it's just been there for so friggin' long now. (blows nose) It was part of me just scared that even if there was something that I wouldn't be able to let go of it. As opp (pause) something bloody stupid 'cos by God. Oh I don't know. You taunt yourself in your head. You're like a fool in yourself poking a stick in you 'cos you know all the things, 'Neh neh! That's not really true is it? Neh neh! Oh I don't know (sighs loudly). Blimey! (laughs). The other day I wanted to bloody cry can't think where it was whether it was to do with my cousin. Don't think it was that. It was something. I said to [name of wife], 'God I want to cry.' I said' I can't do it any more. Just can't bloody cry any more. Perhaps it was something [name of older brother] said. Dunno! (Big exhalation of breath) it was strange that!
- [Tony, session 5, 0:45:47]

Tony was able to report in great detail how his brother's death had disrupted the personal narrative of his childhood. In order to survive the enormity of the loss he had fabricated a whole story in which his brother had disappeared rather than died; a fantasy world in which brother had become a secret agent, a world in which he had become so entrenched that even the child in the adult Tony continue to believe it. Between home and school he had led a double life. At home he hid from his parents who in their own grief were in his words "tearing each other apart". At school he created a world where his brother remained in a successful career as a young bank manager. As Tony moved into adulthood, still hanging on to unreality, it is arguable that at least in some ways, he had found ways of adapting to the loss. In his counselling he reported establishing a successful business and a loving marriage with two children. The limits of his adaptation were manifested in his deep unhappiness and stress he believed he was placing on his family.

Once Tony accepted the reality of his brother's death it was demonstrable that the ensuing counselling sessions did show him adapting to this reality, witnessed by the ritual talk

with his brother he had chosen to have standing alone on a bridge at night. He reported to his counsellor in session 26.

“I was sort of talking out loud to myself which is slightly a different thing than talking in your head to yourself, isn’t it? And err (pause). I was talking sort of to our (brother) and stuff and (pause). I don’t know I just (pause). Telling him you know, I was trying to let go and (pause). And I did. I sort of walked down to the bridge and I sort of said my goodbyes to him sort of thing, and I didn’t (pause). I sort of said it outside and (pause) it was a nice place and a nice night and (pause) I didn’t (pause). I just sort of did it if you like as opposed to building up to something or (pause). There wasn’t anything to (pause). I thought I’ll just have a conversation and it felt (pause), I don’t know (pause). There was no big moment of feeling inside me after I’d talked to him and said goodbye and (pause). I don’t know if (pause). I don’t know if anything has changed, but had that conversation with him and I’m glad I did and I’m glad I did it that night and sort of did it before I knew I could stop myself saying or doing it.”

[Tony, session 26, 0:13:1]

Following from Tony’s acceptance and ritual separation from his brother, there was a clear example of Tony talking to himself about moving forward with his life.

“...that tiny thought of like our (brother) is alive somewhere. You sort of knew it wasn’t but it was there and that germ of it to accept that that is going to happen and that isn’t going to happen, these finites, these definites, as opposed to always thinking, ‘Well it could(pause).’ And realising that ‘No, the things of what’s happened, that *is your life*. It isn’t going to be another life where you get it better, that *is your life* and that’s how it’s been, and it’s, you’ve got to accept.’ You sort of knew it before, but you didn’t, don’t know. It’s that tiny subtlety of them little grains what are, from a different brain if you like, which are still holding true in your(pause) affects your other thoughts; how you look at things (pause) um (pause). I suppose it comes to that thing of (pause). That tiny bit of that growing up (pause). Cos there’s a lot of that isn’t there? There’s a lot of that being trapped with so many of that little lad’s thoughts.”

[Tony, session 27, 0:16:30]

Evidence that it was the bereavement counselling process which facilitated Tony's narrative reconstruction comes from his reflections on the sessions.

- Tony: I'll tell you what I'm doing, I'm doing all right. I am doing bloody (pause). Tell you what, after that last thing ..
- Counsellor: Yes.
- Tony: ..It didn't half feel like a bloody er (pause). It felt like the final click for me. All the stuff we've been doing, it was all good, all that was right, but in a way that, and it's, but that, so glad that that happened, because (pause). And at the time it sort of depressed to be in the (pause) .Well it didn't really depr (pause). I sort of got in and got out of it quick (pause). But put it behind me which was all good, you know, I couldn't even bloody remember it really, it was all good but it was still that bloody thing, that the damn thing had happened, and you think, 'God' It was all that was until it? When I was here before and it's like, 'Do I have to put up (pause). Is this it?'. And then that (pause) there was that (pause) there's been so many little moments. Moments of revelation and, er, um, enlightenment to things, but that, I think that was the one last thing, and quite a big background running thing. [Tony, session 34, 0:03:42]

The "background running thing" referred the client's previously used metaphor of his narrative sense-making; scanning like spyware in a computer operating system and in the background outside of his awareness. Tony continued to reflect on his counselling experience.

"It's all, it's all so good John, it's just, it's quite silly really, it is quite silly and you're just thinking, "God, if that hadn't happened, if that hadn't happened if I hadn't been going there (pause) And that was the other one, about it suddenly dawned on me, like going away and sort of a bit guilty when I was coming home, I felt more and more angry and it was like 'I took all these people away and it had been bad weather 'sort of thing. It was another guilt thing and it just, it applies to so many things, and I can just see it now. And there was a bit going on the other day, and I could (pause) semi sort of wave of it (pause). There is no guilt and you could just (pause). You've got the magic gun to (pause) dunno. It feels very bloody liberating, and I do feel more energetic." [Tony, session 34, 0:45:53]

Applying the theory to Jacqui's case study

Jacqui exhibited some elements of broken attachment distress, although this was not immediately apparent as a presenting issue. She had come to counselling more because of her family concerns for her wellbeing than for her self-identified need. As such, her personal narrative disrupted by her father's death was overshadowed by other factors; not least her alcohol use which was very possibly more problematic than she was either willing or able to acknowledge²⁹. Other factors she mentioned were the relationship with her mother in which she felt criticised, and her relationship with her partner; by her description sometimes affected by alcohol. These issues, plus the work stress from self-employment, compounded Jacqui's attachment distress and contributed adversely to the narrative disruption caused by bereavement. It was only towards the end of her counselling that she mentioned standing by the door looking up at the sky in a symbolic search for her father; behaviour which she said had changed during her counselling.

In Jacqui's case it was difficult to conclude that the number of complicating factors mentioned above was proportional to the extent of her narrative disruption, largely because she was reticent in acknowledging the full effects of her bereavement. Also, after immersing himself in Jacqui's transcripts, the author suspects that she may have benefitted from further counselling in greater depth. However, in this case study, the theory that the extent of the client's narrative disruption could be measured by the time she chose to remain in counselling, was not demonstrated. There was little evidence of grieving through narrative reconstruction with one exception. Jacqui used the picture her father had painted as the starting point for developing a continuing bond (Klass et al., 1996), which she was able to generalise:

"I feel that he's still around me" [Jacqui, session 2, 0:36:00].

In addition, the awareness that Jacqui gained through discussing problematic experiences other than grief, in particular the relationship she had with her mother, followed the APES sequence.

There was only minimal evidence of Jacqui adapting to life without her father during and between the counselling sessions, principally because little adaptation was necessary. Her father was not a daily presence in her life, so his death in terms of a changed assumptive world (Parkes, 1971) had only a small effect. Also it is likely that because of her father's lifestyle and previous health crises, she was at some level prepared for his death, and may have even

²⁹ There were references to her drinking habits in sections of transcription not included in this thesis, including the effect that alcohol could have on her behaviour, and the concern of family members.

distanced herself from attachment. Jacqui's parents had separated during her childhood, so the parental bond had very likely diminished at that time. From her accounts, Jacqui and her father had become mutually non-judgemental drinking partners as much as they were bonded as father and daughter. This may help to explain the limits of her attachment distress.

In summary, when the author's theory of grief is applied to Jacqui's case study, there is limited evidence to fully support all aspects of the theory as they are outlined in Table 8.1. Conversely, neither is there adequate evidence, from this short case study which could conclusively refute any aspect of the theory. It was Jacqui's choice to limit how much she shared by choosing to end counselling as soon as she did, although she was clear that she had taken what she needed from the experience.

Applying the theory to Sam's case study

Sam's distress of broken attachment for her adult son Mark was intense.

"It's not just losing a child, it's losing half your world with it" [Sam, session 1 0:43.35].

As hard as Sam found the loss she had in place strategies to distract herself from her grief on a daily basis, and tactics to avoid contacting painful emotions during her counselling sessions. Having enrolled on a foundation degree in counselling shortly before Mark's death, Sam has plenty to keep her busy. However the course requirement to keep a personal journal challenged her defences. Torn between overwhelming grief and a need to maintain control (Machin, 2013), Sam developed somatic symptoms which were eventually diagnosed as atrial fibrillation. She also reported a 19 kg weight gain.

Sam had not been in daily contact with her son for many years. Since they had both lived separately, Mark's death was not the shock to Sam's assumptive world (Parkes, 1971) that it would have been if it had disrupted the routine of her narrative. What was, however, disrupted was Sam's implicit belief that Mark loved life and would do all he could to stay alive. When Mark chose to have surgery, which had a significant chance of ending his life, Sam struggled with his choice, and regretted that she had been unable to save him with advice to lose weight rather than submit to surgery. This was resolved to her satisfaction when she was able to read her son's diary. She concluded that he was unhappy living as he was, and that he saw the surgery as a last ditch attempt to lose weight. She believed that had he not had the surgery he would have died anyway, of his various weight-related conditions.

There were none of the widely recognised complications (Burke & Neimeyer, 2013) present in Sam's narrative disruption other than the loss of a child, making it difficult to test with this case study the proposition that the number of complicating factors was proportional

to the extent of Sam's narrative disruption. Since Sam also chose to end her counselling before reaching a problem solution, the fourth proposition in Table 8.1: that the extent of narrative disruption may be measurable by the time a client chooses to remain in counselling, is not demonstrated. This outcome raises further propositions. Had Sam reached APES 6 or 7 in a short number of sessions with a number of attendant complicating factors present, then proposition 4 of the theory would have been falsified. In the event, Sam recognised that she terminated her counselling whilst still in a state of narrative disruption. This was confirmed in her post-counselling interview at which her case study was discussed.

There were examples in the transcripts of Sam's counselling which demonstrated narrative reconstruction through the assimilation of new schemas.

- Sam: I talk to him. I don't think that's unhealthy. I quite often talk to him, you know, either out loud or in my head or something like that. I don't feel it's unhealthy to talk to him, you know. I have the odd angry moment. 'You could have gone on a bit longer (laughs), it's not fair this' (laughs again). (Sam, session 3, 0:25.42)
- Sam: You can easily avoid um grieving for people by the fact that you keep away from where they've been. (Sam, session 4, 0:18:53)
- Sam: I was quite happy doing nothing yesterday, but then the other voice comes in and says 'You're not going to get anywhere if you spend the day doing nothing'. (Sam, session 5, 0:35.15)
- Sam: I feel a different feeling in the last couple of weeks, whereas before I couldn't see wood for the trees and down, I was really down. Last couple of weeks validated me. I'm a more positive me. I've been meditating more. I've gone back on vitamins. Back's gone, that doesn't hurt any more. Why was that a problem? But how much was that associated with what was going on up here (pointing to brain)? (Sam, session 10, 0:14:55)

In spite of her premature exit from counselling, Sam's account of her grieving process at her post counselling interview suggested that this narrative reconstruction continued, and that it followed the sequential stages of APES. Sam was explicit that counselling had facilitated this process. Sam's choice to end counselling tests the premise of 8.1.4 (page 150), that the duration of counselling is related to extent of narrative disruption. Sam explained her decision in the follow-up interview (Appendix 6, pages 259-263) At the time she believed her counselling had gone as far as it could, and she had, she said, "gone into protective mode"

(page 262). Whilst there was limited evidence that Sam adapted to accepting the reality of Mark's death during her counselling, she had accepted it three years after her counselling had ended (and more than four years since Mark's death). Sam also fulfilled her goals expressed during counselling; to visit the places she had enjoyed sharing with Mark; places she had at first avoided. It is no great stretch of interpretation to regard this as successful adaptation to loss.

Applying the theory to Amanda's case study

Amanda had been very close to her grandfather, and the distress she felt after his death, described by her in moving detail, showed clear evidence that it was as a result of the broken attachment bond. Amanda's distress correlated with an eating disorder and associated health complications. For a time she even experienced suicidal thoughts. The nature and extent of Amanda's disrupted narrative was so great that she struggled to move forward with her life; repeatedly drawn back to recalling her grandfather's final days and hours. Searching behaviour was reported, as she related her confusion at feeling she needed to return to the ward where he died.

There were no complications to her grief, other than the strength of the grandfather/granddaughter bond. As a result, the nature of the narrative disruption concerned attempting to renegotiate this affectional bond to a more lasting, symbolic, continuing bond (Klass et al., 1996). There were signs that this process was beginning. By her eighth counselling session she could drive past the hospital where he died without becoming upset but she admitted "I don't know how to have a relationship with him now cos he's gone". Having said that, Amanda acknowledged feeling close to him when she was gardening. "I copy what he did". She also felt that he lived on in his great-grandchildren, who had talked about wanting a vegetable patch like he had.

In spite of the intensity of this single complication, the absence of other complications meant that Amanda had only eight counselling sessions plus one ten minute session three months later. This would add a small degree of confidence to the theory that the number of complicating factors is proportional to the extent of the narrative disruption providing that clients with more complications showed greater disruption and a need for more counselling.

The narrative reconstruction that took place followed the APES sequence as Amanda slowly adapted to a world without her grandfather. This process of meaning making, in which Amanda assimilated new schemas, was facilitated by her counselling, demonstrated from these sections of transcript, taken from session 7.

Amanda: Now my Granddad has died, I've felt adult feelings for him now he's died; I've felt feelings, adult feelings that I've never felt before, because I'd never dealt with it. (Session 7, 0:19:14)

Amanda: Something is pulling me to go back to the ward. And I don't know what it is. I feel that I should go and I'm not sure why. I don't know why. [Amanda, session 7, 0:23:00].

She repeated her compulsion to go back to the ward two days after her grandfather died,

Amanda: Even two days after he died we went down to [name of hospital] and I said to my mum 'I've got to go back up, I've got to do it'. [Amanda, session 7, 0:25:33].

Amanda said it was similar to that feeling she had now, only much stronger. She talked about sitting outside the mortuary on the day that he died finding it hard to leave him on his own. She talked again about doing his intimate personal care.

Counsellor: You weren't ready for him to die.

Amanda: No. Turning into a child again. I thought it would never happen. It had never happened before (sobs). I didn't believe it would happen. [Amanda, Session 7, 0:36:00].

She recalled again giving grandfather permission to die.

"It was me that said, 'if you want to go you can go. We're not going to hold you back. We'll all look after each other'. I promised I'd look after my Nanna." [Amanda, session 7, 0:40:30]

She said that he couldn't talk at the end, but he said 'I love you' with his eyes. Even on the day that he died, Amanda said that she wasn't expecting it. Once again she described his last breath. When he stopped breathing she thought perhaps he was holding his breath as if he was playing a game, 'playing dead' to joke with them.

“And he didn’t. He didn’t wake back up. And it was real.” [Amanda, session 7, 0:45:50].

“When I do think of the ward I think it’s because er that’s where I was closest to him really. Well in me now I feel I was closest. It was personal. In the end it was, it was personal, and you know, I was doing his (pause) private things, do you know? So it was like totally, our relationship had totally changed. It was totally different actually (pause). But I think looking at the ward I’m not sure if it’s just because that’s where I felt closest , where (2 second pause) I held his hand. What I pine for is to hold his hand again. And I’ve said it to my mum and I’ve said it, I think it’s because that’s all I did for the last (pause) last year, but more so for the last month or so before he died. When he did die it was weird and it was like part of me was missing.” [Amanda, session 7, 0:46:12]

Applying the theory to Sophie’s case study

Sophie’s case study revealed a story of stereotypical spousal bereavement with complications. Her husband David died prematurely young, and although he was receiving palliative care, the nature of his death was sudden, unexpected and traumatic. His death was witnessed by the whole family. Sophie was left with sole responsibility for three children and two elderly in-laws. Whilst for most of the time relations with her husband’s parents were harmonious, there were periods of tension when their needs and grieving style conflicted with Sophie’s. During her period of grief she felt an additional sense of loss when her daughter left home for university.

Sophie exhibited all the distress of broken attachment in her tearfulness during the initial sessions.

“He always looked after us (sobs) He always knew the right thing to do”.
[Sophie session 3, 0:47:29]

Seven months after David’s death she entered a period diagnosed as depression. In Session 13 she described her emotional state as “pretty rubbish”. Although the weekend had been “okay” her mood had dropped on Monday. She had reached a point where she could see that antidepressants might help. However she also had a helpful grasp of what events helped and what hindered her positive affect. She said that to friends she had not been admitting that she was not okay, and instead saying that she was fine,

“I feel like I’m just putting up a front, just saying I’m alright and everything. And since I’ve admitted it, friends have rallied round again”. [Sophie, session 13, 0:09:15].

Sophie displayed her own version of searching behaviour in which she spent time in the marital bedroom where David had died. In her initial assessment session sixteen weeks after her loss, Sophie said that David’s death seemed more like a film than reality. She said that she had not moved anything in the bedroom, including David’s clothes, which she found a comfort. For some time after his death there had been a “sweet smell” in the bedroom. Although she felt unable to sleep in what had been the marital bed, she spent a lot of time in the room talking to him and she could feel his presence.

Each of these examples show evidence of a disrupted personal narrative, adding weight to the theory discussed here. Five of the complications listed by Burke and Neimeyer (2013) were present³⁰. In addition, Sophie was experiencing the concurrent loss of her daughter leaving home to go to university. As was anticipated in applying the theory to the case, Sophie experienced considerable narrative disruption from these complications, and chose to remain in counselling for 45 sessions spread over 2 years. Extracts from Sophie’s transcript (Appendix 7) reveals how she brought to counselling each of these complications. Slowly there was narrative reconstruction of each of these issues, sometimes during the counselling and sometimes reported by Sophie. In Session 10 for example, Sophie had met for coffee with a woman who had lost her husband two years earlier, and Sophie reflected on their relative progression along the journey of grief. Both of them have children and Sophie said that it helped to know others had gone through a similar experience. She noted that they had both got upset, “and it was fine” (Session 10 0:04:03). Of the other widow, Sophie said,

“She’s not all doom and gloom. It was quite light-hearted, some of the stuff”
[Sophie, session 10 0:07:22].

As can be seen in Chapter 7 and in Appendix 7, Sophie’s narrative reconstruction followed the APES sequential stages. Gradually she began to ‘relearn the world’ (Attig, 2001), and adapt to life without David. In session 10 Sophie talked about her children’s grief, her feelings of responsibility and about the pressure of lone decision-making. However, she noted that she had successfully managed buying a car since David had died. This caused her to reflect on her progress to date.

³⁰ Death of spouse, deceased’s age, violent death, death was unexpected, saw the body,

- Sophie: I do feel like I'm getting somewhere.
- Counsellor: I can see the difference in you
- Sophie: At the time when you're feeling like that you just think you'll never get past it. I don't know how people manage without counselling to be honest (laughs). [Sophie, session 10, 0:34:47]

In summary, Sophie's case study adds weight to every aspect of the theory. There was separation distress and searching activity. The loss of her partner disrupted Sophie's narrative, and this was compounded by the complications which accompanied the bereavement, such that many hours of counselling were requested. It took Sophie a long time to reach a stage of her grief when she felt able to adapt sufficiently not to need professional support, and transcripts made of her counselling reveal both evidence of how it helped and the sequence of assimilation by which change occurred.

Applying the theory to the case: Summary of the first five case studies

Tony's distress of broken attachment from his brother (Table 8.1: 8.1.1, page 150) had lasted for many years, but had been largely ignored through the distraction of career and family. Counselling allowed him to renew his contact with that distress. Jacqui's attachment distress for her father was probably masked by her use of alcohol, by the distraction of self-employment, and by her perceived problematic relationship with her mother. It was only as, in hindsight, she reflected on her time standing on the doorstep searching the sky for her father, that attachment distress became apparent. Sam distracted herself from the intense attachment distress of a mother losing her child. Her counselling training was a powerful distraction until the course requirement to keep a personal journal forced her to confront the loss. A continued attempt at distraction and avoidance, in spite of receiving counselling, correlated with the development of somatic symptoms. Amanda's somatic symptoms were the motivation to seek counselling, and during this counselling her condition greatly improved. She exhibited attachment distress through reporting seeking behaviour for her grandfather. Sophie also exhibited attachment distress through seeking behaviour; as she attempted to stay close to her husband by spending time in the marital bedroom. In sum, all five clients exhibited attachment distress (8.1.1). These observations build incremental confidence in this aspect of the theory.

Tony showed evidence of a disrupted personal narrative (8.1.2) as he talked about his childhood. Much of his awareness of the extent of the disruption had been buried as he struggled, as a child, to cope with his father's injuries and his mother's reaction to the traumatic loss. During his counselling it became clear to Tony that the effect of this narrative

disruption had continued to affect his behaviour in his adult life. Any disruption to Jacqui's narrative was hard to observe in just three sessions of counselling. Much of this time was spent discussing her relationship and her business plans. The part her father played in her life had, during her adulthood, been restricted to meeting him in a pub for a drink. She reported that she missed this. Sam's son had not been a significant part of her life for many years. Sam lived some distance from her son and she had a busy life which did not involve him. In spite of her attachment distress, narrative disruption was minimal. Amanda's grandfather had, by comparison, been a huge part of her life on a daily basis and her narrative disruption was significant. Likewise, with the death of her husband and father to her children, Sophie's narrative was changed beyond almost all recognition. In sum, the extent of narrative disruption, observed in the initial phases of bereavement counselling (8.1.2), is related to the part played by the deceased in the daily life of the client.

There were many complicating factors (8.1.3) in Tony's grief for his brother, and they were complex. All appeared to have contributed to Tony's disrupted narrative through his childhood, teens and adult life. For the reasons discussed in the previous paragraph, it is difficult to draw conclusions about either the complicating factors or the narrative disruption in Jacqui's case. As reported on page 156, Sam's grief had none of the recognised complications (Burke & Neimeyer 2013, see page 23) other than the loss of a child. Similarly, Amanda had no complications other than the strong bond with her grandfather³¹. Yet when compared with Sam, Amanda demonstrated a high degree of disruption. Sophie had many complicating factors (Spousal bereavement, marital dependency, saw the body, violent death and unexpected death) and a highly disrupted narrative. It appears that the number of complicating factors is not necessarily related to the degree of narrative disruption (8.1.3). Whilst a high number is likely to cause significant disruption, so too can attachment distress, regardless of the presence or absence of complicating factors.

Regardless of the causes of narrative disruption, there does appear to be some relationship between narrative disruption and the duration of the counselling needed (8.1.4). Although Tony's narrative had been disrupted three decades earlier, the distress was enduring and 39 sessions of counselling were provided. Sophie, who had experienced overwhelming disruption, attended 44 sessions. Amanda, as part of an extended family which included her grandfather had significant disruption. At the same time, as a wife and mother, there were aspects of her life which were not disrupted. Amanda had 9 sessions, although she chose to spread them over 6 months. On the other hand Sam chose to have 10 sessions in spite of little evidence of disruption. This may be explained by the attachment distress of losing a child

³¹ Bonds with the deceased are not recognised as a complication (Burke & Neimeyer, 2013), other than for the spouse or parent of the deceased. There is a recognised potential risk in being female. See page 23

(8.1.1). Jacqui's father had not been a daily part of her life since her childhood, and attended 3 sessions. The author concludes that the extent of narrative disruption is related to the time the client remains in counselling (8.1.4).

All five clients showed evidence of narrative reconstruction (8.1.5) although this was, in most cases, related more to meaning making than to adapting to a world without the deceased (8.1.7). Each used their counselling to meet their individual needs. Tony used it to make sense of his behaviour; Jacqui to establish a symbolic continuing bond (Klass et al., 1996) with her father; Sam to establish a continuing bond, and to better understand her son's high risk choice of gastric bypass surgery; and Amanda to make sense of her grandfather's final days. Sophie was the exception. Her narrative reconstruction was closely related to her devastated assumptive world (Parkes, 1971, 2009) as she adapted to life as a widow and single mother.

In all five cases, the client's narrative reconstruction followed the APES sequence (8.1.6) up to the score reached when the client chose to end counselling. All clients showed some change as charted by the APES scale. As expected (see page 101) clients were around APES 2: 'vague awareness', when they sought counselling, although they were able to describe situations which matched earlier APES stages. Evidence from the data demonstrates the validity of APES in these case studies.

In the broader sense, these clients did show evidence of adapting to a world without the deceased (8.1.7). It could be argued that Tony, successful in business and marriage, had adapted, in the three decades since his brother's death. He had, however, been treated for depression for many years. In using counselling to accept the reality of his brother's death and coming to understand his behaviour, Tony felt that he had achieved the therapeutic change he sought (see page 118). Jacqui and Sam each in their own way showed evidence of adapting to their post-loss world, even though, as discussed under 8.1.5 above, adaptation does not necessarily relate to reconstructing a changed assumptive world (Parkes 1971, 2009). Amanda and Sophie did however, have to adapt to a world in which the person they loved had gone from their daily lives. The author concludes that the counselling sessions in these case studies did show the client adapting to a post-loss world (8.1.7).

Applying the theory to the cases of Caitlin, Sue and Maureen

Caitlin

Caitlin had been bereaved of her mother five months before she was assessed. She was referred by her doctor after experiencing panic with accompanying somatic symptoms, including palpitations. It would be easy to assume that this was evidence of the distress of broken attachment. However, closer examination indicated that there were other factors which

could account for these somatic symptoms. Caitlin had been traumatised by her mother's intellectual deterioration through dementia, and it had been stressful finding appropriate care for her mother. The point at which mother had been attacked and injured by another dementia patient in residential care had not helped. Shortly after mother had died, Caitlin had an early miscarriage, which added to her stress. Although she had accepted this and was not apparently grieving the loss, she acknowledged it as "a massive setback". Caitlin also worked freelance from home in a high-powered and stressful job. She had three children to care for, and although her partner shared the child care, he was away from home a great deal, leaving Caitlin to balance childcare with work deadlines.

What Caitlin appeared to struggle with most, was the injustice her mother had endured for so long. Having suffered years of spousal abuse in order to keep the family together as the children grew up, Caitlin had wished her mother a long, healthy and happy life free from this abusive husband and father. This was not to be, as the dementia appeared soon after she left him and lasted for the fourteen years until her death from dementia and a broken hip that would not heal.

With so much going on in her life that could be sources of stress, it was not possible to say if broken attachment between mother and daughter was a factor in this case. The chain of events which preceded and followed Caitlin's bereavement can all be seen as complications to her grief, which had evidently disrupted her narrative. Yet given the space afforded by the assessment session, Caitlin was able to reflect on what had happened. Her transcript is rich in narrative reconstruction, from her reflections on the miscarried baby: "I trust nature and I just think it was not viable and I'm cool with that," [Caitlin, assessment, 0:27:00], to her sense of peace that ultimately she and her sisters had done the best they could for their mother, in difficult circumstances. Although Caitlin did go on to have five sessions of counselling, much of this involved problem-solving to reduce her stress levels, including taking a holiday and acquiring domestic help.

Because the author did not conduct the ongoing counselling, and no transcripts exist, it is not known whether the counselling sessions showed Caitlin adapting to a world without her mother. However, because of the busy life that Caitlin was leading whilst trying to care for her mother, it seems likely that although her assumptive world had been changed by the loss, this was mitigated in the reduced stress of not having to be part of her mother's care. Although no evidence was collected to test if the counselling sessions facilitated adaptation through narrative reconstruction, it seems likely from the assessment session, that this client was able to self-facilitate her adaptation, and that her reflective skills enabled 'cognitive reappraisal' (Troy & Mauss, 2011, p. 11) (see page 50).

Sue

Sue presented for her assessment five months after her husband Gary's death. Nothing said in the assessment indicated attachment distress although it may have been present. Although the intensity of the distress may have waned in the initial five months, her habit of controlling her grief may have masked it. There were however many sources of narrative disruption. Gary's cancer had been a feature of both of their lives for four of their eighteen years of marriage, a large part of which was spent supporting her mother with dementia. When Gary was diagnosed with cancer Sue's mother's dementia was at a severe stage, and she died a year before Gary. Before her happy marriage to Gary she had been in an abusive marriage for twenty five years, so there is little wonder that Sue had an all-pervading sense of unfairness in the way life had treated her.

Sue's difficult life experiences could be construed as complicating factors, on top of which there were multiple, clinically recognised complicating factors: two bereavements close together, the loss of a spouse, and Gary's sudden death, which was also traumatic and unexpected³². Yet there was little to support the author's theory that these factors should have produced such narrative disruption that counselling would be a prolonged need. With some reluctance Sue did agree to counselling, and met with a different counsellor five weeks later. In this session she repeated her anger and disappointment; both at the initial lack of chemotherapy as a treatment to back up the surgery, and at what she saw as the intrusion of chemotherapy in the final months of Gary's life: "He could have been happy if only for a month if he did not have his last treatment" (said in these words at the assessment: 0:13:55).

Because of Sue's decision not to have further counselling, the remaining aspects of the author's theory are not demonstrated. Narrative reconstruction as part of the grieving process was not observed, and the extent of Sue's adaptation to a world without Gary through narrative reconstruction, was not observable. However, one of Sue's reasons for not needing counselling was that she could talk to her sister-in-law. It is possible that she regained adequate narrative reconstruction from these conversations. Equally, the process of narrative reconstruction, of a post-loss world, may not be universal as the author's theory suggests.

Maureen

Maureen's case was a re-referral to the same bereavement service, seventeen years after the birth of a stillborn daughter. The previous counselling took place sixteen years ago. The form of this counselling is not known, although it took place over many weeks. At that time the bereavement support service model was predicated on the first edition of Worden's

³² Although Gary was terminally ill, in the event his death involved Sue attempting to administer CPR until paramedics arrived, and later the room was sealed as a possible crime scene, due to the unexpected nature of his death.

stages of grief (Worden, 1983), and on a benign person centred model where there would have been a little if any active attempt to help the client construct meaning from her loss.

What Maureen described demonstrated an attempt to maintain a continued attachment to her daughter, through regular grave visits and to the crematorium Book of Remembrance on every anniversary of her death. She was tearful throughout the assessment session suggesting continued attachment distress. Events surrounding the birth were described in vivid detail, as though they were never far from her thoughts. She also mentioned that when telling the story of her stillbirth, “nine times out of ten I’ve not got upset”, indicating that even many years after the loss, by her own estimation she *did* become tearful ten percent of the time. Yet Maureen maintained that her grief had recently re-emerged. She did not know why this was, although she mentioned that her 18-year-old daughter was about to leave home for university.

Maureen mentioned that both of her parents had been cold and distant towards her, suggesting the possibility of an insecure attachment style. Were Maureen to be anxious/avoidant, this would be likely to affect her grieving style, making it likely that she would attempt to control and avoid her grief (Parkes, 2009). Her own mother’s injunction to keep busy because “it’s happened and that’s it” (said in the assessment, 0:21:00) would strengthen Maureen’s resolve to control her emotions against overwhelming odds.

There were two recognised complications to Maureen’s grief, her attachment style and the loss of a child (Burke & Neimeyer, 2013). The narrative disruption caused by the loss of this second child appears to have been life changing for almost eighteen years. Maureen went on to have six sessions of counselling and her counsellor reported fluctuating mood with periods of feeling low, punctuated by pangs of grief. There was no evidence that she was using the opportunity to effectively reconstruct her disrupted narrative (page 150, 8.1.5), and after six sessions she chose to end the counselling. It seems unlikely that she had adapted to her loss, and very possible that at some time she would return to the bereavement service for more counselling. This does refute any aspect of the theory outlined in Table 8.1, which refers to clients who engage, and make effective use of counselling if it is needed.

Applying the theory to the cases of Ted and Fiona

Ted

There is no doubt as to the distress of Ted’s broken father/son attachment. Ted reported crying and crying until he almost passed out. He found himself waking up and immediately thinking about his son. Ted’s grief was complicated not just by the death of his son but by the death of his daughter three years earlier. Inevitably, both losses would have created a huge degree of narrative disruption, yet it was on his strategies for coping by distraction that Ted chose to focus on during his assessment. These included playing golf and

spending time with friends. Hence there was little evidence of Ted's narrative reconstruction, apart from a very detailed revisiting of his son's suicide, in which he made sense of the circumstances surrounding his son's suicide. These included events leading up to his son's actions, in particular the ill-fated interactions with his estranged wife, and also the nature of his son's suicide, in particular determining to his own satisfaction whether Jimmy intended to die.

Fiona

Fiona showed evidence of the distress of broken spousal attachment. She talked about crying a great deal before and after her husband died and she described herself as "broken hearted" (assessment, 0:05:10). She also mentioned being "scared", although she could think of no reason for this other than "I just miss him." [Fiona, assessment, 0:06:30].

As with Ted, a huge amount of narrative disruption was inevitable in Fiona's case, as she had cared for her husband for a long time following a stroke before his cancer diagnosis. As he learned to talk again she had acted as his interpreter. Like Ted, Fiona was choosing to distract herself from the disruption by spending time with friends and family, and also by avoiding painful reminders such as photographs and music. However, just as Ted had needed to make sense of his son's death, so Fiona had sought explanations from her surgeon son. Knowing and understanding the trajectory of her husband's cancer had been helpful.

The part played by resilience

In choosing not to have counselling, both Ted and Fiona demonstrated resilience. In managing her grief with lifestyle changes, and in choosing only five counselling sessions, Caitlin was also resilient. These three clients test the theory outlined in Table 8.1 on page 150.

Ted and Fiona (see page 167) exhibited the distress of broken attachment. Fiona's personal narrative was possibly more disrupted, since she had shared her life with her husband, whereas Ted's son was not living in Ted's home. The only potential complicating factor (Burke & Neimeyer, 2013) for Fiona was the loss of a spouse, although in the author's experience, evidenced by the work with Sophie, spousal bereavement in a major disrupting factor. For Ted there were three potential complicating factors: the loss of a son: violent death; and sudden unexpected death. Caitlin (see pages 164-165) had played a central role in her mother's care, and her life changed dramatically when her mother died. Evidence of broken attachment distress was inconclusive. There were no potential complicating factors from Burke and Neimeyer's (2013) list (see page 23) to contribute to the changed life presented to Caitlin. She did, however, talk of being traumatised and stressed by the experiences of her mother's dementia, and described the stress of her job.

The author's theory, outlined in Table 8.1 is tested by these three case studies. Resilience, explored by Bonanno (2004; Bonanno et al., 2008), appears to be the common thread in all three of these case studies.

Applying the theory to the ten cases: Conclusions

Table 8.1 set out the author's theory under seven headings. Only Sophie's case study unambiguously gave weight to every aspect of the theory. All ten case studies showed evidence of the distress of broken attachment; either through direct evidence or as reported by the client implicitly or explicitly. Associated with this there was in all cases, some evidence of disrupted personal narrative. It did not appear to be the case that the number of complicating factors was proportional to the extent of the narrative disruption. Neither was the extent of narrative disruption directly related to the duration of counselling. Since not every client chose to remain in counselling it was not possible to collect evidence which would demonstrate narrative reconstruction as adaptation to loss. However, in all ten case studies, it appeared that making sense of the death was important, including being clear about the circumstances. Three case studies: Ted; Fiona; and Caitlin suggest that resilience plays a bigger part than the author had previously considered. These brief conclusions are examined more fully on pages 169 to 174 as each case is applied to the theory; the next stage in the process of theory building.

Applying the case to the theory

This exercise is about identifying gaps in the original theory (McLeod, 2010). Aspects of the original theory are analysed "from the perspective of the case" (ibid, p. 165). This is the process described by Stiles in which the researcher is required to "turn the observations back on the theory in order to improve it" (Stiles, 2007, p. 125). Each case study presents the opportunity to identify any gaps in the theory, to address any aspects of each case not covered by the theory, and to make appropriate modifications. Numbers in brackets refer to the 7 aspects of the theory, Table 8.1, page 150.

Applying Tony's case to the theory

The complex nature of Tony's case challenged the theory. Whilst the many strands of Tony's counselling followed an APES sequence, far more was involved than assimilating constructs around either his father's or his brother's deaths. It was coming to understand his own behaviour in relation to his losses that formed the most significant part of his counselling. Part of his behaviour involved a pattern of hiding from difficult situations. Tony came to identify his choice of working away from home as a form of hiding, and he also reported taking opportunities to hide from his co-workers on building sites when the pressure got too

much. As a child he had also created a false narrative in which his brother remained alive and would one day return.

Modifications to the theory based on Tony's case would be:

- i. The client can articulate the link between his grief and behaviour.
- ii. For narrative reconstruction to be helpful, new narratives need to reflect reality. (8.1.5; 8.1.6; 8.1.7)

Applying Jacqui's case to the theory

There seems little doubt that Jacqui was avoiding some aspects of her grief by using alcohol. Although she never fully acknowledged this, it was at the root of her family's concern for her welfare, and the reason that she consented to counselling. As in Tony's case, Jacqui found it difficult to relate her grief to her behaviour.

Because her father was not part of Jacqui's day to day existence, her assumptive world (Parkes, 1971) was not greatly challenged by his death. One aspect of the original theory was that counselling would show the clients adapting to a world which no longer contained the physical presence of the deceased. Evidence from this and other case studies indicate that this will only be a focus if the deceased played a major part in daily life. There is, however, a caveat in Jacqui's case. Although father's occasional presence made it easier for Jacqui in that, as discussed on page 155, she had got used to not having him around, this does not take into account the full extent of any separation distress. It seems possible, from her drinking pattern, that she was controlling overwhelming feelings of grief (Machin, 2013).

Modifications to the theory based on Jacqui's case would be:

- i. The client can articulate the link between her grief and behaviour.
- ii. The adaptation necessary for successful narrative reconstruction is related to the psychosocial transitions contingent on the client's life, i.e. they will be more idiosyncratic than the original theory postulated. (8.1.5; 8.1.6; 8.1.7).

Applying Sam's case to the theory

Sam's case strongly identified the negative effects of attempting to control overwhelming grief; in Sam's case from the distress of a broken mother/son bond. Somatic illnesses developed. Had Sam not acknowledged them and sought medical help, they could have become life-threatening. Like Tony and Jacqui, it was important that she was able to recognise how her behaviour was affected by her grief. Such recognition offers the opportunity for choice.

Sam's case challenges the too simplistic link between the number of complications and the degree of disrupted narrative. Some complications, including the nature and intensity of the bond, and the associated attachment style of the bereaved person, are more influential

than others on the Burke and Neimeyer (Burke & Neimeyer, 2013) list of complicating factors (Chapter 3).

Like Jacqui, Sam did not need to make huge changes to her assumptive world, but it was important that she made sense of many aspects of her son's death, in particular the high risk choice he made, and the tragic outcome of this choice. She also needed to use her idiosyncratic assimilation of reconstructed schemas to form a helpful symbolic bond with Mark.

Modifications to the theory based on Sam's case would be:

- i. The client can articulate the link between avoidant behaviour and harmful outcomes
- ii. It is the *intensity* of each factor, rather than the *total number* of factors, that complicates grief. (8.1.3)
- iii. The adaptation necessary for successful narrative reconstruction is idiosyncratic. (8.1.7)

Applying Amanda's case to the theory

Amanda's case gave weight to the revised theory that attachment distress plays a large part in complicating grief. Although she found the separation hard, she was helped by the opportunity to revisit and to make sense of her grandfather's death. It was a surprise to the author, and it did not fit the original theory, when she chose to end counselling having not fully adapted to life without him. She was not alone in this. Like many of the cases in this theory building exercise, from the client's point of view, sense-making through schema reconstruction was a more important function of counselling than was grief resolution per se.

Modifications to the theory based on Amanda's case would be:

- i. Clients can achieve a successful problem solution to their grief when they can make sense of the circumstances surrounding the death, and are able to talk about it. This broadens the definition of narrative reconstruction (8.1.5) away from coming to terms with a changed assumptive world (Parkes, 1971, 2009), and encompasses meaning construction (Neimeyer, 2001b) in a wider sense

Applying Sophie's case to the theory

As has already been stated, nothing in Sophie's case challenged any aspect of the theory as originally stated. In spite of this, Sophie was still experiencing the pain of separation more than two years after her husband died, yet she was happy to end counselling, recognising that for a long time, the stage she had reached in her grief was as good as it was going to get. Sophie did use counselling to adapt to life without her partner more than any other client,

because he had figured so largely in her life and that of the family. She also used the opportunity to better understand the events surrounding the death and her own reaction to it.

Sophie's case was used to bring together all the theoretical revisions and to test the revised theory. This is discussed on pages 184-188

Applying Ted and Fiona's cases to the theory

Although each of these clients adds weight to theoretical aspects of attachment distress and the need to make sense of the death, they illustrate the part played by resilience for many clients; as many as 46% according to the findings of Bonanno and colleagues (2010; 2008; 2002)³³. Fiona said that the opportunity to talk about her husband's death and her grief reaction had been helpful, and it is hypothesised that even a single session of counselling can be helpful for resilient clients (Wilson et al., 2016). The author suggests that a feature of resilience is the ability to adapt to change through a self-activating process of schema reconstruction, which although it does not require counselling, may be helped by it. This is a difficult hypothesis to test qualitatively, since most resilient clients are, by definition, less likely to present for counselling. It does have close similarities to "The process of active self-healing" proposed by Bohart and Tallman (1999, subtitle of the book).

As did most of the clients in the study, Ted and Fiona spent time out from their grief with activities that allowed avoidance and distraction. Although Jacqui, Amanda and Sam's cases demonstrated that avoidance can be harmful when grief is overwhelming, part of successful avoidance appears to involve mindful oscillation between grief and restorative activities, as originally proposed by Stroebe and Schut (1999, 2010).

Modifications to the theory based on Ted and Fiona's cases would be:

- i. Resilient clients are able to manage their grief without professional support, providing that they can make sense of the death and of their grief reaction.
- ii. The ability to oscillate between grief and purposeful avoidance is helpful.

Applying Caitlin and Sue's cases to the theory

Although both of these clients showed aspects of resilience, demonstrated by their minimal use of counselling, each had a story with the potential to compound their grief. For Caitlin it was the unfairness of her mother's life; the unremitting tragedy of a life at first blighted by an abusive marriage. Then, no sooner than she was free, the onset of dementia which grew worse over many years, culminating in some frightening experiences in residential care. For Sue it was the timing of her husband's chemotherapy, and his insistence on pursuing

³³ The value of 46% which Bonanno cites comes from a sample of bereaved spouses (n= 205) interviewed, before the loss of their partner, as part of the Changing Lives of Older Couples Study, and subsequently at 6 and 18 months and post loss (Bonanno et al., 2002).

treatment right up to the end. Both of these clients appeared to be helped by the opportunity to share their stories with an empathic listener. Without this there was a chance that a repetitious loop could have developed in which, in the process of revisiting the same schemas³⁴ over and over again, Caitlin and Sue could each have become mired in unhelpful ruminative coping (Nolen-Hoeksema, 2001). The ability to construct fresh schemas as a way out of ruminative coping is possibly another feature of resilience. For clients who lack this ability, attempts to find new meaning following a bereavement, may be counterproductive (Stroebe & Schut, 2000).

Caitlin appeared to resolve the story through her constructed narrative that she and her sisters had done all they could for their mother and ultimately she was at peace. For Sue the outcome was less clear. In a single session of counselling following her assessment, she repeated the story of her husband's chemotherapy and then chose to have no further sessions. It may be that she was able to recognise that no good would come of repeating the same story, so she chose to end counselling rather than dwell on existing schemas on her husband's treatment and death. It seems that she did not feel able at that time to assimilate new narrative constructs, nor did she use the opportunity offered by counselling to adapt to life without Gary. It seems likely that counselling had been of little constructive use to Sue other than giving her two occasions to express her sense of unfairness.

Modifications to the theory based on Caitlin and Sue's cases would be:

- i. Clients who successfully make use of counselling take the opportunity to reframe constructs which might otherwise result in ruminative coping. The ability to reframe constructs is a recognised aspect of resilient behaviour (Troy & Mauss, 2011) (see pages 49-50).
- ii. Clients unable to reframe unhelpful constructs surrounding the death are best served if they avoid or distract themselves from this aspect of their grief.
- iii. Futile and repeated attempts to find meaning can lead to ruminative coping.

Applying Maureen's case to the theory

Maureen's reappearance for counselling almost nineteen years after her daughter's stillbirth indicates an unresolved grief. She also left her counselling suddenly and very possibly without resolution. Therefore, if her case is to be useful in building a theory of how to reach a problem solution in grief, it is essential to identify what she could have done differently, and compare this to the cases where clients have managed their grief well.

Maureen's regular visits to her daughter's grave and annual visits to the Book of Remembrance strongly suggest a client that wanted aspects of her grief to remain unresolved.

³⁴ The definition of a schema appears on page xxii

Maureen also seemed to be unable to identify the very likely link between her unresolved grief for her first daughter and the grief for her second daughter being about to depart for University. It also seems likely that Maureen had continued to ruminate on the daughter's death for many years; possibly aided by conversations with her son and daughter. Her case highlights the importance of bereavement counselling that challenges clients' 'cognitive conservatism' (Janoff-Bulman, 1992, p. 26) and facilitates the assimilation of new schemas in the process of narrative reconstruction.

Modification to the theory based on Maureen's case would be:

- i. The client must be ready and willing to abandon unhelpful schemas and construct new ones (8.1.5; 8.1.6; 8.1.7).
- ii. For counselling to be successful, clients are required to reflect on their processes and to make decisions about what is helpful and what is unhelpful towards the resolution of their grief. Cooper (2008, p. 74) describes this ability as 'psychological mindedness'.

Modifying the original theory based on the case studies

Table 8.2 on the next page is related to Table 8.1 on page 150, and is informed by applying the theory building method: pages 149 to 177). It shows how applying the original theory to the cases, and the cases to the theory, has contributed towards modifying aspects of the theory. Missing from the original theory, and now added to it, is the role of resilience, the part played by oscillating between grief and avoidance, and the dangers of ruminative coping. Clients also need sufficient self-awareness to be able to assess the effect of their grieving behaviour on their health and emotional welfare, modifying their processes accordingly; for example choosing when to avoid their grief and when to address it. The part played by attachment style and separation distress in some clients had been underestimated in the original theory. Whilst evidence presented in this thesis suggests that the origins of separation distress are neurological (see Chapter 4), for many clients, particularly those with less resilience, this distress spills over into narrative reconstruction. Ruminative coping may result from separation distress and grief may be prolonged in some cases. Two of the cases, Sue and Maureen, have helped to illustrate two key preconditions to successful bereavement counselling. These are readiness to change on the part of the client and an adequate level of psychological mindedness for changes to be achievable through counselling.

For clients who engage effectively in the counselling process:		
	Original theory	Cases applied to the original theory and original theory applied to the cases
8.1.1	Initial phases of counselling show evidence of the distress of broken attachment.	Yes, although for many clients this distress has diminished before they present for counselling (see pages 169-174)
8.1.2	These initial phases also show evidence of disrupted personal narrative.	Yes, narrative disruption is an observed phenomenon (see pages 151-169)
8.1.3	The number of complicating factors is proportional to the extent of the narrative disruption.	No, some complicating factors, such as attachment distress and relationship to the deceased appear to be more significant than others. Whilst a high number is likely to cause significant disruption, so too can attachment distress, regardless of the presence or absence of complicating factors. (see pages 151-174). Resilience mitigates complicating factors for some clients (see pages 169-174)
8.1.4	The extent of narrative disruption is measurable by the time a client chooses to remain in counselling	Not necessarily. Whilst this is true for some clients, there is a wide degree of individual variation (see pages 151-169). Resilience plays significant part in both narrative disruption and duration of counselling (see pages 169 -174)
8.1.5	The grieving process reveals examples of narrative reconstruction.	Yes, in the sense that all clients who show helpful changes do so by making sense both of the death and of their own reaction to it (see pages 151-169, and 174)
8.1.6	This narrative reconstruction follows the sequential stages described by the Assimilation of Problematic Experiences Scale APES.	Yes, APES remains a useful tool for understanding and describing the sequences observed in bereavement counselling (see pages 151-164.
8.1.7	Counselling sessions show the client adapting to a world without the deceased.	This is true in the broader sense that counselling helps bereaved clients construct meaning, both of the death and of their reaction to it. Adaptation to daily life without the deceased is related to the extent of disruption to the client's assumptive world (see pages 151 to 174)

Table 8.2 Modifications to the original theory

Two important findings emerge from this the theory building case studies. The first is that a client's trajectory through bereavement counselling follows the APES sequence. The second is that the effect of complications to normal grief is not as straightforward as the original theory anticipated. Some factors for some clients appear to be more significant than others. In addition, individual resilience may go a long way in reducing the impact of complicating factors. (see section 8.1.3 on Table 8.2).

Refining the theory

It was clear from the two previous stages of theory building, that when accommodated schemas cease to be useful to bereaved clients, fresh schemas are assimilated. Through this process of continuing and interrelated assimilation and accommodation, meaning is constructed which enables the client to make sense of their world without the deceased. It was also clear that in grief, as with other problematic experiences, the Assimilation of Problematic Experiences Sequence (APES) is a useful way of describing the process. Clients work through the assimilation process at different speeds and in different ways, but what became evident from the observations is true for every case study client, regardless of the counselling received. Clients reach a problem solution once they can:

- i) accept the reality of the death;
- ii) make sense of the death;
- iii) acquire and practice coping strategies (distraction and avoidance can play an important part in this);
- iv) accept that for a time, sadness will be 'as good as it gets';
- v) find meaning in a life without the deceased;
- vi) form an individualised and creative continuing bond with the deceased: moving forward in a continuing *symbolic* relationship.

By recognising that clients can acquire these outcomes over time, an assimilation sequence such as APES allows the features of the modified theory to be integrated. Readiness to change, one of the preconditions of a successful outcome, may develop in the client as for example they become willing to change the nature of their attachment to the deceased. In the early stages of counselling the client may become more psychologically minded. Ruminative coping may be addressed during the counselling, thus enabling the client to overcome this tendency. Separation distress is easily accommodated within the theory. As clients moved through the sequence, distress diminishes and positive affect is re-established in the final stages of the assimilation sequence. Resilience plays a part in several aspects of the refined

theory. Resilient clients may find it easier to accept the reality of the death and to acquire coping strategies. Machin (2013) has described how resilient clients can oscillate freely between grief and avoidance. Resilient people by definition, adapt to change successfully. The path of resilient clients through the sequence is likely to be more rapid, and this has been demonstrated in the grief trajectories of resilient clients observed in other research (Bonanno et al., 2008).

Refining APES for grief outcomes

Because the six criteria for reaching a problem solution for bereavement in this refined theory (as outlined on page 176 and in Table 8.2, page 175) are so specific, a version of APES dedicated to grief outcomes was devised to accompany the theory. This has been called the Assimilation of Grief Experiences Sequence (AGES) (Table 8.3)³⁵. There is the same number of stages, 0 to 7 and conceptually they follow the same pattern of growing awareness, recognition and naming of a problem, working through the identified problem, and finally reaching a solution which at best gives mastery over future similar issues. This is not a replacement for APES but a modification of the descriptors in each stage, designed to serve the specific problematic experiences associated with bereavement. AGES also addresses the helpful aspects of avoiding negative affect in grief, and distinguishes it from the aspects of avoidance in APES which could be concerned with dissociating from the problematic experience.³⁶

³⁵ The AGES table can be compared with the APES table which appears on page 72

³⁶ This distinction does not challenge the validity of the APES sequence nor shed doubt on APES as a theory of assimilation. Dissociation, e.g. grief denial as an APES stage, differs from grief avoidance where this is a feature of oscillation between grief and distraction. Obsessive avoidance and the dissociation from grief are as harmful as dissociation from other problematic experiences.

Table 8.3 The Assimilation of Grief Experiences Sequence (AGES)

Stage 0 Warded Off

Managing the pain of grief

The client is in a state of numbness; dissociating from grief and associated reminders of the deceased.

Circumstances

The client avoids the circumstances surrounding the death. Clients frequently refuse to talk about what has happened.

Relationship to the deceased

The client dissociates from the reality of a physically ended relationship. Clients report reluctance to leave the body, or wanting to prevent the burial/cremation from taking place. In some instances, the client may refuse to talk about the deceased, and reminders of the loved one, e.g. wardrobe contents, are hastily packed away or disposed of. Clients do not generally present for counselling at this stage, but may report these events retrospectively.

Stage 1: Unwanted thoughts

Managing the pain of grief

Reminders which intensify the grief are avoided. Some clients manage this by “keeping busy”. The client is often unaware of the full extent of her grief, although it is obvious to friends and family, who may begin to worry and suggest professional help.

Circumstances

Client shows extreme difficulty in talking about the circumstances of the death. If pressed to do so, the account is short and brief. The client avoids reminders, e.g. music, photographs etc. As she approaches stage 2 she becomes more willing to talk about the events with others, but does not easily raise the topic. She may become upset and tearful.

Relationship to the deceased

Client clings to pretence that the loved-one is still alive. They talk as if the loved one was still there, e.g. greeting them on returning home from being out. The house remains unchanged, including the possessions of the deceased. Places associated with the deceased are often avoided. The client may express difficulties with being away from home, because they feel they are abandoning their loved one. Client may cry out in anguish, calling to the deceased. There may be regular, even daily visits to the grave or place where ashes are

scattered. The client sometimes displays searching behaviour which may be desperate and distressing.

Stage 2: Vague awareness

Managing the pain of grief

This is the most distressing stage, and counselling tends to hasten its onset; such that clients feel worse before they feel better. The client may talk of a loss of identity and purpose: "I am nothing without them. My life is over". She is likely to dwell on the loss.

Circumstances:

Client becomes able to introduce a conversation about the death although she is likely to become upset. Guilty feelings and unfinished business surrounding the death are discussed. Voices are often confused: 'I don't know what to think/feel/believe'. Reminders of the deceased become more tolerable.

Relationship to the deceased

Client 'knows' the loved one has died, but may still expect them to return. The client may look for signs and messages from the deceased – e.g. butterflies, white feathers, noises in the house and unexplained phenomena. They may contemplate (or even go through with) a visit to a medium at this time. The client may be drawn to places which remind her of the deceased, including the hospital /hospice ward where the loved one died. Thoughts about the lost loved one are seldom, if ever, far away. The client can feel guilty if she is distracted from her grief, or if she catches herself laughing. Anger towards the deceased is largely avoided. The client may spend significant amounts of time talking to the deceased. She may seek out the smell of the lost loved one, e.g. on a dressing gown or in the wardrobe. Frenetic searching behaviour begins to diminish.

Stage 3: Problem statement/clarification

Managing the pain of grief

Early in stage 3 the client still spends much time centred on her grief. Tears and low mood appear as if from nowhere, fixating the client on the loss. For some clients this includes both extrinsic, environmental triggers, and intrinsic factors such as personality traits, e.g. resilience. As she moves through this stage she experiences periods of respite and she begins to notice the extrinsic triggers to her grief; including anticipating difficult times, e.g. anniversaries. Some clients talk of guilt at finding grief respite; interpreting it as a sign of 'not

loving enough'. For these clients, ruminating on the grief may become a sign of loyalty to the deceased.

Circumstances

Events surrounding the death are described in an unhurried and detailed narrative. Client identifies areas of guilt and unfinished business they wish to work on. They may begin to recognise the irrationality of some of their guilt, as voices become less confused and begin to work together. Reminders, e.g. photographs, even if upsetting, begin to be an aid to healthy grieving.

Relationship to the deceased

Client's conversations with the deceased begin to lose aspects of magic and pretence and start become symbolic rituals. She articulates human feelings towards the deceased. Examples include, "I am angry with you for leaving me". and. "A fine mess you've left me in!" Client starts to become comfortable with some happy thoughts about the deceased. Searching behaviour becomes less frequent, and more symbolic, such as online searches for references to the deceased, e.g. social media pages.

Stage 4: Understanding/insight

Managing the pain of grief

Through this stage there is an increased acceptance of the grief. The client is able to "go with the flow". The client articulates an awareness of being able either to avoid grief or to contact tears when it feels appropriate. She has identified coping strategies; for example, restoration activities such as hobbies and social events. These may help the client to get temporary respite from the loss and grief. Client may seek out the experiences of other bereaved people in order to understand normal grief. This may include talking to others with similar experiences, reading internet pages and browsing online forums. Grief is embraced as fear diminishes, although feelings of guilt may be associated with successfully managing the grief.

Circumstances

Voices come together in accepting the cause of the death and discussing the events coherently. The client is generally comfortable with deliberately evoking memories of the deceased (for example, looking at photographs, listening to music). Searching behaviour diminishes. Negative affect may at times begin to decrease as pain gives way to a quieter sadness.

Relationship to the deceased

Talking about the deceased becomes sad rather than painful. Client begins to rationalise personal objects and becomes selective over which of the deceased's possessions hold significant meaning. Magical thinking such as finding white feathers becomes less important. Guilt at 'being happy' is diminishing. The client is able to gain comfort, even enjoyment from photographs and videos of the deceased and is comfortable with the memories they elicit. She is able to locate a symbolic place for the person they have lost. This may be a physical place ('I can feel them near when I am in my study'), and/or a spiritual/religious place ('Heaven'). Most clients develop a sense of holding the loved one within the self ('in my heart').

Stage 5: Application/working through

Managing the pain of grief

The client has learnt to oscillate comfortably between spending time dwelling on the loss and engaging in restorative activities. Thus periods of grief avoidance become helpful. The client becomes more accepting of her 'up and down' moods. Feeling 'down' becomes less frightening. Feelings of guilt at 'moving on' become successfully managed and sadness is no longer identified as essential for continued love loyalty towards the deceased. The interludes of grief and sadness become accepted and integrated into daily life: 'That is how it is, and how it will be for some time yet.' This stage can be summed up as 'Keep calm and carry on'.

Circumstances

Client begins to reach a new understanding and acceptance. She articulates, perhaps with prompts and open questioning, that she can make sense of the circumstances surrounding the death. She may articulate a religious or spiritual meaning in which the client says they find comfort. Examples include, 'She is at peace now' and 'He died so as to be there in heaven for his grandson'. At this stage there is often an acceptance that grief will be here to stay for a while, but pain is being replaced by sadness.

Relationship to the deceased

Visits to significant places, e.g. the graveside, become less important and have less significance. Client is increasingly comfortable about being happy in relation to the deceased. Relationship to the deceased is negotiated and renegotiated towards a symbolic form. 'Magical' expectations that they can ever physically return become increasingly rare and fleeting. Client can find meaning in the life of the deceased, including shared experiences.

Examples of things the client says include, 'He had a good life', 'We did so much together' and 'She achieved so much in her life'.

Stage 6: Problem solution

Managing the pain of grief

Client finds new meaning in post-loss life. She begins to establish a new identity. She articulates future plans as part of post-loss adaptation. This may include new hobbies and interests, new (or rekindled) friendships, house moves and job changes. Guilt at moving forward diminishes. Painful memories fade and happier memories take their place, although anniversaries may continue to be difficult for many years. The client is able to return to engagement with everyday life and the need for either grief or grief avoidance fade away. The client may experience having grown as a person, sometimes reporting feeling more compassionate and understanding of others.

Circumstances

Client accepts the reality of the death and may even have found a meaning: e.g. "He would not have wanted to be disabled or dependent". Religious and spiritual meanings may comfort some clients at this stage. Affect becomes positive. Guilt and other unfinished business is largely or completely resolved. Where no meaning can be found, for example following the death of a child, the client articulates a conscious decision to cease searching for meaning.

Relationship to the deceased

Client has formed a symbolic continuing bond with the deceased through objects which they find comforting. This may include items of clothing, photographs, items of jewellery and personal possessions with imbued meaning. Sad memories are tempered with happier ones. The client may contemplate new close relationships.

Stage 7: Mastery

Managing the pain of grief

The client is able to use her experience of grief and the strategies acquired to better cope with future losses.

Circumstances

Loss is integrated into a past which can be talked about reflectively with minimal negative affect. Any search for meaning has ceased. Client acquires a resilience which prepares her for future losses.

Relationship to the deceased

A symbolic and lasting bond with the deceased becomes integrated into the life of the client and is free of negative affect for nearly all of the time. The client becomes open to new close relationships whilst holding their lost loved one in their heart.

Table 8.3 The Assimilation of Grief Experiences Sequence (AGES)

APES and AGES: Similarities and differences

AGES deliberately reflects the same eight stages of APES, and is analogous in its basis as an assimilation model. AGES arises from the theory building exercise that has been described on pages 149-177. There is one apparent difference. In APES early stages (Table 5.1, page 72), clients are observed warding off or dissociating from their grief (APES 0) and trying to avoid ‘troublesome voices’ (APES 1) (Varvin & Stiles, 1999). In grief counselling, the value of taking time out from grief by engaging in distracting activities is known to be helpful (Machin, 2013; Stroebe & Schut, 1999, 2000). This is discussed by the author on page 20, where he reflects on grief distraction as a strategy chosen deliberately by many clients. This ability to oscillate between grief and restorative activities is part of managing the pain of grief, and comes into focus at AGES stages 4 and 5 (pages 180-182). It is important however to stress that this is an *apparent* difference to APES stages 0 and 1. Bereaved clients also dissociate from their grief. Tony, Jacqui, Sam and Amanda all described behaviour which suggested that they had dissociated and warded off their grief before recognising that counselling might help. Dissociation and avoidance are both described in AGES stages 0 and 1 (pages 178- 179).

Pragmatic modifications to Stiles’ theory testing approach

Pragmatic modifications were made in the light of limitations imposed by the finite duration of the project. To have followed Stiles’ (2007) theory testing approach to the letter would have meant a) completing and transcribing the work with each client, b) subjecting the case studies to assimilation analysis using APES, and c) subjecting each case study independently and consecutively through the theory building approach illustrated in Figure 8.1 (page 150). At each cycle there would have been a fresh refinement of the theory. However, as can be seen in Figure 6.1 on page 75, much of the client work overlapped. In order to minimise the effect of the research on the clients concerned, and in the spirit in which ethical permission was granted by the hosting organisation, a decision was made to complete the counselling of each client before transcribing any of that client’s sessions. Even listening to session recordings, would, in the view of the author, have carried the risk of affecting the

therapeutic interventions he was likely to make. No limit on the duration of the counselling was imposed on any of the clients. As a result, Sophie's counselling filled all of the time in the project set aside for data collection, and some of the time allocated to data analysis.

The pragmatic compromise was to refine the theory on the basis of the collective findings from each independent case study (Table 8.3, page 178). Similarly, because the duration of the project was limited to 6 years, no time remained to test the revised theory with new clients. A second pragmatic compromise was to subject the revised theory to existing data using Sophie's case study. This is described below.

Testing the revised theory as described by AGES

Sophie's progress through her grief was originally charted using APES. In order to test the revised theory, the case material was re-evaluated using AGES. Ideally a fresh case study would have been used, but as outlined above, no time remained within the parameters of the project, to recruit, record and transcribe another client.

Iterative protocol: Sophie's case study

Eighteen experienced bereavement counsellors were invited to read a shortened³⁷ version of Sophie's case study in which 20 moments of meaning making assimilation randomly selected³⁸ from the text had been highlighted (Appendix 7). Each participant was given a copy of the AGES scale (see Chapter 8) and asked to score each of the highlighted passages. Table 8.4 below shows these transcript extracts set in context.

³⁷ The full case study for Sophie was 11,600 words. The author deemed it unreasonable to expect colleagues to read all of this in order to rate 20 randomly selected passages and it was felt that few would participate. By introducing a shortened version 18 raters were recruited.

³⁸ Using a random number generator app on an iPad.

Table 8.4 Randomly selected extracts from Sophie's transcript

Session number	Time into Session [hrs:mins:secs]	Transcript	AGES Score *
Assess	[0:12:11]	On the previous evening, Sophie had gone out with a female friend because she felt that she needed a break. Looking back on the occasion, she felt guilty now because David had not wanted her to go. During the evening she had confided in her friend her stress that caring for David might go on for months or even years. "Then I felt awful saying that cos the next day he died"	1.9
Assess	[0:24:00]	Although she felt unable to sleep in what had been the marital bed, she spent a lot of time in the room. "I talk to him. I feel that he's there". She found herself looking for signs from him, like a wardrobe door that opened. "Did he open the door?"	2.0
5	[0:06:00]	She had found herself engaged in searching activities. "I find myself Googling David's name. Also I've been going over hospital letters which had discussed his diagnosis and prognosis".	2.4
7	[0:10:00]	"Stuff has been popping into my head. I've not been sleeping well and my mind has been racing" (as she thought of the circumstances surrounding David's death).	2.3
19	[0:12:00]	Sophie had begun to recognise the value of taking control of her life. "I've begun to keep a memo book in place of post-it notes".	4.4
26	[0:19:45]	"I keep thinking that I could have, and I know I've said it loads of times, that I could have done something else, or changed something, done something on that day (3 second pause). It just seems like (sighs) I'm putting this pressure on myself thinking that, I mean I'm not medically, I can't, you know, but I just feel as though that (pause) I might have been able to do something that nobody else could have done. I know that sounds really stupid, I could have changed the outcome".	2.8
30	[0:10:15]	"I know I'm a mum and everything, but what's the other bit of me doing? Do you know what I mean? Where do I go from here? (sobs) Don't know, don't know. I can't see a plan".	3.2
30	[0:30:40]	"I just feel like is every week just going to feel like this now?"	3.5
32	[0:00:58]	The counsellor began by asking Sophie how she was. "Same old same old. It feels like that's how it is and that's how it's going to be".	3.7
32	[0:21:30]	"Maybe I think that I can't move on until Michael's older. Then then I'm thinking maybe 'Am I going to feel like this for the next 10 years or something?' And then I can start living. It's not like I want to be party animal. I don't want to be going out and things like that. It's not that I want something, I don't know. It's really hard to explain".	3.9
32	[0:41:36]	Sophie turned towards thinking about David. She said that she felt close to him in the bedroom where he died but that she still cannot sleep in that room. Each time she left the bedroom she always shouted back upstairs, "'See you later' sort of thing. And I don't shut the door, cos he hated being shut in".	3.8
32	[0:58:08]	She reflected that she has often held back on her tears to her detriment. "I do feel I'm holding back on my crying".	4.4
33	[0:03:00]	Sophie said that she was continuing to "go with the flow". She said that life did not feel as intense as what she referred to as "the blip" in session 32.	4.5

41	[0:20:00]	Sophie reflected that nearly two years had passed since David was diagnosed with cancer. It was hard to believe, and she felt that she had “skipped a whole year”. To miss the year in which he died was a “strange peculiar feeling.” She recognised how far she had come, and cited as an example, her ability to go out without feeling guilty.	5.4
41	[0:49:00]	At times, David’s death still did not feel real. “Sometimes things will like trigger things. Like there’s a car parking outside and just for a fleeting second you just think ‘Oh David’s home’ It’s really weird. Just for a second”.	4.5
41	[0:50:00]	“It’s okay to let myself be like that. It seems weird thinking that next year it will be two years, because it doesn’t feel like two years”.	5.3
42	[0:17:40]	Sophie said that now she could think about things that they had done or talked about that now felt comfortable. For example, she and Emily had been into a television shop and had talked about how Dad would have liked one of the big screens.	5.6
42	[0:25:00]	“I get changed in our bedroom, but I still couldn’t sleep there. Having the empty space makes it more noticeable compared to sleeping in a single bed”.	4.9
43	[0:30:30]	“I recently went through David’s hospital letters and looked at his Twitter page. I don’t know why I did that”	5.2
45	[0:33:47]	I feel like I’m missing him more now because I want to be able to do things, everyday things with him and things like that. It’s weird really, but I feel I’ve just got to get on with it, can’t do anything about it. I have joined the WAY Foundation	5.8 ³⁹

*AGES score determined from the mean rating of 18 raters

As with the previous iterative exercise on Tony’s case study (Chapter 7, page 121), the rater reliability of the scores for Sophie’s transcript extract was determined using the Intraclass Correlation Coefficient (ICC) (McGraw & Wong, 1996) with SPSS Software (IBM Corporation) (See also, p. 126). Reliability was found to be excellent: ICC = 0.966. See Table 8.5 opposite.

³⁹ Scores highlighted are used to construct Figure 8.2, page 188

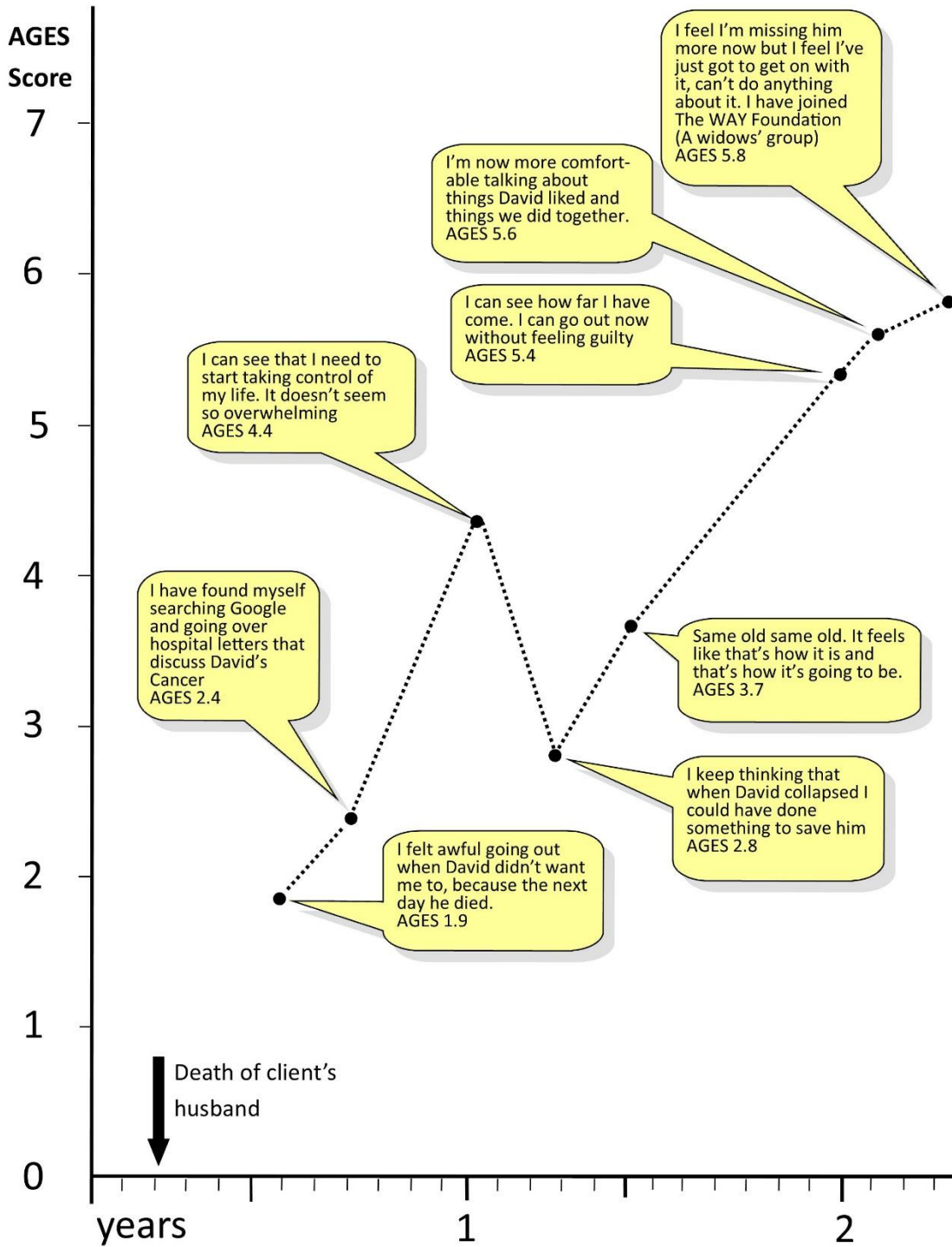


Figure 8.2 Sophie's transcript extracts with AGES scores showing progression through the sequence

Testing the revised theory against further cases

The revised theory is outlined on page 176. Although no more data have been recorded to test the revised theory, the author has been aware that since revising the theory and testing it with Sophie's data, confidence in the AGES sequence is reinforced by evidence from reflective practice. In this section the author reflects on this evidence whilst mindful of the confidentiality afforded to clients who have not given informed consent for case studies to be used.

i) Accepting the reality of the death

The author has noted that many clients 'know', at a rational level that their loved-one has died, but find it hard to believe; imagining that one day they will magically return. When the client accepts reality most of the time, counselling may not be requested. Sometimes a single session is sufficient for a client to explore her thoughts and feelings sufficiently come to terms with reality (Wilson et al., 2016).

ii) Making sense of the death

Having identified the pivotal part played by this aspect of meaning making, the author is now far more proactive in supporting clients as they assimilate and accommodate new constructs to understand the details of the death. In one case a client had been struggling to understand the violent death of a sibling; believing it to be suicide. Schemas which initially served the client well were disrupted when an inquest recorded an open verdict. The possibility that the death had, after all, been a tragic accident threw the client into dissonance. Much of the work concentrated on supporting the client to weigh up the balance of probabilities based on knowledge of the sibling and circumstances of the death. Another client spent the counselling sessions trying to understand a spousal death which was preceded by a long and demeaning physical and intellectual deterioration. The focus was in trying to interpret from the available evidence, how much the dying partner understood what was happening, and whether the treatment in the final days was appropriate. The author has learnt to be aware of the very real dangers of rumination in cases such as the two considered here, and with both of these clients this potential risk was carefully monitored.

iii) Acquiring coping strategies

An important part of every initial assessment is to determine the client's degree of oscillation between loss and restoration. Resilient clients with no complicating factors to their grief and who demonstrate the ability to move freely between revisiting their sadness and engaging in restorative activities, are reassured and advised that they are unlikely to need counselling. The author has developed a high level of confidence in making this judgement, and this is confirmed by outcomes. When the author makes a routine telephone call to these

clients three months after the assessment, then only very rarely do these clients self-assess as needing ongoing support.

Where clients are stuck in either loss or restoration coping styles, progress is made if the client learns to successfully oscillate. The Adult Attitude to Grief (AAG) scale (Machin & Spall, 2004; Relf et al., 2010) has been used to measure and monitor this change.

iv) Accepting the enduring sadness

The sentiment of Sophie's moving words (page 185, session 32), recognising that the sadness of her grief would last for a long time is regularly heard from clients by the author in the course of his practice. Rather than a sign of resignation on the part of the client, it is taken as an acknowledgement of the enduring sadness of broken attachment. The resilient clients can learn to live with this sadness, accept its normality and take time out through restorative activities. Reflective practice has taught the author that in a typical normal grief trajectory, emotion connected to broken attachment begins with pain and moves to sadness, which in time progresses to happy memories tinged with the sadness of regret. The author sometime describes this to clients as "happy grief". In time most clients come to understand and accept this concept.

v) Finding meaning in a life without the deceased

When the author first began to work with a client in her mid-70s bereaved of her husband she was distraught; regularly voicing her view that she would never recover from the loss. Throughout their married life, husband and wife had maintained separate interests, as well as doing much together through common interests. As the raw pain of her broken attachment subsided, she was able to continue with her hobbies and find purpose in her charitable volunteering. This was instrumental in her finding new meaning to her life. Many widows and widowers find meaning in supporting their children and grandchildren, and this client was no exception. Others recall their partner's admonition to keep going and to live for the both of them.

vi) Forming an individualised and creative continuing bond with the deceased

The author is regularly impressed with the creativity of clients as they form continuing bonds with the person they have lost. Some clients need the possibilities explained to them whilst others do this intuitively. Such bonds usually develop from memories triggered by photographs or other reminders of the deceased. The story of "Betty", and the way she used counselling to develop a continuing bond with her husband is a notable example in the author's practice. The trigger to recalling forgotten memories came in handling artefacts produced by her husband as part of his hobby (Wilson, 2014, pp. 132-133).

In reviewing his reflective practice since completing the theory building process and formulating AGES, the author is confident that assessed clients who meet all the criteria in

sections i) to vi) above do not need ongoing professional support. Those that do receive counselling are able to end support once the criteria above have been met. This does not necessarily mean their grief has ended or that they have stopped being sad. It does, however, mean that they have acquired strategies to manage their situation; one of the components of resilience discussed on pages 204-209.

Chapter 9: Discussion

The proposition of this thesis is that grief complications are resolved through a process of meaning making, after which the bereaved person is able to make sense of the death, of their own reaction to the death and of their renegotiated relationship with the deceased. The thesis proposes that this is achieved through a process of assimilation and accommodation. Finding that existing schemas can no longer be accommodated in a world disrupted by loss, the bereaved person assimilates new schemas which can be accommodated into a post-loss narrative. As the bereaved person moves through her grief, her construal of the new situation in which she finds herself is constantly changing; such that assimilation and accommodation exist in the state of dynamic interplay described by Piaget (1954, p. 351). The research undertaken for this thesis has focused on observation of this process in ten clients. In the sections which follow, the observations made in these case studies are compared with conceptualisations of grief drawn from other research.

The assimilation/ accommodation dynamic

In Chapter 4 it was noted that assimilation takes place in response to accommodating change. By the nature of their grief, every client in this study was striving to accommodate the experience of loss, which in some cases, was also traumatic. Bereavement challenges certainties and changes realities; little wonder that some clients are reluctant to confront this. In the face of loss, Amanda found it hard to accept the death of a much loved grandfather. Initially unable to accommodate the reality of the death her health suffered and she sought counselling. Her early narratives she described in moving detail the intense close relationship she shared with her grandfather in his final days. She found it hard to leave him behind in the hospital. In time she was able to assimilate new schemas, picturing grandfather in a better place and renegotiating her relationship with him in symbolic form.

Once the reality of events was accepted, every client was able to assimilate schemas surrounding the circumstances of the death. In spite of the harrowing circumstances of his son's suicide by hanging, Ted assimilated a detailed construct of the "procedure" (p. 124) based on his experience as a serving police officer; having attended suicides in the course of his duties. He was even able to modify this schema to match the exact circumstances revealed at the inquest, by talking to the Coroner's Officer. Past experience helped Ted to accommodate the loss; something that is probably true of all clients. However, even after they have begun the process of accommodating the loss, bereaved clients exhibit instances of 'cognitive conservatism' (Janoff-Bulman, 1992, p. 26). Clients who display this behaviour continue to

conserve accommodated schemas long after they have outlived any effective usefulness⁴⁰. In the second year after her loss Sophie spoke of always calling upstairs to her husband when she left the house (see page 115), and on hearing a car stop outside, entertained for a fleeting moment, a belief that he had returned (see page 135).

Many moments of assimilation in grief counselling illustrated the sense of ‘felt bodily shift’ (see page 196) which characterised the affective aspects of dissonance. Early in his therapy Tony experienced a moment of intense elation as he began to recognise the part his delayed grief played in his chronic anxiety and depression. Contact with intense emotion was repeated in session 30; near the end of Tony’s counselling, resulting in him being able to assimilate an understanding of years of misplaced guilt.

The author concludes that the case studies reported in this chapter lend weight to an assimilation model. Accommodation was implied in the clients’ behaviour, whereas moments of assimilation could be observed directly in the counselling sessions. Dissonance could often be observed in the behaviour of the client, taking the form of distress, tears, laughter, excitement, and even elation.

Individual skills and differences in assimilating grief experiences

Individuals show different styles of assimilation. Clients who move away from a simple narrative, in which they relate events as a story, and include reflection, have better therapeutic outcomes than those who find self-reflection difficult. All five of the clients counselled by the author showed some element of reflection; some more than others. It is the author’s experience that clients who relate their experience of bereavement purely as a simple narrative, are unable to make effective use of the client-centred model of grief therapy proposed here. Although for the ethical reasons discussed in Chapter 6, Section 1 no transcriptions can be presented as evidence to support this, many years of therapeutic practice leave the author confident in making this observation.

Tony presented in every session with a great deal of personal reflection, in this extract as he looked back of his adult life, much of which was spent away from his native home:

“I was escaping, and I sort of knew that but perhaps I forgot it. And, because there wasn’t reminders of my brother and things like that and I didn’t perhaps have to look at my mum and dad. I wanted to be able to work out what I was doing. I don’t have a world where I can go and escape to any more, do I?” [Tony, session 1, 0:29:30]

⁴⁰ Cognitive conservatism is discussed more fully on page 204

Sophie tended to present with a narrative account which she would explore before following with a reflective element.

“I felt so guilty, I felt really guilty and horrible and it made me cry.” [Sophie, session 22, 0:05:27].

“I think, ‘Maybe I wasn’t ready for going out’, but then I think ‘If I wasn’t I wouldn’t have gone’.” [Sophie, session 22, 0:14:16].

Sam’s counselling tended to show far more reflection than narrative.

“Obviously I find it difficult to believe. There’s still denial that he’s dead, because up until 2007 I’d been three years up here and he’d been three years in Sheffield, so there’s distance. So am I being unreal and thinking he’s going to come round the corner one day?” [Sam, session 1, 0:47:53].

Amanda’s early sessions tell a highly personal story of her time with her grandfather in hospital, tinged with reflection.

“I fed him his last dinner and gave him his drink and he died within two hours. So he was going on his own accord. He was going with a full stomach. He hadn’t eaten for weeks. Now looking back on it I’m thinking ‘You knew!’ (laughs). ‘You was having the last bit of mash and gravy and stuff’. So I can laugh about things like that thinking, ‘You greedy beggar! You knew’. So things like that it does make you happy, thinking, ‘You were still funny right to the end’. You couldn’t have asked for anything better. He did it as he wanted and we didn’t even know it was happening. He stayed calm for all of us”. [Amanda, session 1, 0:48:50].

Amanda was however, capable of deep and moving reflection. There she is reflecting on how she had whispered to her grandfather that it was okay to let go of life.

“I could have easily have turned round and said ‘No don’t you dare leave me’, but he wanted to go and he was ready and I didn’t want to see him in any more pain or suffering like that. So I am, I *am* happy with that. The only thing I would say that I

weren't happy about that is my own selfish reasons, but I'm glad I said what I said".
[Amanda, session 1, 0:16:56].

Jacqui was capable of reflection, although much of it concerned keeping in control of difficult thoughts and feelings, as though this was part of her life script (Berne, 2010).

- Jacqui: I'm quite positive, I *am* a positive person but I don't think it's good to look back, it's best to go forward.
- Counsellor: So you have to be quite emotionally self-sufficient?
- Jacqui: Yes.
- Counsellor: And you've always had to be?
- Jacqui: Independent_on your own. I mean my husband will say I've got brick walls but they're not on bricks they're on hydraulics and they'll go up and down just to protect myself.[assessment session 0:18:50].

It seems that self-awareness and the ability to reflect are important features of grief counselling, but this is not enough on its own. For the counselling to be effective it is important for the client to be able to reflect on the many facets of her bereavement.

The therapeutic alliance

Working effectively towards the assimilation of grief experiences involves a collaborative endeavour between counsellor and client. Like Bohart and Tallman (1999) the author believes that for the alliance to be effective, the counsellor helps the client identify what he or she wants to achieve in the relationship and facilitates the therapeutic process. Central to this process is the counsellor's attitude towards the client. Over the duration of this project the author acquired some expertise in the operation of the assimilation model with bereaved clients. However, at all times the author regarded each client in the study as the expert in their own lives, trusted to be able to identify their own needs and frame their own goals. For the assimilation model to be effective, trust needs to be mutual. There were many times during Tony's counselling when he became despondent at his apparent lack of progress. The author was successful in facilitating Tony's trust in himself and in the therapeutic process. There was a serendipitous reciprocity in fostering this trust. Once Tony came to trust the process and was more able to achieve therapeutic change, this reinforced the author's confidence; not just in the assimilation model as a useful tool, but in his use of therapeutic skills and his effectiveness as a bereavement counsellor. At the end of Tony's therapy there was mutual delight in his successful outcome. In short, the assimilation model works best when client and counsellor

trust themselves, each other, and the therapeutic alliance. There are many facets to developing this alliance but in essence they all involve putting the client as much as possible in control of his or her counselling. For example, each client in the study was able to remain in counselling for as long as they felt it was needed, and where appointments became less frequent this was in every case at the behest of the client. Once trust was established, the counselling space became a safe environment in which each client was able to stop dissociating from grief and could begin to progress through the grief assimilation sequence. The client's sense of control appears to come with the realisation that engagement in this sequence is the beginning of a mastery over the grief experience.

The therapeutic alliance in action

Just as Attig (1991) emphasised the importance of seeing grief as an active process (see Chapter 4), so also is the process of effective grief therapy. In the case studies discussed here, appropriate interventions encouraged dissonance and aided the formation of new schemas. Sometimes the intervention involved empathy. In session 35 Sophie reported dreaming that husband David had died peacefully at home rather than suddenly and traumatically. She recalled his moment of death and wondered if he knew he was dying.

- Sophie: I still beat myself up that I could have done more. And I know I couldn't and I know I keep going over it, but I still think I could've.
- Counsellor: It's like knowing that you couldn't but feeling that you could.
- Sophie: Yes and I suppose I've just got to learn to live with that. [Sophie, session 35, 00:26:20].

In session 2 Tony was attempting to explore his lack of motivation to tackle the simplest of tasks. The author suspected this related to earlier explorations where Tony's reflections on the death of his brother and father left him with a sense of futility. He addressed this with empathic paraphrasing:

- Counsellor: So there's just an overriding voice that permeates everything unless you distract it, which just says "What's the point?"
- Tony: Pretty much, it sort of does come to that. [Session 2, 0:06:41].

At best, the therapeutic intervention brings about the 'felt bodily shift' posited by Bohart and Tallman (1999, p. 220). In this extract Tony was struggling with two voices in

opposition. One voice wanted to be free of the pain of grief for his father and brother. The opposing voice believed that freedom from painful memories risked ending relational bonds.

- Tony: Free of *it* and I think I put 'free of it' as in free of like throwing my brother away and throwing my dad away.
- Counsellor: And you wouldn't do that. You can be free for your misconceptions without losing either of them.
- Tony: (Bursts into tears). You can't work it out can you?
- Counsellor: You don't want to lose either of them why should you?
- Tony: No I don't. That's what you can't work out. You can't work it out on your own.
- Counsellor: But you're working it out with my help.
- Tony: Yes it is. I can feel it (cries loudly). It feels good. I can even let myself believe a tiny bit. It's just been there for so long now. It was part of me just scared that even if there was something that I wouldn't be able to let go of it. [Tony, Session 5, 0:49:00].

In the therapeutic alliance of each case study, the author sought to support the client's capability for exploration (Bohart & Tallman, 1999). The author developed this by being explicitly curious about the client. In the best of work, an attitude of curiosity, providing it is genuinely congruent, becomes infectious. What is initially modelled by the counsellor becomes mutual. This was particularly prevalent in the work with Sam who in this extract began by touching on her guilt and helplessness in not being able to save her son.

- Sam: I could have saved him if he had listened, if he had not been 41 and had his own mind. If he had been a machine and I could have kept on saying to him "Don't have the operation, just lose weight". I couldn't protect him could I?
- Counsellor: What does that do to you, if you just stop and stay, instead of disappearing off somewhere? This idea, where is it touching you?
- Sam: Well intellectually
- Counsellor: I'm inviting you not to. I'm inviting you to see where, in your body, or wherever, it sits.
- Sam: Yes, in here (pointing to her gut). It's a (5 second pause). I've seen that many people die that I know.

- Counsellor: Stay with the “It’s a...”. You were going to say something about feelings.
- Sam: It’s a fuzzy feeling. It’s a warm fuzzy feeling if you want to put it that way. Because I’ve actually realised with seeing so many people die, that that’s what we do, we die. But again, it’s not what I was hoping that got me into feeling it. I’ve rationalised it again. I got a really warm feeling that he was back. And that’s the warm feeling. That’s where I’m stuck. That’s the warm feeling.
- Counsellor: What does that warm feeling want to say to you?
- Sam: It’s comfort
- Counsellor: What would it say to you?
- Sam: It remembers him as he was. It’s saying to me “Remember him as he was”.

[Sam, session 2, 0:54.25].

The medicalisation of grief

In Chapter 2 the author explored the twentieth century psychoanalysts’ contribution to grief theory, which led both to the medicalisation of grief and to the concept of ‘grief work’. From the author’s extensive, albeit predominantly anecdotal experience, grief reactions in clients referred to Saint Catherine’s Hospice Bereavement Support Service seldom displayed pathology. In none of the ten cases, which form the subject of this thesis, was there, from the author’s observations, any need to view the clients from a pathological perspective. This claim does, however, require qualification. The author regularly sees clients who have been prescribed antidepressants, and there have been times when the author has suggested to a client that he or she makes a doctor’s appointment to determine whether clinical depression is accompanying their grief. Sophie was one such case. Her doctor did prescribe an antidepressant, although in the event, talking therapy proved adequate, and she did not use this medication. Tony made the unilateral choice to cease taking antidepressants as part of his talking therapy, because he believed that they were numbing his emotions. He believed that this decision was instrumental in the successful outcome of his counselling.

Even when clients are using antidepressants, this does not in itself medicalise grief. Prigerson and colleagues (Prigerson et al., 1996; Prigerson et al., 1995) concluded that grief related depression is distinguishable from complicated grief. Clients grieving normally may still experience a depressive episode, and evidence, from this thesis, suggests that a talking therapy for normal grief may be adequate.

Prolonged grief

Having rejected the term *complicated grief* for the second time, the authors of DSM-5 (APA, 2013) introduced the possibility for physicians to diagnose *prolonged grief* in clients grieving for more than six months (Wilson, 2014, pp. 45-46). Bonanno and colleagues (2008) demonstrated that clients whose grief was complicated failed to show any marked improvement over a two-year period. By DSM-5 (APA, 2013) criteria, since Sophie's grief lasted far longer than six months, she could have received a medical diagnosis of prolonged grief. However, Sophie's steady progress through AGES, illustrated graphically on page 188, demonstrates a grief trajectory which is normal and healthy. In the view of the author, this case study adds further weight in challenging those who view an extended period of grief as invariably a symptom of a disorder. So long as the grief trajectory maintains a steady improvement in affect, as described by Bonanno (2010. see page 2 of this thesis), the author maintains that grief is normal.

Evidence in contradiction of the grief work hypothesis

This thesis supports the conclusions of Stroebe and colleagues (Stroebe, 1993; Stroebe & Stroebe, 1991; Stroebe et al., 2002; Stroebe et al., 2005) and Wortman and Silver (1989, 2001), that grief work is not an essential prerequisite of successful grief resolution. For neither Ted nor Fiona was counselling necessary. Caitlin and Sue received a minimal amount of counselling. For Caitlin, the counselling she did have was more about finding practical solutions to her situation than it was about a need to make sense of her grief. By the time she presented for assessment she had accommodated new schemas for being at peace with her mother's death and had concluded that she and her sisters had done all that was possible to make their mother's last months comfortable.

To support a normally grieving client by encouraging her towards grief work may encourage ruminative coping (Nolen-Hoeksema, 2001). This may explain the findings that in some instances, a counselling intervention for normal grief can serve no useful purpose and may even be harmful (Schut et al., 2001). Maureen's case study suggested that she had been ruminating on the stillbirth of her daughter for over two and a half decades. The author played no part in the six counselling sessions that Maureen received and so was unable to challenge her long-standing ruminative coping strategy. Nevertheless this case study does support critics of the grief work hypothesis. The effect of rumination on resilience is explored below.

Evidence in support of the Dual Process Model (DPM)

Eight of the ten case studies add weight to the validity of the DPM (Stroebe & Schut, 1999). Sophie found comfort in social activities once she had got over her initial guilt at

enjoying them. In any case, the demands of a family acted as a distraction, encouraging her to take time out from her grief to pursue outings and activities with her children. Both Ted and Fiona made healthy use of social contacts and time with family members as a means of restoration orientation. Yet seven of the case studies suggest that there is a fine balance between purposeful oscillation on the loss/ restoration continuum, and avoidance of overwhelming feelings through obsessive distraction. Tony had spent all of his adult life developing an elaborate pattern of avoidance; working away from a home town which carried the ghosts of his past and the roots of his grief. Jacqui was using alcohol in an attempt to avoid her sadness; to the detriment of her health. Sam's strategy for coping with the death of her son involved immersing herself in academic study. When interviewed by the author, Sam was convinced that the resultant stress, coupled with her grief, was the cause of her medical condition of atrial fibrillation.

Caitlin appeared to be somewhere between the healthy style of oscillation observed in Sophie, Ted and Fiona, and the obsessive control of Tony, Jacqui and Sam. At her assessment Caitlin talked about "being like a machine" in the way that she juggled domesticity and self-employment. She described herself as overwhelmed and recognised that her ability to "keep going" was "probably to my detriment". At the same time she had fitted an exercise regime into her schedule, found time to relax at home, and she spent time with friends who gave her permission to be tearful.

These observations support Machin's (2013, pp. 34-39) theoretical approach. Drawing on the DPM, she suggests that a client's resilience can be measured by the ability to oscillate smoothly between grief and restorative activities. Vulnerable clients, according to Machin (ibid) are those who attempt to manage their overwhelming emotions with obsessive control.

Evidence of grief resolution through adaptation to change

Of the ten case studies, only Sophie, Fiona and Sue were presented with a major challenge to their respective assumptive worlds. To lose a partner with whom you have shared a life on a day-to-day basis for many years, cannot fail to be disruptive; both to one's identity as a partner, and to routines which very likely will have been taken for granted. Essential tasks, such as domestic finances and housekeeping are very often carried out by one member of the relationship. The other may look after information technology, household repairs and general maintenance. After a bereavement the surviving partner is faced with learning new skills. Attig (2011) has called this 'relearning the world'. In a world of information technology, one of Sophie's foremost worry was having neither the knowledge nor the technical know-how to support her youngest child through his education in the same way that husband David had supported the older two.

At the time of her assessment and in her one counselling session, Sue was preoccupied with the unfairness of life and with her attempts to make sense of her husband's cancer treatment. It seemed that she got what she needed from talking to her family. Fiona chose not to have further counselling once she was reassured by her assessment session that she was managing her grief normally and healthily. Whatever the extent of narrative disruption caused by the loss of one's assumptive world, it appears that many bereaved partners can manage to adapt without ongoing professional support.

Partners are not the only group that can be dealt a shock to their assumptive world following a bereavement. In communities where extended families live in geographical proximity, the loss of a family member who was an integral part of one's daily life can cause significant disruption. Such was the case when Amanda's grandfather died. However, Amanda did not use her nine sessions of counselling to explore changes to her assumptive world. Her need was to make sense of her broken attachment to grandfather. This is discussed below.

As hard as it is to lose a child, once that child reaches adulthood and moves out of the parental home, the shock to a parent's assumptive world should the child die, tends to be not as great as it would be were the child still living at home. To some, this might seem counterintuitive, but this is the author's experience in working with bereaved parents. One likely explanation is that although the pain of broken attachment does not differ, the additional stress of a changed assumptive world (Parkes, 1971) if the child is a regular part of life, adds to the complexity of the loss. In neither the case of Sam nor Ted was the son still in the parental home. Ted was sufficiently resilient not to need counselling and Sam used her sessions both to overcome her fear of facing her emotions and to make sense of her son's death.

Evidence of meaning making

The conclusion implied in the section above, is that a client's need to use counselling in order to adapt to a changed assumptive world is by no means universal. Yet all ten case studies show evidence of clients assimilating and accommodating new meanings. As was discussed in the last chapter, evidence from all ten clients indicated that they used counselling to make sense of their grief, accept and understand the reality of the death and renegotiate the relationship with the deceased. These findings have been borne out by other research. For example Currier, Holland and Neimeyer (2006) found that an inability to find meaning in a loss was a predictor of grief complications.

Evidence for continuing bonds with the deceased

Continuing bonds theory originated as a counter to Freud's claim that the "work of mourning" involved breaking the bond which bound the deceased to the lost love object

(Freud, 1957, p. 245). The idea became established in popular Western culture, that in order to stop grieving one had to let go and move on. By the end of the 20th century a generation of bereavement counselling practitioners had discovered for themselves that most clients do not 'let go'; they successfully find an idiosyncratic way of continuing a bond with the lost loved-one. Even Sigmund Freud had eventually been forced to admit that he found it impossible to let go of family members he had lost (Wilson, 2014, pp. 54-55). In an edited collection, Klass and colleagues developed the widespread refutation of Freud's claim (Klass et al., 1996). Two of the editors suggest that the formation of the continuing bond involves "a process of adaptation and change in the postdeath relationship and the construction and reconstruction of new connections" (Silverman & Klass, 1996, p. 18).

It is the author's experience, confirmed by the evidence from the ten case studies, that the adaptation and reconstruction central to the formation of a healthy continuing bond, takes time. Jacqui was beginning to develop a continuing bond with her father through the picture he had painted for her. Sam's continuing bond with Mark was developing as she visited their old haunts, but this was after her counselling had finished. A year after her husband's death Sophie could voice her continuing bond for David as she shared memories with her children. This family also maintained Christmas rituals that had been part of the children's lifelong experience.

The variety and the wealth of creativity employed by individuals and families in the development of continuing bonds is testament both to their value and to their individualised nature. Yet there is an important caveat illustrated by the case studies of Tony and Amanda. Right into adulthood, Tony had maintained the pretence that his brother was still alive; never completely abandoning his childhood fantasy that his brother had survived and had been spirited away after the crash to become a government secret agent. Although Amanda's counselling did not start until seven months after her grandfather's death, she was still struggling to accept the reality that he had died, and still felt drawn to the hospital where she had last seen him. In the author's view, more qualitative research is required to investigate the nature of healthy, and therefore helpful continuing bonds, as opposed to those which lock the bereaved relative into a pattern of denial and pretence.

Evidence for attachment theories of grief

Nearly 50 years have passed since Bowlby and Parkes (1970) developed their stages of grief based on attachment theory. Although Bowlby maintained a psychoanalyst's discipline throughout his life (Bowlby, 1975, p. 15), he approached his ideas from a biological, rather than a Freudian position, embracing ethology and evolutionary theory (ibid, pp. 449-453). Bowlby's systematic thinking concerning biological control mechanisms to explain attachment behaviour (Bowlby, 1969, pp. 235-262) leaves little doubt that he would have embraced the

opportunities afforded by advances in neuroscience. The work of Freed and Mann (2007) and O'Connor et al. (2008) has employed fMRI technology to investigate the regions of the brain related to grief. Panksepp's (1998) work has identified mammalian brain areas related to attachment⁴¹. The author believes that incentive salience (Berridge & Kringelbach, 2008; Berridge & Robinson, 1998, 2003) provides a mechanism that links Bowlby's theory of attachment with modern neuroscientific principles. This has implications for understanding grief. Wolfgang Stroebe and colleagues (Stroebe, Stroebe, Abakoumkin, & Schut, 1996) have distinguished emotional loneliness from social loneliness. The latter comes from social isolation, but emotional loneliness is not alleviated by social contact; it is related to the "pangs" of grief (Bowlby, 1980, p. 86) experienced in an attachment broken by bereavement.

The emotional loneliness of broken attachment was exhibited particularly strongly in Tony, Sophie, Amanda and Maureen. For Tony and Maureen, the distress it caused had been part of their lives for many years. Emotional loneliness figured largely in Amanda's counselling as she struggled to make sense of the strong attachment to her grandfather. Sam and Jacqui employed avoidance strategies in order to cope. Sophie exhibited an extended, but normal, grief trajectory as she came to terms with her emotional loneliness. Ted recounted the tearful aspects of his emotional loneliness, and Fiona described herself as "broken hearted". Sue did not allude to her emotional loneliness, as she concentrated on the unfairness of her husband's death. This did not, however, mean that it was not a feature of her grief; simply that at assessment she had other priorities to discuss. Caitlin may well have severed the bond of attachment with her mother during her period of dementia. With the support of her sisters it is very likely that she found comforting meaning in having done the best job they could in their mother's care.

Based on the evidence of the ten case studies, the author posits that the emotional loneliness of broken attachment is a universal feature shared by all people bereaved of a close attachment figure. In general, the closer the bond, the greater will be the potential for clients to exhibit distress. Salient factors include complications to the loss, resilient characteristics, and attachment style (See for example Parkes, 2009). Most importantly, the author posits that the outcome of broken attachment described as emotional loneliness is unlikely to be helped by counselling. Evidence in support of this position comes from the well-researched conclusions of Schut and colleagues (Schut et al., 2001), who in an extensive meta-analysis, concluded that routine counselling for clients grieving normally is ineffective, that counselling for more severe normal grief only has a temporary positive outcome, and that only those grieving with complications benefit from counselling in the longer term. The author believes that the ten case studies go a significant way towards explaining these findings.

⁴¹ A detail examination of Panksepp's ideas was covered in Chapter 4

Resilience

The ten case studies suggest that resilience in bereavement involves a complex interplay between many factors. These are listed in table 9.1

Resilience after loss comes from:
<ol style="list-style-type: none"> <li style="margin-bottom: 5px;">i. abandoning conserved schemas <li style="margin-bottom: 5px;">ii. constructing new schemas <li style="margin-bottom: 5px;">iii. a secure attachment style <li style="margin-bottom: 5px;">iv. an adaptable personality which embraces change <li style="margin-bottom: 5px;">v. active participation in the process of change <li style="margin-bottom: 5px;">vi. acceptance of the emotions associated with broken attachment <li style="margin-bottom: 5px;">vii. oscillation between grief and restoration <li style="margin-bottom: 5px;">viii. avoidance of ruminative coping

Table 9.1 Factors affecting resilience in bereaved clients

Resilience from abandoning conserved schemas

Resilience requires that the client demonstrates a willingness to abandon pre-existing schemas. Janoff-Bulman (1992, p. 26) introduced the concept of ‘cognitive conservatism’. She suggests that some people attempt to retain schemas that can no longer be realistically accommodated. Such resistance to change can lead to a state of confusion sometime described as cognitive dissonance⁴². An example from the author’s practice is a client bereaved of his wife, who in searching for her had stopped several neighbours in the street to ask if they had seen her, even though he had been present at her death. Recalling the incidents he was puzzled by his behaviour, but explained that at first it had been hard to accept reality. This is an extreme example, but it does give validity to Janoff-Bulman’s idea. In the author’s experience, bereaved clients frequently take time to fully accommodate new realities, particularly if they

⁴² Note that this use of the term *cognitive dissonance* differs slightly from its use by Festinger (1957). In this context it refers to the Piagetian phenomenon of unsuccessfully accommodating either of two conflicting schemas. In grief work an example would be Martin and Doka’s (2000, p. 58) example of an “intuitive” griever attempting to grieve as an “instrumental” griever, or vice versa.

have, for whatever reason, not seen the body. Tony as a young child is a typical example of cognitive conservatism.

Resilience acquired by constructing new schemas

Related to ‘cognitive conservatism’ (Janoff-Bulman, 1992, p. 26) is the variation in clients’ ability to construct schemas. Reflective clients appear to be particularly good at this. It may be that clients who are more psychologically minded (Shill & Lumley, 2002) are better at assimilating a new understanding of their situation. However, emotional difficulties in accepting the reality of the loss also appear to play a part. Tony found that he needed to be in a heightened emotional state before he could assimilate new schemas, which is the main reason that he abandoned the tranquilising effect of medication. He became frustrated during the plateaus of little psychological change, but euphoric in moments of rapid assimilation and accommodation. Sam struggled to accommodate her son’s determination to submit to surgery when he understood the high stakes and the risk of fatality which came to tragic fruition. She also took time to construct a new narrative in which she was willing and able to abandon unhelpful avoidance of emotions and assimilate an understanding of her physical and emotional vulnerability. Much of Sam’s meaning making occurred after her counselling had finished, but was reported to the author during her follow-up interview.

Jacqui had found it difficult to confront her emotions, but was able to construct a simple but adequate schema for a continuing bond with her father, symbolised in the picture he had painted for her shortly before he died. Overall however, Figure 6.3 on page 87 shows how few moments of meaning making there were in Jacqui’s transcribed sessions. By contrast, Amanda’s sessions were dominated by her attempts to make sense of her grandfather’s last days, and of her grief reaction. As a result the transcripts were rich in examples of assimilation and accommodation. Sophie’s transcripts also showed that she very naturally reflected on her situation and her transcripts are similarly rich in examples.

Both Ted and Fiona’s assessment sessions were rich in examples of how they made sense of what had happened. Fiona could calmly talk about the nature of her husband’s cancer and the circumstances of his death. Ted had gone to great lengths to understand how his son had died, and what circumstances had led to his suicide. The fact that, having made sense of their respective situations, neither needed ongoing support, gives weight to the idea that resilience is linked to the ability to assimilate and accommodate new meaning.

When Maureen told the story of her loss in the context of nearly eighteen years of prolonged grief, her account was rich in narrative but short of reflection. She even acknowledged that she knew neither why her grief was prolonged nor what had triggered her recent relapse. Significantly, she did not volunteer any possibilities, something that clients like Ted, Fiona and Sophie were observed doing naturally.

Resilience from a secure attachment style

The interrelationships between attachment style, the complexity of grief and willingness to engage in counselling have been investigated by Parkes (2009). Securely attached adults were found to be less likely to experience grief complications. Burke and Neimeyer (2013) have listed attachment style as a risk factor which has the potential to complicate grief. However, a mechanism to link attachment style to resilience has not been established. The author hypothesises that securely attached clients are less prone to ‘cognitive conservatism’ (Janoff-Bulman, 1992, p. 26) and are more likely to take the risks associated with trying out new ideas. Securely attached individuals are likely to be good at using a constructivist model of bereavement counselling in order to assimilate and accommodate a new understanding of their situation and are less likely than insecure clients to need professional help.

Attachment styles of the case study clients

In none of the ten case studies was the attachment style of the client formally evaluated, although five of the ten clients described their childhoods to the author. Tony’s childhood had in his view been idyllic up to the age of 11. He described his family as “Like the *Waltons*”⁴³. After the fatal accident the physical health of his father and the mental health of his mother were affected and Tony’s familiar security disintegrated for the rest of his childhood. Sam described a difficult childhood unable to express her needs due to her parents’ mental health. Jacqui had experienced a home affected by alcohol abuse leading to her parents divorcing during her middle childhood. She remembered finding her parents’ break-up difficult. Caitlin’s father had severe mental health issues and he subjected his wife and daughters to psychological abuse. However Caitlin reported that her mother had gone to great lengths to bring up her three daughters securely. When Sophie talked of her relationship with her parents there was nothing to suggest any factors that would predispose her to an insecure attachment style. Nothing is known of the childhoods of Ted and Fiona, both of whom were resilient, or of Sue and Maureen who demonstrated vulnerability. Amanda’s close relationship with her grandfather suggested a secure attachment base, and of all the clients, she showed more examples of verbalised assimilation than other clients. From the data collected, the author’s hypothesised link between attachment style and assimilation skills cannot be properly tested, but observations suggest that this could be a fruitful area of future research.

⁴³ Television series about a fictional idealised family in Virginia USA (Harris, 1972).

Resilience from having an adaptable personality, including active participation in the process of change

Closely related to attachment style, is adaptability; a personality type and outlook on life which demonstrates a willingness and ability to embrace change and to participate actively in the process of change (Griffin & Hesketh, 2003; Meneely & Portillo, 2005). Securely attached individuals are more likely to embrace changes in their circumstances than insecure people (Parkes, 2009). Change is not a cause for fear but is seen as an exciting challenge; an opportunity rather than a threat. When secure people are bereaved of a significant relationship they grieve for the broken attachment; often very intensely as did Ted and Fiona. At the same time they recognise that they will eventually be able to move forward with their lives. The adaptability and creativity which Caitlin used to establish her own freelance business would have equipped her in adapting to the loss of her mother. Even Tony, who had struggled with coming to terms with the broken attachment to his brother, had gained sufficient attachment security in his early childhood to remain adaptable to change. He had built a successful business from scratch and was in a secure marriage with a young family. After selling the business to become a house-husband whilst his wife built a professional career, he had adapted to his new domestic role.

Resilience from the acceptance of the emotions associated with broken attachment

Resilience does not mean an absence of grief reaction. As has been discussed above, all ten of the case study clients talked of the physical expression of their grief. The expression of emotions which accompanies a bond broken by death appears to be universal (Stroebe & Stroebe, 1987, p. 39). However, resilient clients accept these emotions and learn to be at ease with their emotional expression associated with broken attachment. This was observed in Sophie. When in session 32 she was asked how she was feeling, she replied “Same old same old. It feels like that’s how it is and that’s how it is going to be.” This was said in a tone of realistic acceptance rather than in depressed resignation⁴⁴.

Resilience from oscillation between grief and restoration

Another characteristic of resilience is a willingness and ability to oscillate between grief and restoration. This is easiest for clients who have activities, including hobbies, employment, and volunteering opportunities; any or all of which allow the client to take time out from her grief (see page 14). It is the author’s experience that unemployed clients on a subsistence income, those with limited mobility and those with a diagnosis of chronic

⁴⁴ This is a good example of cognitive reappraisal discussed in Chapter 4 pages 49-50

depression, can become stuck in grief, with neither motivation nor adequate opportunities to pursue a restoration strategy. Couple this with an insecure attachment style, cognitive resistance to change and a lack of adaptable personality traits (Griffin & Hesketh, 2003; Meneely & Portillo, 2005) and the bereavement counselling dyad is beset with complications. All of the ten case study clients had both opportunities and motivation to take time out from grieving, either from employment or family responsibilities, including parenting and grandparenting. In trying to compare case studies, one of the difficulties of qualitative research, in this field, is that less adaptable, insecure and depressed clients fearful of change are less likely to give permission for their counselling to be recorded and transcribed. Clients who are open, approachable and curious about their process of change, are self-selecting for observational research. They are also likely to possess a tendency towards resilience.

Resilience which comes from strategic avoidance of ruminative coping

In Chapter 4 it was established that meaning making promotes resilience, providing that the client does not keep revisiting the same negative thoughts. Where this is the case Stroebe and Schut (2000) have concluded that in the context of the DPM, the bereaved person is best helped by being encouraged to avoid the aspects of loss orientation which are likely to lead to ruminative coping. It is the author's experience that bereaved clients diagnosed with bipolar disorder and borderline personality disorder commonly exhibit a ruminative coping style. So too do clients with a history of depression and anxiety, even though they have no diagnosed disorder. Clients with a recognised mental health condition were excluded from the author's research and, as has been discussed above, clients with chronic anxiety or depression were unlikely to allow their counselling sessions to be recorded. With little available data in the theory building case studies, it has been difficult for the author to explore the link between resilience and ruminative coping. From the assessment sessions it seemed possible that Sue was at risk of developing a ruminative coping style, and very likely that Maureen's prolonged grief was a product of ruminative coping. However, to have confidence in the conclusion that a client is ruminating, the practitioner/ researcher would need to observe her revisiting the same material week after week with no new schemas being assimilated and accommodated. The author was not able to work with either Sue or Maureen beyond the assessment session.

To reach any conclusion in this section the author must move outside of the current ten case studies and draw on examples from his reflective practice. Client A had a history of anxiety and depression. When she presented for counselling she was ruminating on the death of her husband in an accident and emergency department. Her concern was that he had not received timely treatment on his arrival and that consultant expertise that could have saved him had been delayed. As her counsellor, the author supported her in arranging meetings with the hospital to go over her husband's case. These included an opportunity to talk to the consultant.

In counselling sessions the author helped her to make sense of what she could from the available evidence, letters and minutes of her meetings. Once she had assimilated adequate schemas for explaining events, even though they were not in her view perfect, the author encouraged her to decide when she had done enough and if she was likely to be able to assimilate any new meanings. Ruminative coping was avoided and the client moved forward in her grief resolution. Client B believed that her brother had taken his own life. She assimilated and accommodated a schema which left her believing that her brother had made that choice. At the inquest an open verdict was recorded, leaving the possibility that his death had been accidental. This verdict put the client in a state of cognitive dissonance with risk of rumination as she went over and over the circumstances of the death. The author contracted to support her in counselling sessions to explore what had happened, with the proviso that she was, with the author's help, also prepared to assimilate the limitations of available evidence surrounding her brother's death; in other words, like client A, to recognise when she had gone as far as she could and to stop. Ruminative coping was avoided and resilience appeared to have been enhanced. If the schema set that both of these clients found helpful was verbalised, it would say:

“I feel confident that I have done all I can, out of love and loyalty to my loved one, to make sense of what happened. What I have found out does not make perfect sense, but I choose to accept that realistically this is as far as I am going to get. I risk prolonging my distress if I pursue this any further to no new purpose.”

Figure 9.1 attempts to illustrate the complex connections between the factors associated with resilience in individuals with a secure attachment style. There are no directional arrows on this diagram, and each line is connected to every factor.

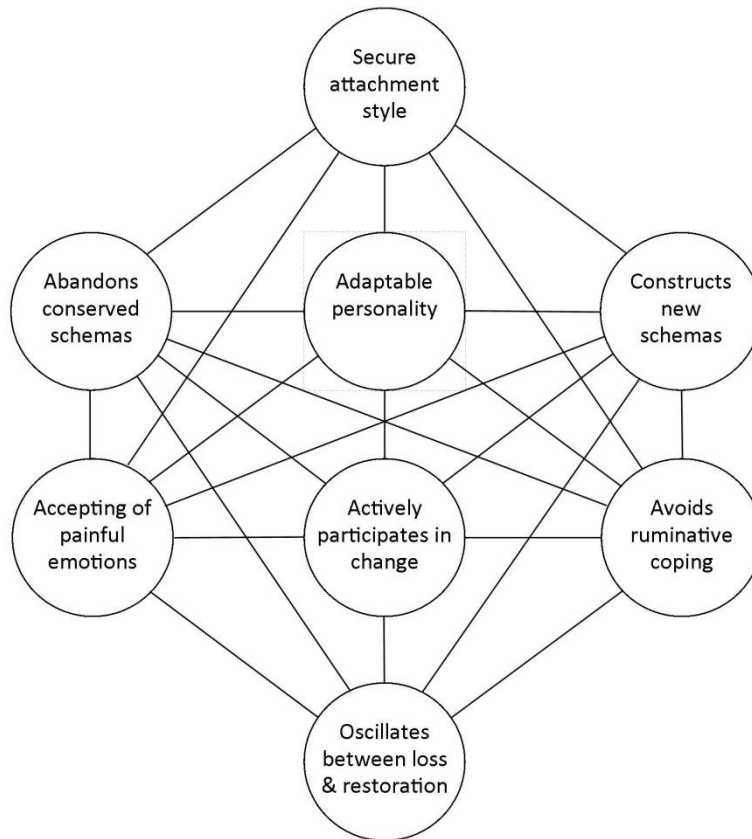


Figure 9.1 Inter-relationship of factors associated with resilience and secure attachment style

Case study comparisons with other models of grief: Conclusions

Classic and current theories of grief have been revisited in the light of the ten theory building case studies. No evidence was found that medicalisation of these clients' grief would be either necessary or helpful. Sophie's case study challenged The DSM-5 (APA, 2013) disorder of prolonged grief since her grief trajectory, though it extended beyond two years, resembled one of normal grief. Similarly several of the case studies challenged the twentieth century grief work hypothesis, since six of the ten clients managed with little or no counselling. Ted and Fiona demonstrated the salience of resilience. Jacqui, Caitlin, Sue and Maureen and, to some extent, Sam and Amanda chose to manage a significant distance of their grief trajectory without professional help. Even Sophie acknowledged that after two years her grieving was far from over when she ended her counselling.

The evidence collected in this study suggests that counselling can facilitate the process of meaning making in loss and grief. Hence it can alleviate the distress of confusion and cognitive dissonance which can complicate grief. It cannot, however, take away the pain of the broken attachment which resides in the more primitive areas of the human brain and which

serves an evolutionary function of keeping loved ones in close relationship and proximity. For most people this pain dissipates naturally in its own good time, providing the complications of grief are not exacerbating this attachment distress. Grief work is not an essential component of this process⁴⁵.

The study has demonstrated the usefulness of the dual process model (Stroebe & Schut, 1999). Clients can be taught to oscillate between loss and restoration, but evidence from the ten case studies and from the author's reflective practice demonstrates that resilient clients naturally take time out from their grief by employing distracting activities. The author suggests that this behaviour is one of a set of behavioural adaptations related to attachment security.

The case studies in this thesis have added weight to some existing theories, but have challenged others. In each case the conclusions reached from the ten theory building case studies are supported by evidence from the author's 17 years of reflective practice and careful observation of his clients. At the BACP research conference 2016 the author was asked if the AGES sequence suggested a return to a stage model of grief. AGES is a *progression* rather than a *stage* model. The eight points in the sequence represent identifiable moments along a continuum.

Tinbergen's Four Questions revisited

In Chapter 5 the author stated that in choosing a naturalistic methodology to observe the grieving client's process of assimilation and accommodation, he was approaching this scientifically from an ethological position. He applied Tinbergen's four questions on the aims and methods of ethology (Tinbergen, 1963) to observe assimilation as a biological behaviour.

Question 1: What are the proximate causes of assimilating (or seeking to assimilate) new experiences?

The author posited that *incentive salience* (Berridge & Kringelbach, 2008; Berridge & Robinson, 2003) is a proximate cause of assimilation. He cited Freed (2009) and O'Connor et al (2008). Inasmuch that the negative affect, caused by loss, may motivate the client to seek professional help and thus become actively engaged in assimilating new schemas, this proposition has validity. However, from an ethological perspective the proximate cause of assimilation is not conclusively demonstrated by incentive salience. The wanting and seeking behaviour exhibited by the bereaved client cannot bring the lost love object back. In time,

⁴⁵ This raises questions about social and emotional loneliness (Stroebe et al., 1996) in older bereaved spouses, many of whom become isolated. If counselling models of support are unlikely to help, then more practical, social and spiritual models of support may be more appropriate. However, counselling can have a part to play, in facilitating oscillation between loss and restoration activities (see page 14), providing social opportunities are available to the client.

seeking behaviour ceases as the client disengages from the lost love object and forms new symbolic continuing bonds with the deceased. Yet the weight of evidence from the ten case studies, from the author's reflective practice and from published literature leaves no doubt that it is a human attribute to be constantly striving to make sense of one's environment. This is realised through a constant process of assimilation and accommodation. It seemed reasonable to hypothesise that assimilating the discomfort of dissonance and restoring homeostatic balance through accommodation is in some way linked to the reward systems in the brain, and that this involves a neurological feedback loop. In time, advances in neuroscience may identify the proximate cause of assimilation.

Question 2: What is the survival value of assimilation in grieving clients?

In Chapter 5 the author described some of the recognised harmful outcomes of not being able to accommodate new schemas following a loss, including medical conditions, loss of appetite, depression and suicide ideation. (Stroebe et al., 2007b). By logical extension, those clients who are able to adapt to their changed circumstances are more likely to survive. In societies without access to psychotropic medication and curative medical procedures, individuals without well-developed skills in assimilation and accommodation would have been far less likely to survive and pass on their genes to the next generation. As a species, resilient characteristics would confer an evolutionary advantage. This could explain Bonanno's (2010) finding; that 46% of individuals in a Western developed society are resilient. It is notable that of the five clients who worked only with the author, all but Sophie had experienced health consequences. Tony had chronic depression, Sam had atrial fibrillation, Jacqui had alcohol related health issues, and Amanda suffered an eating disorder and mouth ulcers through malnutrition. All, to a greater or lesser extent, were helped by counselling which facilitated assimilation. This in turn facilitated and elicited resilience.

Question 3: What is the developmental course, or ontogeny, of assimilation in the grieving process?

As the author reported in Chapter 5, the ontogeny of assimilation has its roots in childhood development. (Piaget, 1950, 1952, 1954). The author also reported that children are known to grieve differently than adults. If one assumed that cognitive development concerned with assimilation is completed in childhood and adolescent development, then because this thesis has involved only adult clients the case studies cannot answer this question. However, if as evidence suggests (Cozolino & Sprokay, 2006; Lövdén, Wenger, Mårtensson, Lindenberger, & Bäckman, 2013) the adult brain retains sufficient neural plasticity for further cognitive development, this could be a further field of study in the ontogeny of schema acquisition. It may be that Tony in adult life was showing neural plasticity in abandoning long-held schemas about his brother's life and death as part of his grief resolution. The ontogeny of assimilation in adults receiving bereavement counselling could be a fruitful area of study.

Question 4: What is the evolutionary mechanism that favours those able to effectively assimilate change following loss?

The fact that almost half of the Western population demonstrate resilience in their grief suggests that natural selection could play a part in the acquisition of resilient and adaptive traits. It would be difficult to ascertain how much is due to genetics and how much to cultural transmission, including cultural transmission from kinship elders. The author has noticed that clients who demonstrate poor resilience often tell stories of having parents with poor resilience. Primate research on rhesus monkeys (Suomi, 2006) has identified a specific allele⁴⁶ which affects resilience. However, the behavioural manifestation of the resilient allele is affected by the upbringing of the monkey. Monkeys raised with peers but deprived of their mothers *and* who carried the deficit allele exhibited poor resilience. Monkeys who carried the resilient allele exhibited resilience regardless of their upbringing. In contrast, monkeys with secure maternal attachment *but* with the deficit allele had some resilience conferred on them by their upbringing. Similar variant alleles are found in humans but not in other primates (*ibid*, p. 52). There does appear to be compelling evidence that the evolutionary mechanism for the skills associated with narrative reconstruction have a genetic foundation, but environment plays a significant part. Of the five clients that worked solely with the author, all demonstrated a degree of resilience. Those who identified secure childhoods showed the greatest resilience.

The therapeutic alliance in relationship to Tinbergen's questions

On pages 195- 198, the concept of a therapeutic alliance was discussed. The collaborative process was emphasised. Trust is involved, as well as a sense of mutual curiosity. Although no proximate cause was identified, the answer to Tinbergen's (1963) Question 1 above noted that given the right environment, the client will seek to assimilate new meaning in order to overcome the dissonance of distress. Bohart and Tallman (1999, subtitle of the book) refer to this process as 'active self-healing'. This is similar to Rogers' (1961, 1963) concept of self-actualisation. The biological imperative to make sense of one's environment for survival (Tinbergen's Question 2) is also relevant to assimilating new, post-loss meaning. The ontogeny of assimilation (Tinbergen's Question 3) develops from childhood and may be fostered in adults by a trusting therapeutic alliance which capitalises on neural plasticity. An evolving tendency towards resilience in grieving humans (Tinbergen's Question 4) can also help the counsellor to facilitate assimilation, since one practical definition of psychological

⁴⁶ An allele is the variant form of one of a pair of genes that appear at a specific location on a chromosome and gives rise to a particular characteristic. For example the gene for eye colour has blue and brown alleles. In this example the allele controls serotonin metabolism which in turn affects the monkey's ability to stay calm when subjected to stress.

resilience, discussed on pages 49-50, is the ability to reframe a schema as a means of reappraising a stressful event.

The concepts of active self-healing and self-actualisation, point to the appropriateness of person centred counselling for bereavement. Yet there are caveats. Once the counsellor accepts that grieving is an active process (Attig, 1991), and that there are proactive techniques involved in constructivist counselling (Neimeyer, 2009b), it becomes apparent that a pure person centred approach has limitations. This is discussed below.

Person centred bereavement counselling in the context of grief

Person centred counselling based on the teachings of Carl Rogers (1957, 1961) is the usual approach taken by bereavement counselling services (Wilson, 2014). At its best this model is appropriate since it is responsive to the client's needs. Evidence from this thesis suggests the need for a caveat in a Rogerian approach to bereavement work. Clients are unlikely to be helped if the counsellor is unaware of the risks of grief work, and as has been discussed in several sections of this thesis, there is a small theoretical risk that they may be harmed. By using the core conditions, the counsellor can help the client to build a picture of any factors which may be complicating grief, in particular circumstances surrounding the loss and personality characteristics of the client. Burke and Neimeyer's (2013) list of complicating factors presented in Chapter 3 serves as a helpful checklist, but it does not include idiosyncratic factors, such as any unfinished business perceived to exist between the client and the deceased. The philosophy which underpins person centred counselling was described by Rogers (1961, p. 351) as "man's tendency to actualise himself", by which he meant to reach full potential. Yet Rogers was aware that self-actualisation may be obscured by "layer after layer of encrusted psychological defences" (ibid, p.351). This is very likely to be true of bereaved clients and, in the author's view, the person centred bereavement counsellor should be gently proactive in supporting the client to remove these layers of defence. Evidence from the case studies suggest that resilient clients have well-developed self-actualising skills. For less resilient clients and for those with complicating factors, a counsellor who understands the nature of narrative reconstruction through assimilation and accommodation will be able to facilitate this process more effectively than one who relies purely on the client's self-actualising process.

Might some aspects of grief be beyond the reach of an assimilation model?

The bereaved individual faces far more than confusion of meaning and the disruption of her assumptive world, since central to the bereavement is the loss of an attachment figure. Hence the continued relevance of stages of grief first posited by Bowlby and developed by

Parkes (explored here in Chapter 3). Parkes (2009) demonstrated that attachment style is a mediating factor in adapting to this loss. Emotional loneliness (Van Baarsen, 2002; Van Baarsen, Van Duijn, Smit, Snijders, & Knipscheer, 2002), and the neurological changes associated with grief discussed in Chapter 4 are other aspects which contribute to the negative affect of grief. The perfect storm which combines attachment loss, neurologically derived emotional pain⁴⁷ and emotional loneliness whips up distressing turbulence. Unfortunately, *if the grief is free of any additional complications*, evidence suggests grief counselling can do little, if anything, to calm this turbulence (Schut et al., 2001). The author's experience concurs with this finding in most circumstances. An important exception would be where the focus of the counselling concerned an insecure attachment style⁴⁸. Such a client could be helped by an exploration of the sense they could make of the ways in which insecurity impinged on her grief.

Counselling is, however, demonstrably effective in complicated grief reactions (ibid). Most of the complications in grief are due to factors external to the client, but a client's insecure attachment style is also a recognised complication (Parkes, 2009). Appropriate grief therapy can, at least for those insecure clients able to assimilate and accommodate new schemas, help them make sense, both of the loss and of their personal reaction to the loss. AGES takes into account the client's assimilation of the management of her grief. In this way, the distress of broken attachment in normal grief, not easily helped by counselling, may be ameliorated to some extent.

Using abduction to build the theory

On page 69, abduction was described as a logical operation in theory building methodology. Abduction allows a theory to be modified, rather than abandoned, in the light of fresh evidence. Case studies for bereavement and loss are often complex and idiosyncratic. The recovery trajectory of normal grief (Figure 1.1, page 2), in which the individual adapts to life without the deceased with few complications, is more likely to be observed in individuals who do not present for counselling than in those who do. Thus it was not unexpected that the project would reveal complexities that challenged the author's theory. Sophie's case study came closest to confirming the theory set out in table 8.1 on page 150. When each case study was applied to the theory (pages 169 to 174), each of the remaining nine case studies confirmed some aspects but disconfirmed others. Rather than refute or abandon the theory in the light of disconfirmations, abductive logic allows for previously unappreciated and unconsidered aspects of the case study to be taken into account in the modification of the theory (see page

⁴⁷ The pain of grief has a neurological basis, and in fMRI scans is observed in the periaqueductal gray PAG, see page 41

⁴⁸ Insecure attachment is in any case recognised as a grief complication.

69). Tony and Jacqui were examples of clients able to articulate the link between their unresolved grief and their behaviour in relation to other close family members. Aside from her grief reaction, Jacqui had other issues with family relationships, probably related to her alcohol use. Sam became aware of how her unresolved grief affected not only her behaviour but also her health. Behaviour and health awareness appear to be important factors in the APES sequence (page 72) from dissociation to the formation of a meaning bridge. Amanda's health had been greatly affected by her grief during her phase of avoidance and dissociation, this played little part in her counselling. Amanda more than any of the other clients, concentrated on making sense of her grandfather's last days and hours, and in doing so, found meaning in the closeness and intimacy of their relationship. Although her health had greatly suffered in the early stages of her loss (see page 95), this was not an issue over which she chose to focus her assimilation.

Abduction allows for the effect of previously unappreciated factors to be taken into account (page 69). In this project, the part played by resilience had been greatly underestimated, notably in the case studies of Ted and Fiona, who because of their resilience could each accept the reality of their bereavement and could find healthy balance in oscillating between grief and restorative activities (see Figure 2.1 on page 14). Caitlin and Sue were each able to overcome rumination on the story of their loss through cognitive reframing (see pages 137- 143), a process which began in the assessment with the telling of the story, and continued in their counselling sessions. This ability to assimilate and accommodate more helpful narratives did in turn foster resilience. In contrast, Maureen's continued unresolved grief for her daughter could be explained by her behaviour, which included avoidance of painful emotions, retention of unhelpful schemas and limited ability to reflect on the consequences of her process (page 174). Rather than challenge the author's theory of grief resolution, Maureen's story contributes a small increment of confidence in it. To summarise this section, whilst only Sophie's case study closely matched the predictions of the theory outlined on page 150, applying the logic of abduction to the other cases studies, modified and expanded, rather than refuted the theory.

Researcher/practitioner bias

This case study research has yielded an abundance and richness of data, both through direct observation in real time, and retrospective observation from recording and transcribing each session. A hazard of being both researcher and practitioner is the constant danger of seeing what one wants to see. Since the limitations of space means that only a small subset of transcribed material can appear in this thesis, there is the risk of selecting material which confirms expectations. However, as with any hazard, once it has been identified it is easier to

avoid. Conscious bias was avoided as far as possible by adopting an attitude of integrity. This required the author to give equal value to results which confirmed predictions and those which challenged them, and in doing so, the theory was modified and expanded as described in the preceding section. The theory building protocols which identified gaps in the original theory (see Chapter 8) assisted this process. The modified theory has been built on the total set of data collected. To further minimise unconscious bias, samples of the total set were triangulated using the range of procedures discussed in Chapter 6. The subset of data which appears in this thesis is illustrative of a greater subset of results, analogous to the way in which a qualitative research report could illustrate a vast amount of complex data with numbers and graphical representation.

As discussed in Chapter 3, a degree of subjective bias is unavoidable. This is why, in evaluating the validity of qualitative research, McLeod (1994, p. 99) emphasised the importance of researcher credibility. By relating his credibility as an experienced bereavement counsellor to his reflexivity as a researcher (see pages 65-66), the author addressed this potential bias. In addition to the logic of abduction described in the preceding section, the author also applied introspective reflexivity (Finlay, 2003). This allowed the outcomes of each of the ten case studies to be compared with the author's experience of working with a client with similar salient factors, for example, age, gender, cause of death, relationship to the deceased, attachment style and other complicating factors, on many previous occasions over 16 years. Predictions of grief outcomes for each of the ten case studies, enhanced by the author's reflexive practice, allowed for a theory to be built and which can be tested against the observed experiences of past and future clients. This is discussed in the next section.

Limitations of the study

As discussed in the previous section, there are limitations to the conclusions that can be reached from ten case studies. However, as discussed in Chapter 5, the methodology of theory building utilises the results from each separate case study as a small incremental step towards building the theory, and the door to modifying the theory is always left open. It would help to develop the theory further if it was possible to carry out case studies on clients less able to assimilate their grief; for example, those who find it difficult to tell the story of their loss and also find it difficult to reflect on their feelings, at least in the initial stages of grief. Unfortunately, as was discussed earlier in this Chapter, it was not possible to recruit clients exhibiting these characteristics.

A constraint placed by the bereavement service which hosted the PhD project was an agreement that the study of each client be minimally invasive, save for the digital recorder present in the room. Because of this, no clinical tests were administered which would have provided a secondary source of evidence that the emotional health of each client had improved.

To address this limitation, the original intention was that each of five main clients; i.e. those who completed their counselling with the author, would have the opportunity to read his or her completed case study and discuss it in a structured interview. For the reasons discussed in Section 2 of Chapter 6 this only happened with one case study. Some of the constraints and limitations this imposed were addressed using an iterative process which employed peer group consensus on Tony's case study (see Chapter 6) and by using an inter rater reliability test on Sophie's case study (see Chapter 8).

It was an unfortunate outcome of researching in this setting, that it was not possible, due to the priorities of the service (see pages 90 and 128), for the author to go on to work with three of the clients he assessed: Caitlin, Sue and Maureen. It was possible for the author to draw on his experience in order to make sense of the assessment data in interpreting the counselling outcomes of these three clients. It also helped that the author had access to the brief notes made by each client's counsellor. However, the evidence would have been stronger had the author worked with these clients and had been able to record and transcribe these sessions.

Implications for bereavement counselling, including service recommendations

Evidence from the case studies, together with previous research explained by the observations in this thesis, strongly suggests that counsellors and psychotherapists need to be very clear about their philosophical approach to bereavement work. Even where counselling is focused on specific client needs, the author's observations support the quantitative research (Schut et al., 2001) which indicates that working with a normally grieving client is unnecessary and produces no positive result. If the work is unfocused and reliant on a benign interpretation of a person-centred approach, the client is likely to be left floundering. Moreover, if the counsellor is unaware that there is no evidence to support the grief work hypothesis, she or he runs the risk of becoming embroiled with the client's normal pain of broken attachment. Rather than reassuring the client, this counsellor engages with a process which, if left alone, would probably heal itself. Unnecessary engagement may even lead to the client being drawn into a ruminative cycle. Importantly, any complicating factors that it may be helpful for the client to explore could get missed.

Bereavement counsellors need to be aware of the potential pitfalls of entering into grief work. Bereavement services should review how they respond to people assessed to be grieving normally. If a client grieving normally seeks support because she is anxious, the focus of the work should be on normalising her grief, offering reassurance and facilitating the acquisition of strategies to manage grief, as described in the AGES sequence. A counsellor who engages the client with loss-orientated thoughts and feelings, for a prolonged period of time, may unwittingly foster ruminative coping. This is particularly risky for clients who

exhibit an insecure attachment style. Clients who are socially isolated can be helped by being made aware of the practicalities of the Dual Process Model and by being encouraged to engage in restorative activities. A client who is actively dissociating from her grief, for more than a few months after her bereavement, should also be introduced to the DPM, and should be gently invited to spend time focusing on her loss. Counsellors should, however, be aware that for some people, taking long periods of time out from orientation on the loss can be a helpful strategy.

Bereavement services would do well to familiarise their counsellors with theories of meaning making through narrative reconstruction. This should include training counsellors to listen carefully to the client's process of assimilation and accommodation. Counsellors should be taught, through the application of their counselling skills, how to bring unhelpful schemas into the client's awareness and how to support the client in assimilating and accommodating new and helpful schemas.

Implications for continuous professional development

This research has demonstrated a need to revise both the skills and knowledge components of bereavement counselling training. An approach to person-centred counselling, which both recognises the importance of narrative reconstruction following loss, and provides the counsellor with the skills to facilitate the assimilation of new schemas, would better equip bereavement counsellors. So too would a better understanding of the relationship between psychological resilience and adaptation to loss. Although 20th century theorists compared separation protest in children to grief in adults (Bowlby, 1980; Bowlby & Parkes, 1970), and Parkes (2009) demonstrated strong negative correlations between insecure attachment styles and grief complications, there has previously been no clear mechanism to explain attachment distress and grief trajectories. The author believes that the relationship between resilience and attachment style provides an explanation (see figure 9.1, page 204). Although more research is needed, it is suggested that bereavement counsellors are taught about the nature of resilience and its significance in grief.

An assimilation model and grief counselling assessment

Assessment serves three purposes. The first is to evaluate the client's risk factors, the second is to determine the needs of the client and the third is to predict the likelihood that the client has the potential to make effective use of a counselling model of support. At best an assessment session is also the foundation of a therapeutic space (Wilson, 2014, p. 183). Not all clients are able to make effective use of counselling; some may better be supported in social or practical situations. Of those assessed as able to make use of counselling, the section above

suggests that those grieving normally will not be helped by it. An understanding of the assimilation model allows the assessor to make judgements and negotiate with the client a helpful way forward. If there are additional complicating factors, and if the client demonstrates that she is already assimilating and accommodating her loss, then an appropriate candidate for grief counselling is identified. It is incumbent on the skilled assessor to create a therapeutic space which optimises the client's ability to begin to assimilate some of their grief experiences during the assessment. In the cases of Ted and Fiona, assessment was sufficient to meet their needs. Both were resilient people who were grieving normally without being affected by additional complicating factors.

AGES as an outcome measure

Although the nature of a theory building approach relies on accumulated data, results to date suggests that, subject to more formal research involving inter-rater reliability, AGES has the potential to be an effective and reliable measure of a client's progress through counselling, but only of practical use in the hands of a skilled and experienced user. Most experienced bereavement counsellors introduced to AGES for the first time, were able to use it to score a client's progress based on transcript extracts, and the scores allocated to each extract showed a high degree of reliability. Feedback suggested that the process was time-consuming, although it is the author's experience that using assimilation analysis (Honos-Webb et al., 2003; Honos-Webb et al., 2006; Varvin & Stiles, 1999), as a measure of client progress, becomes easier with practice. Although bereavement counsellors convinced of its value may be motivated to persevere and could be trained in its use, its relevance may be more as a research tool than as a routine clinical measure. AGES could however form the basis of a self-assessment questionnaire, in which clients rate their point on the AGES scale on a range of criteria.

Suggestions for further research

More grief case study research is needed in order to continue building a theory of grief assimilation. One way forward would be for other bereavement counsellors to conduct assimilation analysis (Honos-Webb et al., 2003; Honos-Webb et al., 2006; Varvin & Stiles, 1999) on client transcripts. If a research network could be established to collate transcripts, then a large number of analyses would make it possible to compare each client's assimilation skills with other variables, including scores on existing measures such as CORE (Barkham et al., 1998). It would be interesting to explore the relationship between a bereaved client's resilience and the ability to adapt to change through the assimilation of new schemas. The characteristics of clients who find assimilation difficult would be a valuable field for study, but

problematic, given the difficulty of recruiting such a cohort. On the other hand, any insights gained may help individuals in this vulnerable group. Such a project would require some creative approaches to recruitment, which almost inevitably would mean balancing ethical constraints with the potential benefits that could come from such endeavours.

Given the observed limitations of AGES as a useful clinical tool, there could be two ways forward. One would be research into means of successfully training not just practitioner/researchers, but also bereavement counsellors, in its use. An alternative route would be the development of a separate outcomes measure based on the AGES sequence. Such a measure could become both a clinical and an additional research tool.

This thesis has demonstrated some limitations in answering Tinbergen's four questions. There would be value in more explanation of the proximate cause or causes of narrative reconstruction in grief. Work with children using the techniques developed in this thesis could answer questions on the ontogeny of narrative reconstruction. As has been discussed on page 212, there is more work to be done on the ontogeny of adult assimilation.

The author has posited a theoretical relationship between attachment style and aptitude for narrative reconstruction, suggesting that resilience is determined by attachment security. In order to test this hypothesis, each client's attachment style could be determined by administering an adult attachment measure (Fraley, Waller, & Brennan, 2000; Roisman, Fraley, & Belsky, 2007). The nature of the attachment could be compared with the client's assimilation analysis (Honos-Webb et al., 2003; Honos-Webb et al., 2006; Varvin & Stiles, 1999). This has the potential to be a rich field for qualitative research and will have further implications for good practice. AGES would also be a useful tool to investigate the link between attachment style and individual patterns of oscillation between loss and restoration behaviour. This could lead to new ways of working therapeutically with adults experiencing impaired attachment security.

Final conclusions

The theory building approach outlined in this project adds confidence to the theory that part of successful recovery from loss involves the accommodation and assimilation of new schemas. From these observations, APES has been adapted for grief: the Assimilation of Grief Experiences Sequence: AGES. This sequence of grief resolution through narrative reconstruction is relevant where bereavement is complicated by the client's confusion in attempting to make sense; both of the circumstances of the loss and of her reaction to bereavement. AGES offers a template to follow this process and equips the counsellor to facilitate the grieving client's acquisition of adaptive schemas. AGES also allows the client's progress through the sequence of adaptation to be monitored.

This assimilation theory of grief offers a plausible explanation for why the efficacy of bereavement counselling is limited to grief with complicating factors. All people bereaved of a loved-one experience this pain and sadness, and for many, natural resilience makes accommodation of grief relatively straightforward. Counselling helps those who need to accommodate and assimilate the experiences of added complications. Significantly, there was no evidence from the research that medicalisation of these ten clients' grief would have helped them.

The author believes that this study makes a significant contribution to the accumulating weight of research in the field. Some of the previous research supports and explains the results of this study. In turn the author suggests that the current research may offer fresh explanations for the results of others. Such explanations are offered modestly and tentatively, in the belief that an understanding of this huge and complex field is achieved in small incremental steps. The author will continue to build a theory of grief assimilation through further research, will disseminate this theory to other researchers and will seek to develop good practice in grief counselling based on current and future developments.

Future directions

This project has revealed some interesting areas for further study, and the author is fully committed to ongoing research. As was discussed in the section above, the findings of this project help to explain the findings of Schut and colleagues (2001), which demonstrated that counselling for normal grief is ineffective. The thesis also puts meat of the bones of meaning making theories, by presenting transcribed evidence of how schemas are constructed. In the light of evidence collected here, these 21st century theories, and other conceptual models of grief, will be reviewed by the author in future papers. For example, the existing transcribed data illustrates the role of resilience in bereaved people. Together with a review of existing research into resilience, this will be brought together for publication.

An outcomes measure based on the AGES scale has already been mentioned. Using his professional networks, the author intends to ask other bereavement services to take part in a pilot study, with the intention of producing a helpful clinical tool. The aim is to refine this tool, both to focus the counselling and to measure client progress.

Finally, this thesis highlights the central role of assimilation and successful accommodation of new schemas in the resolution of individual grief. Transcripts of the sessions convincingly illustrate this. However, the role of the counsellor as facilitator of assimilation has not been explored. This is a fruitful area for a major project, with the potential to change effective approaches to bereavement counselling, and would provide an evidence base for training in constructivist bereavement counselling. The author will make this a major focus, both in research and teaching, in his future work.

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Appendix 1: Assessment form used in the case studies

CONFIDENTIAL



Bereavement Support Service

Initial Assessment Notes & Consent Form- Adult

FULL NAME:

DATE OF BIRTH:

CASE NUMBER:

PREFERRED NAME:	PHONE:	MESSAGE?
ASSESSMENT DATE:		
GP/SURGERY:	PERMISSION TO INFORM GP?	YES/NO
KIND OF REFERRAL:		
If self how did they find out about BSS?		
Permission to request mental health history/liaise with other professionals e.g. psychologist/psychiatrist/doctor? YES/NO		
Permission to disclose home address to known person in the event of a home visit? YES/NO		
INFORMATION (verbal & written)		
About Evaluation <input type="checkbox"/>	AAG scale <input type="checkbox"/>	
Confidentiality <input type="checkbox"/>	Client information leaflet <input type="checkbox"/>	
Volunteer supporters <input type="checkbox"/>	Signed Consent form <input type="checkbox"/>	
Cancellations <input type="checkbox"/>		
[1] What has brought the client now? (recent/past loss, nature of death, story of their loss)		
[2] How are they coping? (strategies, support, inner resources, cultural & spiritual beliefs around death)		
[3] Assessment of Risk (see BSS guidance) *Complete risk assessment paperwork*		
1. Have they made plans to end their life? Is there any history of suicidal risk eg: previous attempt?		
No Risk() Low Risk() Medium Risk() Very High Risk()		
2. Is there a history or evidence of self-harm/alcohol/substance misuse/dangerous risk taking?		

[4] In your professional opinion, in what ways is our service appropriate to meet the client's bereavement support needs? (If not, what unmet need is client telling you they have or do you assess they have?)

[5] Is there any trauma associated with their grief? (Unwanted images or memories?)

[6] Other significant details? E.g. eating/sleeping difficulties/isolated?

[7] Current medication?

[8] Was person receiving any Hospice services?

[9] Feedback given to client

BSS INITIAL ASSESSMENT OUTCOME

Outcome: YES NO NOT APPROPRIATE Pending client's decision/info
(client to contact within 1 month)

Availability:

Male/Female:

Level of Support:

(Level 1: Counselling / Level 2: Experienced Support / Level 3: Basic Support)

What does the client want from support?

How will client cope whilst waiting for support?

Any other action e.g. referral to other agency/G.P./Information given?

Signed _____ Date _____ Time _____

Assessor's Name (please print)

Appendix 2: Three fold leaflet given to potential research subjects

<p><i>In 2011, John Wilson, one of Saint Catherine's Hospice bereavement counsellors, is conducting a research project to investigate how people make use of the Bereavement Support Service.</i></p> <p><i>You may be asked if you will participate in the research. If you agree John will obtain your permission in writing.</i></p>	<p>their counselling sessions can be recorded, using a digital recorder similar to a tape recorder. The recording device is small and makes no noise. Recording will only take place if clients give their informed consent.</p>	<p>project and these will be stored both electronically and on CD stored in a locked filing cabinet at the hospice. At the end of the research all recordings will be destroyed unless you grant us your expressed permission to use the material on future occasions.</p> <p>Examples of future use might be for training counsellors or for a book to help bereaved people.</p>
<p>What does the project hope to discover?</p> <p>We know that bereavement support makes a very real difference to many people and most of our clients are very happy with the support they receive. This project aims to find out exactly how bereaved people are helped by Bereavement Support.</p>	<p>What will happen to the recordings?</p> <p>In selected cases parts of the recordings will be transcribed into printed text.</p> <p>How will the recordings be kept safe and remain confidential?</p> <p>All recordings will be stored safely and securely and can only be accessed with an electronic code known only to the researcher.</p> <p>How do I know that printed copies of the counselling sessions will remain confidential?</p> <p>When the tape is transcribed your name, names of anybody and any other identifying details you mention will be removed so as to make the text anonymous</p> <p>What will happen to the sound recordings when they have been transcribed?</p> <p>Most will be permanently deleted. A few may be of use at a later stage of the</p>	<p>Will I be expected to do anything else other than have my counselling sessions recorded?</p> <p>No.</p> <p>If I agree to take part, will the counselling I get be any different as a result?</p> <p>No, you will get the same counselling whether or not you agree to participate.</p>
<p>What does the project hope to achieve?</p> <p>The project will look closely at how bereaved people change during their counselling and how the counsellor can best help in the grieving process. This will help counsellors here and in other places become more skilled in bereavement support so that in future, bereaved people are helped more effectively.</p> <p>What will the project involve?</p> <p>Selected clients will be asked if each of</p>	<p>Once I agree to take part in this research, can I change my mind?</p> <p>Yes. You are free to opt out of being recorded at any time without it affecting</p>	<p>What if I don't want to take part?</p> <p>We understand that some people may not want to be recorded and this is a completely free choice.</p>

the counselling you receive.

What happens if I feel that the research is having an adverse effect on my counselling?

This is unlikely but we would encourage you to talk about any concerns. However, if you are still unhappy you can ask to be seen by a different counsellor in our service. If you find it difficult to talk to your counsellor about this, you can contact the Bereavement Support Service Manager.

What will happen to the research results?

A record of each participant's counselling will be written as a case study. Names and identifying details will be changed to hide people's identity. The case studies will be written as a thesis which will be available in University libraries for other bereavement researchers and counsellors to read.

Some of the findings of the study will be used for teaching new bereavement counsellors at Saint Catherine's Hospice and maybe in other Bereavement Support Services.

Findings will also be published in specialist journals and may appear in a book to help bereaved people in their grief.

What happens next?

If you would like to take part and you meet John Wilson for your initial appointment, he will ask you if he can record the session. If you agree he will ask you to sign a consent form.

If you go on to see John on a regular basis he may ask if he can continue to record each session.

You can withdraw your permission at any time.

You will be able to see the case study that is written about you and we want you to be entirely happy about the content.

Any other questions?

John can be contacted on 01723 351421

Email

john.wilson@st-catherineshospice.org.uk



Saint Catherine's Hospice

Bereavement Support Service

Research Project

Appendix 3: Research proposal

APPENDIX 3	
SUBMISSION OF PROPOSED RESEARCH PROJECT TO THE	
RESEARCH ETHICS SUB COMMITTEE	
Name of researcher(s)	John Wilson
Title of research	Moments of Assimilation and Accommodation in the Bereavement Counselling Process
Name of Research Supervisor (if applicable)	Dr Lynne Gabriel: Lead Supervisor Dr Hazel James: Co-Supervisor
Objectives:	
To investigate: How bereaved people use counselling to resolve their grief? How a client's engagement in the process affects the outcomes of bereavement counselling? Why bereaved individuals need professional support for such very different lengths of time?	
Please give a brief justification of your proposed research project:	
<p>Theories of grief have been well documented (Stroebe, Stroebe, & Hansson, 1993; Stroebe, Hansson, Stroebe, & Schut, 2001; Stroebe, Hanson, Schut, & Stroebe, 2008). It has been recognized that there is no one pathway through grief but rather what Neimeyer has described as multiple, qualitatively distinct pathways calling for greater understanding both of complication and of resilience (Neimeyer, 2009). The challenge for the informed bereavement practitioner is threefold: to make sense of the inter-related theories, to translate these into a working model of bereavement counselling and to find meaningful ways of evaluating processes and outcomes.</p> <p>There is a need for further research into how processes and outcomes are evaluated. Many services will rely on questionnaires that gauge client satisfaction. (for example, Gallagher, Tracey, & Millar, 2005) This practice has been questioned by Shut (2008), who makes a clear distinction between the objectivity of effect studies and the subjectivity of "customer satisfaction". Although some counselling services have used effect studies (Rolls & Relf, 2006; Moore, 2006), evidence suggests that many bereavement counsellors practise with no such systematic evaluation (Schut, Stroebe M.S, Van Den Bout, & Terheggen, 2001). Moreover, much of the practice that passes for bereavement help has been shown to be ineffective (Kato & Mann, 1999) and possibly even counter-productive (Schut et al., 2001). While quantitative research has evaluated a range of post-bereavement interventions (Boelen, De Keijser, van den Hout, & van den Bout, 2007; Shear, Frank, Houck, & Reynolds, 2005; Murphy et al., 1998), the creative ways in which individuals resolve their grief can be lost in a sea of tests and measurements. A need exists to develop suitable means for measuring ongoing therapeutic change with individual clients. The Assimilation of Problematic Experiences Sequence (APES) (Stiles, 2006; Brinegar, Salvi, & Stiles, 2008; Honos-Webb, Surko, Stiles, & Greenberg, 1999; Stiles, 2001; Stiles & Brinegar, 2007; Stiles, 1999) offers a possible way forward into qualitative research in bereavement counselling.</p>	

Please outline the proposed sample group, including any specific criteria:

Clients bereaved of a friend or family member whose grief is such that they have sought professional help from Saint Catherine's Hospice Bereavement Support Service (SCH BSS).

Specific exclusions from the study

- Clients aged 18 or under
- Clients referred by a mental health professional,
- Clients under the care of a mental health service,
- Clients with a diagnosed mental condition; including dementia, obsessive compulsive disorder, chronic depression, bipolar disorder, PTSD and borderline personality disorder, Clients with a learning disability.

Reasons for this exclusion

Experience has taught the staff of SCH BSS that clients in these categories frequently have a range of psychological needs in addition to the bereavement. In many instances, in the mind of the client, these needs take priority over the bereavement work. There would also be significant ethical difficulties in working with these groups. Clients with certain diagnosed mental conditions and clients with learning disabilities may be unable to give adequate informed consent. It is also arguable that clients in this group may be an increased risk of being adversely affected by such research tools as recording devices: for example paranoid clients who may have an anxiety about record keeping and may worry about how audio recordings may be used. Gelso (1972, 1973) has researched the inhibitory effects of recording devices on clients with certain specific difficulties. In some states of psychosis, clients would be unable to give informed consent to participate.

Describe how the proposed sample group will be formulated:

Pilot Study

An initial pilot study will follow up to 5 clients either self-referred or referred by their GP. Each client will be followed for up to 10 sessions.

It is possible that some will complete their counselling in less than 10 sessions. The purpose of this phase of the project will be to:

- evaluate the procedures used to collect the data
- trial the Assimilation of Problematic Experiences Scale.
- determine data collection and analysis times and so decide on the number of case studies feasible in the Main Study.

test any difficulties in recruitment and retention.

Main Study

Assuming that:

two concurrent case studies are feasible in terms of recording and transcription,

the number of clients seen by the researcher 2007 to 2010 will be representative of the clients seen in 2013 to 2016,

then it is estimated that the number of case studies that will be conducted over a three-year period is between 2 (both study subjects remain in counselling for the duration of the study) and 10 (based on all subjects receiving the average number of 10 sessions and allowing 20 weeks selection, recruitment and waiting list time per client). The likelihood (and desirability) is that the figure will be somewhere between the two extremes.

Indicate clearly what the involvement of the sample group will be in the research process:

Bereaved clients who are part of the sample group will receive client-centred bereavement counselling from the researcher in the same way as clients not part of the study. All that will be different from the clients' point of view is that with the client's knowledge and consent, each session, including the initial assessment session will be digitally recorded in its entirety.

Specify how the consent of subjects will be obtained. Please include within this a description of any information with which you intend to provide the subjects:

Bereaved people who self-refer or are referred to Saint Catherine's Hospice Bereavement Support Service are sent a letter from the Service Coordinator which asks them to telephone her to make an appointment for an initial assessment. Clients who respond (and who are not, from the referral information available, seen to be in the exclusion categories above) will be advised by the Service Coordinator that a research project is taking place and will be asked if they are willing to take part. Those who express an interest will be sent a leaflet explaining the project in simple terms, with details of how to contact the researcher if they have further questions. A consent form will be sent with the leaflet. These clients will be allocated to the researcher.

At the beginning of the assessment clients will be asked if they are still willing to give their consent and will be asked to complete the consent form if they have not already done so. Only after this is completed will digital recording begin. Clients will be made aware that they can change their minds about recording at any time.

Indicate any potential risks to subjects and how you propose to minimise these:

From the client's perspective, the counselling sessions will appear to be little different than would be experienced by any client, except for the presence of recording devices and the knowledge that what is said is being recorded. Whilst it would be naive to believe that this will not affect what is said, at least until participants have got used to the recording, little is anticipated in terms of risk. It will be made clear to clients that at any time recording can stop, and that there is always the right to withdraw from the research project at any time.

Risks from the dual relationship

The counsellor providing bereavement support is also the researcher. This dual relationship will inevitably colour the nature of the counselling dyad positively or negatively. The client may feel obligated to continue with research participation even if they become uncomfortable with the arrangement. For the researcher there may be a temptation (or an unconscious motivation) to put research ends before the needs of the client; for example by holding on to clients way past the normal span of counselling. The researcher may feel obligated to the research clients, giving them more personal attention than clients who are not the subjects of investigation. Indeed, even though the practitioner may be mindful of this possibility and attempts to avoid unfair advantage, the additional note-taking and re-visiting of recordings and transcripts will unavoidably afford the research subjects more time in the mind of the practitioner/ researcher than will be devoted to other clients.

The researcher's counselling supervisor will be kept informed about the nature of the dual counselling/research relationships in order to minimize any unconscious processes that could harm the client.

Risks associated with completion and publication

There is a slight theoretical risk that in the final counselling session, the process of reviewing and recalling the counselling experience may reawaken thoughts and feelings that supposedly had been resolved.

Research subjects will also be invited to read what has been written about them, agree that this is an accurate record and be asked for consent to publish. Again this could bring supposedly resolved issues to the surface. It is also possible that the client could introduce new material at this point.

In spite of the best efforts of researcher and research subject to be clear about disguising identity in publication, there is always the possibility that a friend or neighbour may identify the client through the details of the case study. This may raise difficulties for the client and others affected by the bereavement: for example if information about the family not previously known outside of a small group of confidants gets into a wider domain.

Contingency planning for client protection

Where a subject feels that despite best efforts, they have been adversely affected by participation in the project, contingency plans for the client's emotional wellbeing are in place. A new assessment of the subject's needs would be carried out by another counsellor within the Bereavement Support Service. It would be ethical to minimise any delay to this process. For this reason, a member of staff not involved in the research project will have "emergency" assessment spaces put aside in the departmental diary should such a need arise.

.Describe the procedures you intend to follow in order to maintain the anonymity and confidentiality of the subjects:

Security of original sound files

Counselling sessions will be recorded on a digital recorder. Each sound file is named automatically with a sequential number by the filing system on the digital device. Some sessions will take place within the Hospice and some in the community: usually in surgeries and health centres. Where recordings are made in the field, the recorder will be transported securely in a locked briefcase back to the Hospice. Audio files will be transferred to the Hospice server as soon as possible and digitally renamed with a client code number and session date, after which these files will be deleted from the original recording devices. Client names will never be appended to the sound files. All BSS clients have a departmental code, meaning that the client's name and other identifying details never have to be recorded outside of the Hospice secure system. These files will be stored as wma files on a password protected memory stick which will remain in a locked filing cabinet at Saint Catherine's Hospice.

Backup copies and transcriptions

A backup of the original sound files will be stored as wma files on York St John University Secure Server

An additional copy of the entire recording file catalogue will be copied onto CD ROM, discs which will be filed in a locked cabinet at Saint Catherine's Hospice

There will be times when the sound files need to be used on computers in order to be transcribed. In such instances, sound files will be transported on a password protected memory stick

Written transcripts will have the name of the client and the names of others talked about, changed at the point of transcription. Completed, pseudonymous transcripts will be stored securely at the Hospice as hard copies or electronically on the University and the Hospice server. When hard copies of completed transcripts have to be transported outside of the Hospice they will be kept in a locked briefcase. Electronic copies in the process of being transcribed will be kept either on a password protected memory stick or password protected laptop computer.

Retention of raw data

The original sound files will be retained until the completion of the research project. Electronic copies will be deleted and CD copies will be shredded.

Replaying of sound file excerpts to others

The research methods adopted by this project are likely to involve the use of an iterative protocol to improve the validity and reliability of the results. This may necessitate playing pseudonymous sections of the original sound recordings to other professionals whose role in the project is to provide a conceptual consensus in the interpretation of data. (Osatuke et al 2005)

Sections that are to be replayed to others will first be edited by the researcher using sound editing software that will beep over any identifying names used either by the counsellor or the client.

Case study descriptions and transcribed sections in the published text.

Clients, their stories and their spoken words will be made anonymous as far as is possible. At the same time it may always be possible that should they read the text, close friends and family of the subject may identify him or her. For this reason, subjects will be asked to give consent to all text intended for publication so that they are comfortable with the degree of personal anonymity and the anonymity of others afforded by the text.

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Please submit the completed form to the Chair of the University Research Ethics Sub Committee (Dr Simon Rouse, s.rouse@yorksj.ac.uk) or to the relevant Faculty Research Ethics Committee where applicable.

Ethical approval was granted by the Research Ethics Sub Committee on 24th August 2011. Reference number UC/24/8/11/JW.

Appendix 4: Informed consent form for the project

RESEARCH CONSENT FORM

Name of Researcher: John Wilson
Title of study: The Journey of Grief & the Process of Bereavement Counselling: A Multiple Case Study Approach.

Please read and complete this form carefully. If you are willing to participate in this study, ring the appropriate responses and sign and date the declaration at the end. If you do not understand anything and would like more information, please ask. My email address is john.wilson@st-catherineshospice.org.uk. My telephone number is 01723 351421 Ext 1092

- I have had the research satisfactorily explained to me in verbal and / or written form by my counsellor who is carrying out the research.

YES / NO
- I understand that the research will involve my counselling sessions being audio recorded so that my counsellor will be able to listen to the sessions again and learn more about my experience of grief.

YES / NO
- I understand that I may withdraw from this study at any time without having to give an explanation. If I withdraw it will not affect me receiving support from Saint Catherine’s Hospice Bereavement Support Service.

YES / NO
- I understand that all information about me will be treated in strict confidence and that I will not be named in any written work or publication arising from this study.

YES / NO
- I understand that any audio-recorded material of me will be used solely for research purposes.

YES / NO
- I understand that audio recordings will be stored on password protected devices kept in a locked cabinet and will be destroyed on completion of your research.

YES / NO
- I understand that you will be discussing the progress of your research with other members of Saint Catherine’s Hospice Bereavement Support Team and other researchers at York St John University.

YES / NO

I freely give my consent to participate in this research study and have been given a copy of this form for my own information.

Signature: **Date:**

Signature of researcher **Date:**

Appendix 5: Issues discussed by Tony, with APES scores

Session number	A 1&2	1	2	3	4	5
	APES STAGES (bold italics denotes change)					
Focus: Awareness & understanding of behaviour:	3.0	3.0	3.2	3.2	3.5	4.0
Contacting emotions is a key component of change	*			*		*
Work stress not the main cause of behaviour	*	*				
Part played by antidepressants in blocking emotions	*	*		*		
Significance of bereavements in relation to behaviour			*			
Narrative:						
Brother's death	*	*	*		*	*
Father's death	*	*	*	*		*
Disrupted childhood security	*	*	*			*
Mother's mental health following the crash	*	*				
Parents' relationship after the crash		*	*			
Childhood obsessive activities & magical thinking					*	*
Childhood denial/pretence around brother's death						
Client's difficult relationship with mother after the crash						
Client's bond with mother since the crash						
Tension between work pressure and caring for dad		*				
Mother's cancer diagnosis and treatment.				*		*
Meaning-making, including metaphors, tensions & dilemmas:						
Behaviour redolent of recalcitrant teenager			*			
Making sense of his anger			*			
Childhood belief he caused the crash by his wishes					*	
Belief he could not 'fall apart' until parents were safe.						*
Hiding from both deaths: resonance between the two						
Sons, granddad & uncle, will never enjoy each other's company						
Possibility of continuing bonds through reminiscences						
Game spoilt, so wait for it to end, then start again						
Metaphors: Meaning in the here-and-now						
Emotions like: waves of nausea: build up, be sick, feel better	*			*		
Compares opposing voices with a background computer program						
Waiting for the train, fearful it won't reach destination						
Issues stuffed into metaphorical cupboard						
Tensions and dilemmas (expressed as voices)						
Letting go versus feelings of betrayal		*				*
Impossible dilemma: wishing either father or brother still alive					*	
Would not have had this wife & these children without the crash						
Dominant voices: client to self						
"I get so frustrated and angry with your behaviour"				*		
"You use past events unreasonably to excuse your behaviour"			*			*
"What's the point?"					*	
NEW ISSUES DISCUSSED	8	+3	+4	+2	+4	+1

Sessions 6 to 11

Session number	6	7	8	9	10	11
	APES STAGES (bold italics denotes change)					
Focus: Awareness & understanding of behaviour:	4.0	4.0	4.0	4.5	4.5	4.7
Contacting emotions is a key component of change		*	*	*	*	*
Work stress not the main cause of behaviour						*
Part played by antidepressants in blocking emotions					*	*
Significance of bereavements in relation to behaviour	*					*
Narrative:						
Brother's death	*	*	*	*		
Father's death	*		*	*		
Disrupted childhood security	*		*	*		
Mother's mental health following the crash	*		*			
Parents' relationship after the crash			*			*
Childhood obsessive activities & magical thinking			*			
Childhood denial/pretence around brother's death						*
Client's difficult relationship with mother after the crash			*			*
Client's bond with mother since the crash						
Tension between work pressure and caring for dad	*					
Mother's cancer diagnosis and treatment.	*					
Meaning-making, including metaphors, tensions & dilemmas:						
Behaviour redolent of recalcitrant teenager						
Making sense of his anger						*
Childhood belief he caused the crash by his wishes	*					
Belief he could not 'fall apart' until parents were safe.						
Hiding from both deaths: resonance between the two	*					
Sons, granddad & uncle, will never enjoy each other's company						*
Possibility of continuing bonds through reminiscences						
Game spoilt, so wait for it to end, then start again						*
Metaphors: Meaning in the here-and-now						
Emotions like: waves of nausea: build up, be sick, feel better				*		
Compares opposing voices with a background computer program		*				
Waiting for the train, fearful it won't reach destination		*				
Issues stuffed into metaphorical cupboard						*
Tensions and dilemmas (expressed as voices)						
Letting go versus feelings of betrayal	*	*				
Impossible dilemma: wishing either father or brother still alive						
Would not have had this wife & these children without the crash			*			*

Sessions 6 to 11 continued

Metaphors: Meaning in the here-and-now				*		
Emotions like: waves of nausea: build up, be sick, feel better				*		
Compares opposing voices with a background computer program		*				
Waiting for the train, fearful it won't reach destination		*				
Issues stuffed into metaphorical cupboard						*
Tensions and dilemmas (expressed as voices)						
Letting go versus feelings of betrayal	*	*				
Impossible dilemma: wishing either father or brother still alive						
Would not have had this wife & these children without the crash			*			*
Dominant voices: client to self						
"I get so frustrated and angry with your behaviour"						
"You use past events unreasonably to excuse your behaviour"		*				*
"What's the point?"	*	*	*			*
NEW ISSUES DISCUSSED			+2	+		+
				1		3

Sessions 12 to 17

Session number	12	13	14	15	16	17
	APES STAGES (bold italics denotes change)					
Focus: Awareness & understanding of behaviour:	4.7	5.0	5.0	5.5	5.5	5.7
Contacting emotions is a key component of change	*	*				
Work stress not the main cause of behaviour	*			*		
Part played by antidepressants in blocking emotions	*	*				
Significance of bereavements in relation to behaviour		*		*		*
Narrative:						
Brother's death				*		
Father's death						
Disrupted childhood security						
Mother's mental health following the crash				*		
Parents' relationship after the crash				*	*	
Childhood obsessive activities & magical thinking						
Childhood denial/pretence around brother's death						
Client's difficult relationship with mother after the crash						
Client's bond with mother since the crash	*	*				*
Father's deteriorating condition					*	
Tension between work pressure and caring for dad						
Mother's cancer diagnosis and treatment.	*	*	*	*		
Meaning-making, including metaphors, tensions & dilemmas:						
Behaviour redolent of recalcitrant teenager				*		
Making sense of his anger					*	*
Childhood belief he caused the crash by his wishes					*	
Belief he could not 'fall apart' until parents were safe.						
Hiding from both deaths: resonance between the two				*		
Sons, granddad & uncle, will never enjoy each other's company						
Possibility of continuing bonds through reminiscences		*				
Game spoilt, so wait for it to end, then start again						
Metaphors: Meaning in the here-and-now						
Emotions like: waves of nausea: build up, be sick, feel better						*
Compares opposing voices with a background computer program						
Waiting for the train, fearful it won't reach destination						
Issues stuffed into metaphorical cupboard	*	*				
Tensions and dilemmas (expressed as voices)						
Letting go versus feelings of betrayal						
Impossible dilemma: wishing either father or brother still alive						

Sessions 12 to 17 continued

Would not have had this wife & these children without the crash						
Dominant voices: client to self						
"I get so frustrated and angry with your behaviour"						*
"You use past events unreasonably to excuse your behaviour"					*	*
"What's the point?"	*	*				
NEW ISSUES DISCUSSED	+1	+1				

Sessions 18 to 23

Session number	18	19	20	21	22	23
	APES STAGES (bold italics denotes change)					
Focus: Awareness & understanding of behaviour:	6.0	6.0	6.0	6.0	6.0	6.5
Contacting emotions is a key component of change	*	*	*	*	*	
Work stress not the main cause of behaviour						
Part played by antidepressants in blocking emotions						
Significance of bereavements in relation to behaviour		*	*			
Narrative:						
Brother's death			*			*
Father's death			*			*
Disrupted childhood security			*		*	
Mother's mental health following the crash					*	
Parents' relationship after the crash			*			
Childhood obsessive activities & magical thinking						*
Childhood denial/pretence around brother's death			*			
Client's difficult relationship with mother after the crash					*	
Client's bond with mother since the crash						
Father's deteriorating condition			*			
Tension between work pressure and caring for dad						
Mother's cancer diagnosis and treatment.	*	*	*			*
Had instigated previously unspoken conversation with mum		*				
Period in his teens, post-accident, when he 'didn't give a toss'					*	
Caring about life again related to parenthood					*	
Meaning-making, including metaphors, tensions & dilemmas:						
<i>Behaviour redolent of recalcitrant teenager</i>		*				
Making sense of his anger		*	*	*	*	
Childhood belief he caused the crash by his wishes						
Belief he could not 'fall apart' until parents were safe.						
Hiding from both deaths: resonance between the two						
Sons, granddad & uncle, will never enjoy each other's company						
Possibility of continuing bonds through reminiscences						
Game spoilt, so wait for it to end, then start again			*			
Metaphor of thread to brother getting thinner						*
Metaphors: Meaning in the here-and-now						
Emotions like: waves of nausea: build up, be sick, feel better						
Compares opposing voices with a background computer program						
Waiting for the train, fearful it won't reach						

Sessions 18 to 23 continued

destination						
Issues stuffed into metaphorical cupboard						
Tensions and dilemmas (expressed as voices)						
Letting go versus feelings of betrayal						
Impossible dilemma: wishing either father or brother still alive						
Would not have had this wife & these children without the crash						
Dominant voices: client to self						
"I get so frustrated and angry with your behaviour"		*	*	*		
Beginnings of kindness to and understanding his inner child			*			
"You use past events unreasonably to excuse your behaviour"	*	*				
"What's the point?"						
NEW ISSUES DISCUSSED						

Sessions 24 to 29

Session number	24	25	26	27	28	29
	APES STAGES (bold italics denotes change)					
Focus: Awareness & understanding of behaviour:	6.7	6.7	6.7	6.7		
Contacting emotions is a key component of change	*	*	*	*		
Work stress not the main cause of behaviour		*				
Part played by antidepressants in blocking emotions						
Significance of bereavements in relation to behaviour						
Narrative:						
Brother's death						
Father's death						
Disrupted childhood security						
Mother's mental health following the crash	*					
Parents' relationship after the crash						
Childhood obsessive activities & magical thinking		*				
Childhood denial/pretence around brother's death	*	*				
Client's difficult relationship with mother after the crash						
Client's bond with mother since the crash						
Father's deteriorating condition						
Tension between work pressure and caring for dad						
Mother's cancer diagnosis and treatment.	*	*	*	*		
Had instigated previously unspoken conversation with mum						
Period in his teens, post-accident, when he 'didn't give a toss'						
Caring about life again related to parenthood						
Meaning-making, including metaphors, tensions & dilemmas:						
Behaviour redolent of recalcitrant teenager						
Making sense of his anger	*	*		*		
Childhood belief he caused the crash by his wishes						
Belief he could not 'fall apart' until parents were safe.						
Hiding from both deaths: resonance between the two						
Sons, granddad & uncle, will never enjoy each other's company						
Possibility of continuing bonds through reminiscences						
Game spoilt, so wait for it to end, then start again						
Metaphor of thread to brother getting thinner						
Metaphor of flawed computer operating system	*					
Lost child, squashed between the anger of others	*					
Saying goodbye to his brother			*			
Metaphors: Meaning in the here-and-now						
Emotions like: waves of nausea: build up, be sick,						

Sessions 24 to 29 continued

feel better						
Compares opposing voices with a background computer program						
Waiting for the train, fearful it won't reach destination						
Issues stuffed into metaphorical cupboard						
Tensions and dilemmas (expressed as voices)						
Letting go versus feelings of betrayal						
Impossible dilemma: wishing either father or brother still alive						
Would not have had this wife & these children without the crash						
Dominant voices: client to self						
"I get so frustrated and angry with your behaviour"						
Understanding of his inner child	*	*	*			
"You use past events unreasonably to excuse your behaviour"						
"What's the point?"						
Becoming kinder and more understanding of self	*	*	*			

Sessions 30 to 35

	30	31	32	33	34	35
	APES STAGES (bold italics denotes change)					
Focus: Awareness & understanding of behaviour:	6.7	6.7	6.7	7.0		
Contacting emotions is a key component of change						
Work stress not the main cause of behaviour						
Part played by antidepressants in blocking emotions						
Significance of bereavements in relation to behaviour				*		
Guilt and self-sabotage				*		
Narrative:						
Brother's death						
Father's death						
Disrupted childhood security						
Mother's mental health following the crash						
Parents' relationship after the crash						
Childhood obsessive activities & magical thinking						
Childhood denial/pretence around brother's death						
Client's difficult relationship with mother after the crash						
Client's bond with mother since the crash						
Father's deteriorating condition						
Tension between work pressure and caring for dad						
Mother's cancer diagnosis and treatment.						
Had instigated previously unspoken conversation with mum						
Period in his teens, post-accident, when he 'didn't give a toss'						
Caring about life again related to parenthood						
Meaning-making, including metaphors, tensions & dilemmas:						
Behaviour redolent of recalcitrant teenager						
Making sense of his anger	*	*		*		
Childhood belief he caused the crash by his wishes						
Belief he could not 'fall apart' until parents were safe.						
Hiding from both deaths: resonance between the two						
Sons, granddad & uncle, will never enjoy each other's company						
Possibility of continuing bonds through reminiscences						
Game spoilt, so wait for it to end, then start again						
Metaphor of thread to brother getting thinner						
Metaphor of flawed computer operating system	*					
Lost child, squashed between the anger of others	*					
Saying goodbye to his brother			*			
Metaphors: Meaning in the here-and-now						

Sessions 30 to 35 continued

Emotions like: waves of nausea: build up, be sick, feel better						
Compares opposing voices with a background computer program						
Waiting for the train, fearful it won't reach destination						
Issues stuffed into metaphorical cupboard						
Tensions and dilemmas (expressed as voices)						
Letting go versus feelings of betrayal						
Impossible dilemma: wishing either father or brother still alive						
Would not have had this wife & these children without the crash						
Dominant voices: client to self						
"I get so frustrated and angry with your behaviour"						
Understanding of his inner child	*	*	*			
"You use past events unreasonably to excuse your behaviour"						
"What's the point?"						
Becoming kinder and more understanding of self	*	*	*			

Appendix 6: Notes on the interview with Sam. 19th August 2015

The interview took place 3 years after Sam's last counselling session which was on 10th August 2012. Several weeks before this interview, Sam had been sent a copy of the case study. Passages which are taken from this case study appear here within text boxes.

Understandably, Sam wanted to talk about the changes she had made in her psychological well-being since her counselling had finished. The agenda of the author was to determine if Sam regarded the case study of a true and accurate reflection of her experience.

Sam began by saying that the counselling had made a difference. She said that her deceased son Mark was now fitting into her life. She gave an example.

Sam [0:04:37] I've got a CD in my car. And every time I drive up to a campsite that he liked, I put this CD on. And I haven't done it, it comes on to this tune, Queen *The Show Must Go On*.⁴⁹ We played it at the crematorium. And you do that, you say it's coincidence, but it's not, but in a way it's comforting.

Sam reflected on the changes she had made since her counselling ended.

Sam [0:06:16] I couldn't cry then, I can now

The author referred Sam to this summary at the end of the first session, and asked her if it was a true reflection:

It was clear from what Sam said during the assessment and the first session, that in the initial period following the loss, she had successfully warded off her problematic voice. By keeping busy she had actively avoided grieving. Through the self-reflection that comes from keeping a personal journal, and in talking to other counselling students, Sam had become aware that all was not well. However, the thoughts remained unwanted, with strategies to deflect a focus on her loss even when invited to do so by her therapist. Sam was however experiencing sufficient negative affect to recognise the counselling was appropriate, suggesting that she was moving from APES 0 to APES 1

⁴⁹ Queen: May, Deacon, Mercury, & Taylor, 1991

Sam agreed that at the time an awareness of her emotions was “a very vague and uneasy feeling” [0:09:08]. It was around this time that she began to experience was somatising distress, which resulted in a medical diagnosis of atrial fibrillation.

Sam revisited this extract from the case study:

Sam said that she had been concentrating on her counselling course. There was also part of her denying the reality that he had died. “Maybe I’m playing a waiting game thinking he hasn’t gone” [0:8:15].

Sam: [0:14:54] I don’t keep away from where I been now. I do go where he was quite a lot.

Sam [0:16:28] I don’t think I was really. I don’t think I ever felt he hadn’t gone, really. I think I knew he’d gone. The impact was huge really.

Sam [0:18:00] And I quickly moved to a cognitive phase (laughs). I’m good at that; I play games with myself.

The author invited Sam to reflect on this summary of session 4:

Sam talked about the circumstances surrounding Mark’s death. She had begun to realise the choices Mark had made. He recognised risks in the operation and had planned his funeral. However she said, did not want to continue to live in the way he was. She agreed with the therapist’s empathic intervention: that and the operation had been “double or quits” [0:07:36]. In response to the therapist’s question about her grief, Sam said that she would always grieve but that at the moment she was getting on with her life, but that there was still an “awful lot of wailing and sobbing left”. [0:13:47]. She believed that grief would come one she had a car and could travel to the places they had visited together. At present she felt she was in a bubble, or bottle, represented by her house. She talked of her techniques for avoiding her grief.

Sam was now able to recognise that there was a balance to be struck between getting on with her life and the “wailing and sobbing” [0:13:47] which she acknowledged she could choose to do. She was increasingly aware of her avoidance strategies and could associate her very valid fear of grief for Mark, with having “fallen apart” following a previous loss. Sam also understood that by

Sam agreed that it was an accurate record of what she had said. She also believed that this was around the time that she began to experience atrial fibrillation.

However, in hindsight, she questioned both what she had said, and what she had believed at the time. [0:22:00]

- Counsellor:** It was the fact that his death meant the end of his suffering, emotional and physical. When you got to that point...
- Sam:** I didn't you know. I said I got to that point at the time but I didn't. I've got to that point since through thinking through. I wanted me to have that point at that time. At that time I was still feeling a bit angry and a bit 'why the hell did he do it? He didn't need to do it'. Since then the anger is really, I've put into context why that was happening at that time.

The author moved Sam on to a point in the case study where he had expressed his congruent frustration:

The therapist pointed out that Sam tended towards thinking rather than feeling, and that he felt excluded from Sam's awareness of her affect. Sam replied, "Have I got an awareness to exclude you from?" [0:28:49]. The counsellor was congruent in his frustration.

Counsellor: I can't help you with your grief from a distance (20 second pause)

Sam: Mmm

Counsellor: Because I'm not a tutor, a long way off, helping you from a distance. This isn't about theory.

Sam: So how do you? (3 second pause) Mmm (5 second pause). Strangely enough, some days when I'm at home and the grief sets in and I cry, you should be there at that time, because then you'd be definitely getting. (6 second pause) I mean I can't have feelings and share towards him, if you know what I mean, but I do grieve, and I do, but I'm very much alone when I do it.

Counsellor: And if you let me in to your aloneness I can see that you could get upset.

Sam: I don't mind getting upset.

Sam agreed with the author that she was very good at using her intellect to avoid her emotions, something she said she had learnt as little girl. She said it was part of her; part of "an avoidance technique" [0:30:17].

Returning to thinking about her counselling, Sam recalled [0:31:08],

- Sam:** I think one of the things I had when I was having the counselling is that I didn't want it to end because you were my support system at

the time. And there was always that kind of panic, “When are these sessions going to end? I don’t want them to end!” And the protection moved in then.

Counsellor: Did you not feel able to voice at the time; that fear?

Sam: I don’t think I ever did, did I? No I don’t think so. Because that would be an admission of not feeling safe.

The author pointed out to Sam that it was her that had ended the session, and that she could have continued for as long as there was a mutual agreement she had needed it. Sam said that she believed that the time she had gone as far as she could and had gone back into what she described as “protective mode” [0:32:22].

The author moved Sam back to the case study, in particular towards exploring the summary at the end of session 8:

When invited by the therapist to explore the meaning of Mark’s death, Sam repeated those meanings she had constructed in session 5, in particular Mark’s determination to have the surgery despite the considerable risks. She was now able to acknowledge the depth of her grief, in the unfillable hole left by Mark’s death.

Sam talked of her continued tendency to avoid her grief, in particular by isolating herself, emotionally and geographically [0:46:23]. She acknowledged the choice she could make, a “pilgrimage” [0:47:22] in visiting places she and Mark had enjoyed together. Here was an increasingly clarified insight that was moving Sam through APES 4.0, towards being able to work through her identified problems.

Sam agreed that this was an accurate record. She noted her regular revisiting of the circumstances surrounding Mark’s death, including his determination to have the risky operation. Since that time she had moved house, become less isolated, had bought a car, and have made pilgrimages to the places they had visited together. She said that she felt different now [0:38:41].

Sam: I don’t feel this huge weight of sadness. I just think about the times and the (pause) I said somewhere about marking his life, and that’s part of marking his life.

The author drew Sam's attention to this section at the end of the case study:

Sam said that she realised now that she was grieving but that she was not hiding anything. For this reason she believed that she did not need any further counselling.

Sam agreed that this was an accurate record of what had happened. The author asked Sam if she would have stayed in counselling knowing what she knew now [0:47:25].

- Sam: No, not where I was at the time no. Because I thought to get any further in counselling I would have had to unpick the rest of my life before Mark really to find out how it was affecting me. A real backlog
- Counsellor: And that would have been too much?
- Sam: Well it wasn't necessary. It was enough to grieve at the time without.

The interview ended which Sam reflecting on this summary of the case study:

She reflected that this could be a time of liberation and change, of being able to get rid of things and move into a new part of her life but with the memory of Mark with her. She believed that she would always grieve, but she did not see that as a problem; it was part of who she was now.

Sam elected to end counselling knowing that long-term grieving for Mark was ahead of her and that she could and would do this outside of counselling. She had explored her options to mark the second anniversary of Mark's death with neither avoidance nor negative affect. She had plans to work professionally with grief at some point in the future. The evidence suggested that Sam had reached the early stages of APES 6.0.

She expressed her agreement with this content [0:47:25].

- Sam: Yes I think that's fair enough, because you can't suddenly get rid of it.

Mark was, she said again, "part of who I am."

Appendix 7: Extracts from Sophie's case study transcripts

The passages highlighted in yellow indicate the randomly selected content used in the inter-rater exercise.

Abbreviations used

T: = Therapist C: = Client

Assessment

Sophie presented for assessment 16 weeks after the death of her husband David from a rare form of cancer. She said that she just wanted "somebody to make it better" [0:00:25]; not just for herself but also for her children, Emily aged 18, Andrew aged 15 and Michael aged 6.

Sophie said that she had been putting on a brave face and that sometimes she thought she did not need counselling. Then an occasion would trigger her yearning for David. For example, a recent school event when mums and dads were together left her with a sense of unfairness. There seemed to be so much to do as a parent on her own that she constantly felt exhausted.

Two weeks after the beginning of palliative chemotherapy, when resting at home, David suffered a fatal embolism. His family heard him fall and rushed upstairs. Paramedics were called but David died. Sophie recalled that she had panicked, and wondered if she could have done more to save him.

On the previous evening, Sophie had gone out with a female friend because she felt that she needed a break. Looking back on the occasion, she felt guilty now because David had not wanted her to go. During the evening she had confided in her friend her stress that caring for David might go on for months or even years.

[0:12:11]

C: Then I felt awful saying that cos the next day he died (sobs). I feel bad saying that. It's almost like somebody heard me say that and then though 'Oh well we'll just take him away then'

T: As if you made it happen

C: Yes (sobs). Sometime I think things like that happen when I think things.

Sophie said that David's death seemed more like a film than reality. She said that she had not moved anything in the bedroom, including David's clothes, which she found a comfort. For some time after his death there had been a "sweet smell" in the bedroom. Although she felt unable to sleep in what had been the marital bed, she spent a lot of time in the room talking to him and she could feel his presence. She found herself looking for signs from him, like a wardrobe door that inexplicably opened. "Did he open the door?" When she mistakenly recorded over a video he'd made, she imagined him being cross with her.

Session 3

Sophie said that she had always felt safe with David and that when he was working away from home she never slept properly until he returned.

[0:47:29]

C: He always looked after us (sobs) He always knew the right thing to do

Session 4

Sophie and all the family, including her in-laws, had been to the football club David had supported in order to perform the ritual of burying his ashes. She described it as “nice but sad”. She had felt the burden of keeping everyone in the family safe; both physically and emotionally.

Sophie talked about the comfort of finding a white feather in the room where David had died. She had noticed how feathers keep appearing from nowhere. This she saw this as a comforting sign, although she recognised the irrationality in the belief. She talked about sometimes finding herself searching for signs of David.

Sophie reflected that at times his death still did not feel real.

Because the quietness of the house, when everyone else was out could be difficult and she was thinking of taking up some activity such as swimming or yoga.

Session 5

Sophie quickly became tearful. Although her week had started well, she noticed that it had gone downhill when her children went back to school and when the reality of her daughter going off to University had hit home.

She had found herself engaged in searching activities, “I find myself Googling David’s name. Also I’ve been going over hospital letters which had discussed his diagnosis and prognosis”.

Sophie said she had been on the website of the WAY Foundation⁵⁰. She also talked about plans to go for a coffee with a friend also recently bereaved of her husband.

Sophie recalled David’s reluctance to go to the doctor, the Christmas delay in getting a confirmatory diagnosis and her own difficulties in accepting the reality of the terminal prognosis.

She said that she needed to know whether the embolism was caused by his condition or the palliative chemotherapy.

She vividly recalled the immediate events surrounding his death at home. Although David’s GP had said that there was nothing anyone could have done, Sophie still wondered if she could have done more.

⁵⁰ The WAY Foundation is a British charity offering mutual support for spouses bereaved of a partner before reaching the age of 50. ‘WAY’ stands for ‘Widowed and Young’.

Session 7

As she thought of the circumstances surrounding David's death: "Stuff has been popping into my head. Also I have not been sleeping well and my mind has been racing". She talked about how difficult it had been to stay with him after his death, and described his eyes not being fully closed and his hands thin and blue.

She reflected that she did try to protect her youngest son from her own emotions, for examples, crying in the shower where he could not hear her.

She said that he did not know she was receiving counselling and she wondered if counselling would help him. Emily had started to see a counsellor at University and Andrew had been a residential weekend for bereaved young people, where he had talked to a counsellor.

Although it was still 12 weeks away, Sophie was already anticipating the effect that Christmas would have on her and her family. She talked about what it was going to be like sending Christmas cards without David's name on.

Although most of her current preoccupation was with her children's welfare, Sophie talked of planning to have a meeting with David's oncologist in order to get answers to some of her questions surrounding David's diagnosis, prognosis and death.

Session 10

Sophie had met for coffee with a woman who had lost her husband two years ago, and Sophie reflected on their relative progression along the journey of grief. Both of them have children and Sophie said that it helped to know others had gone through a similar experience.

She noted that they had both got upset, "and it was fine" [0:04:03].

It had also helped to meet somebody further on with their grief, and to know that things did get easier: "She's not all doom and gloom. It was quite light-hearted, some of the stuff" [0:07:22].

Sophie talked about her children's grief and her feelings of responsibility. She talked about the pressure of lone decision-making, but noted her she had successfully managed buying a car since David had died. This caused her to reflect on her progress to date.

[0:34:47]

C: I do feel like I'm getting somewhere.

T: I can see the difference in you

C: At the time when you're feeling like that you just think you'll never get past it. I don't know how people manage without counselling to be honest (laughs).

Sophie said that counselling provided a place to say whatever you want but not be overwhelmed.

The counsellor asked Sophie what kind of death David would have wanted.

[0:54:50]

C: For him, the one he had, definitely. Yes he wouldn't have liked to have lingered, but he wouldn't have wanted us to go through any of it really. But definitely that way for him.

Session 13

Sophie described her emotional state as "pretty rubbish". Although the weekend had been "okay" her mood had dropped on Monday. She had reached a point where she could see that antidepressants might help. However she also had a helpful grasp of what events helped and what hindered her positive affect. She said that to friends she had not been admitting that she was okay, and saying that that she was fine,

[0:09:15]

C: I feel like I'm just putting up a front, just saying I'm alright and everything. And since I've admitted it, friends have rallied round again.

Session 14

Sophie began by saying that she felt much better knowing that her daughter Emily was coming home.

She had seen her doctor who had diagnosed moderate depression and prescribed antidepressants. To date she had not taken them and had considered that her hesitation may be a sign that she did not need them at present. She had however been considering keeping a diary of her moods and associated events.

Sophie announced that David's Ashes were to be interred in the nearby churchyard at the weekend. She said that it felt like the right thing to do and anticipated that seeing his name on a stone "might be a bit more real" [0:10:15].

She thought the churchyard would be better than being at the undertakers; "somewhere he doesn't know" [0:10:29].

Sophie was intending to keep some of the ashes back in a heart shaped box.

Sophie said that her husband's employers had taken back his work phone and iPad but that she had managed to take off the photographs which she intended to share with the children.

Sophie said that she had kept her husband's iPad cover because it smells of him. She also has the blanket from his bed before he died and reflected how awful it would be if it was inadvertently washed. She noted how "the slightest thing is a connection to him".

She reflected on the triggers to her low mood in recent weeks,

[0:22:05]

C: I feel like initially things knock back when I'm not expecting it, and then it takes time to plough on again.

Sophie's thoughts turned to Christmas. She and the children had discussed the annual family ritual of fetching a tree from a nearby country estate and playing Christmas music in the car. The children had wanted to do things the same as usual.

[0:40:54]

- C:** David would never do any of the tree decorating but he *always* put the star on the top of the tree. That was always his job. One because he was the tallest and two, that was just his, you know that was just his (pause). What do we do this year? Who puts the star on the tree? Or do we not put the star on the tree?
- T:** What's your instinct?
- C:** Well something's saying to me put something else on top of the tree. (3 second `pause) Um (pause) Or I do it, I don't know. I just don't know.

Sophie said that she had even wondered about not having the same size of tree this year; whether to do something different.

[0:42:08]

- C:** I think he'd like it to be the same. (4 second pause). But he loved Christmas, you know. Yes I'm sure he'd want it just the same, for the kids.

Sophie explored the fact that David's death would have on Michael. She reflected that the older two had had longer with their father whereas Michael has missed out. She wondered what extent she could fill his father's role, and thought about future homework.

[0:52:18]

- C:** I always used to say to Emily, 'Go and ask your dad, he'll know. They used to say 'Daddy knows everything' (laughs), and he generally did. Yes, you know I just feel like I won't be able to fill those boots. And he's going to miss out on that.

Session 17

Sophie said that it had been a busy week but that she was "doing alright".

David's ashes had been interred. She described it as "sad but okay".

She said she had been confused about her feelings towards the ashes. Whilst her in-laws saw it as David 'coming home', she did not see it that way. For her David's presence was in the house rather than the graveyard.

She reflected with smiles on his frustration with her post-it note memos and recalled her trying to get her to use spreadsheets. She laughed at his frustration with post-it notes and said, "I even put one in the coffin with him" [0:21:08].

On the same day as interring his ashes, they had chosen to fetch the Christmas tree. It had not been as hard as she had expected it to be. They had chosen not to play music in the car.

Only one tree was left of the size they wanted and Sophie smiled when she saw it as a sign from David because "He did used to get annoyed when I couldn't make my mind up [0:24:30]

Session 18

[0:13:59]

C: Christmas was alright, yes, just alright. It was different, you know it wasn't (pause) yes, it was just (pause).

T: Any tears?

C: Not too much. Emily was a bit Christmas Eve. I was just sort of trying to hold it together really.

Sophie said that she had not wanted it to be "a big teary event" [0:14:34]. It had felt important for David's sake that Christmas was not a tearful time.

Sophie said that she had experienced a peculiar feeling as if David might be going to come back.

She said that she was lonely for him "not lonely for anyone else, but for him" **[0:20:07]**.

Now the first anniversary of David's death in March seemed just around the corner. She had been thinking about sorting out his bedroom although "I just feel like if I'm getting rid of his stuff it's like I'm betraying him" **[0:27:44]**.

Although she could never again imagine sleeping in what had been their marital bed, she did use the room for getting changed.

"And when I go up in the morning I always say good morning to David." **[0:42:05]**. She wondered if changing anything "might make him disappear. It sounds really weird doesn't it?" **[0:42:18]**. She thought that maybe she was waiting for a year to pass before changing anything. Sophie reflected how far she had come. "I feel like I've come a long way." **[0:46:03]**.

[0:46:24]

C: Another thing that keeps coming into my mind, and I feel really guilty about even thinking about them and I don't mean to think about them and I don't mean to, I don't even know why I do it and I feel awful even just saying it that sometimes it pops into my head about 'What if I got remarried?' You know. And I don't even mean to think about these things, it just comes into my head and I feel so guilty about thinking about things like that, you know (pause). Cos I'm not looking for anything else, you know I wouldn't want to and the whole idea of that was quite scary, but (pause). And I don't even know why it keeps dropping into my head, and I feel awful even thinking about it. I don't know why these (pause) I don't know. It's weird; it's weird why I keep doing that. It's really strange and I feel really awful even thinking about it.

T: Just about everybody in your position has those thoughts.

C: Really? (sigh of relief).

Sophie said that friends tell her she is still young enough to remarry which annoyed her, although she knew they meant well.

Sophie recalled David's death and said that sometimes she and her daughter still relive it, Emily quite vividly. However Sophie reflected that David would have hated to fade

away slowly and he did not want to talk about the end of his life. "David would have hated it if it was long and drawn out" [1:02:03]

Session 19

Sophie talked about recognising the value of taking control of her life. "I have begun to keep a memo book in place of post-it notes." [0:12:00]

She had made an appointment to see her husband's oncologist to try to find out why it had taken so long for her husband's first appointment. She said that she needed to understand the nature of the cancer better, in particular the delay in getting a diagnosis.

[0:15:00]

C: It's things like this I want to know, but then I'm worried about some of the answers maybe but (pause, sighs) and I know it won't make any difference, that's the thing. And I can hear David sort of saying 'Why are you doing that? Why are you putting yourself through that? Why?' You know, but, yeah I think I do need to go.

Sophie spent the rest of the session going into details of our husband's treatment.

Session 20

The meeting with the oncologist had not gone well. Sophie had found him defensive and she had not got the answers she needed. She did not feel he had listened to her and she could hear David's voice asking her why she was doing this. However she concluded that it was something that had to be done.

Session 22

Since the last session Sophie had been out with some girlfriends and it had been an enjoyable evening. However when she got home she felt guilty at having enjoyed herself.

[0:05:27]

C: I felt so guilty, I felt really guilty and horrible and it made me cry.

That night she had a nightmare of David dying.

The following day Michael had asked for help with his homework. Sophie found herself becoming hysterical when he said he wanted his daddy to help him.

[0:08:21]

C: I just started crying and I couldn't stop.

However Sophie said that as bad as it had been it allowed her to vent some pent-up emotions and also allowed Andrew to say that he was feeling horrible too.

Sophie questioned whether she had been ready to go out with friends, but answered her own question by saying,

[0:14:16]

C: I think, 'Maybe I wasn't ready for going out, but then I think 'If I wasn't I wouldn't have gone.

Session 25

This session took place two days after the anniversary of David's death. Sophie had "slobbered around the house" and had taken flowers to the graveyard. The following day she had felt angry with her situation. Part of her frustration was with family and friends not responding to her needs.

[0:11:00]

C: I just feel like everybody should know. You know, some people won't know it's the anniversary and I feel like shouting and saying 'Look it's the anniversary today, don't you know?' and I just feel really angry like (becomes tearful) 'You should *know* what today is,' And people don't., cos they're just getting on with everything (sighs, pause) Why don't they know? Why don't they care?

Sophie had found herself Googling 'Widowhood, one year'. She had found a blog which reflected her thoughts and feelings, and it was comforting.

She said that even good friends were starting to close down the conversation when she talked about David. She had found a widow's blog online and she had found it helpful because it expressed exactly what she was feeling.

Session 26

When Sophie arrived she was in an upbeat mood having had a family weekend away. She had noticed, as she had in the past, that this was often a feature of Mondays.

In quiet moments alone she had found herself going over David's illness and death. These memories had been fading but she attributed recent feelings and thoughts to the impending anniversary.

[0:19:45]

C: I keep thinking that I could have, and I know I've said it loads of times, that I could have done something else, or changed something, done something on that day (3 second pause). It just seems like (sighs) I'm putting this pressure on myself thinking that, I mean I'm not medically, I can't, you know, but I just feel as though that (pause) I might have been able to do something that nobody else could have done. I know that sounds really stupid, I could have changed the outcome.

She noted however that mental replays of David's death were not as vivid as I had been in the past and happy memories popped into her head as well.

Recently when she was sorting out David's clothes, she had found herself going through the pockets looking for messages from him.

Session 30

Sophie had been decorating her daughter's bedroom as a surprise and this had left her wondering about the part of her that was not the mother.

[0:10:15]

C: I know I'm a mum and everything, but what's the other bit of me doing? Do you know what I mean? Where do I go from here? (sobs) Don't know, don't know. I can't see a plan.

With Andrew beginning to plan for university, Sophie reflected how empty the house would be without him. Although eventually she planned to sell the family house, she wondered about her life until then.

[0:12:55]

C: People that I don't really know, you know, they see a wedding ring and they you know assume you're married.

Recently she had unanswered question 'what does your husband do?' She noted that this was something of a conversation stopper but although she might have cried at that question a year ago she noticed that now she could cope without getting upset. In another conversation she had been labelled as a single mum.

[0:17:01]

C: I don't think of myself as being single parent. Do you know what I mean? I'm not divorced and I find that a bit annoying. But she lumped me in as a single parent. I don't feel like that. Yes. Is that weird?

T: No I think you're absolutely right.

[0:18:18]

C: I don't like being lumped as a single parent. I then I realise I don't like being thought of as a widow either.

She said that ticking the 'widow' box on forms was horrible.

[0:19:24]

C: That's the sort of box I should be ticking when I'm in my seventies.

[0:24:00]

C: I feel I'm just, I'm not just a mum but I'm a mum and then there's the other box what else am I?

[0:30:40]

C: I just feel like is every week just going to feel like this now?

Sophie said that she was considering changing her job. Her current employment was unfulfilling and involved a lot of lone working. Going to yoga had been a good decision and now she was thinking about taking up swimming.

Sophie looked back over her life with David. She had been thinking about all the places they had visited as a couple.

[0:45:54]

C: We've come such a long way from that, those people we were then, to, to now.

[0:56:02]

C: It's a different future from the one you thought it was going to be.

[0:56:28]

C: It never goes away does it? You don't get a rest from it (laughs). Do you know what I mean? Yeah, even when you're not thinking about it, it's still there.

Sophie concluded the session by noting that she was not the same person as the one who had started counselling a year earlier.

Session 32

The counsellor began by asking Sophie how she was.

[0:00:58]

C: Same old same old. It feels like that's how it is and that's how it's going to be.

She said that she found herself worrying about what might go wrong. She constantly had a sense of not being in control. She also felt on the edge of getting depressed about the state of her life. The counsellor asked if she felt she deserved to be happy again.

[0:17:14]

C: I just feel that I won't be.

[0:17:41]

C: It does feel like there's nothing out there for me. I feel a bit selfish really.

T: Selfish about what?

C: I feel selfish just thinking that I could be happy again. You know?

T: No I don't get that. Why would it be selfish to be happy again?

C: Well I just, maybe it is, maybe it is that I don't deserve, deserve it. I don't know.

There were "silly" resentments in her life, for example, "It's always me that has to drive." [0:19:28]. Sophie looked at her life in the future,

[0:21:30]

C: Maybe I think that I can't move on until Michael's older. Then then I'm thinking maybe 'Am I going to feel like this for the next 10 years or something?' And then I can start living. It's not like I want to be party animal. I don't want to be going out and things like that. It's not that I want something, I don't know. It's really hard to explain.

T: You're doing okay

C: It's just feels all like (3 second pause) is this it? (laughs)

Now Sophie turned towards thinking about David. She said that she felt close to him in the bedroom where he died but that she still cannot sleep in that room. Each time she left the bedroom she always shouted back upstairs.

[0:41:36]

C: 'See you later' sort of thing. And I don't shut the door, cos he hated being shut in.

[0:42:00]

C: So I kind of feel like he's there.

She said that sometimes she still relived the day he died. The image used to be with her all the time but now she can think of him when he was healthy, although she has to look away from death scenes on the television.

As a family they can now laugh about memories of David.

Sophie concluded the session by saying that maybe she needed to get out more and pursue new activities.

She reflected that she has often held back on her tears to her detriment.

She said that maybe she needed to recognise and talk about being on the edge of change.

Session 34

Sophie said that she was continuing to "go with the flow". She said that life did not feel as intense as what she referred to as "the blip" in session 32.

She described a family ritual on Father's Day.

[00:09:35]

C: They, I say 'they', it was mostly Emily; they did a little thing in the sand, She built like a heart in stones and shells and that. Big heart 'Daddy'. And then she took a picture which she put on Twitter, (laughs) which was nice.

Sophie still found herself returning to the day of David's death, although it was generally not upsetting and she felt she could cope with it. However last week she spoke to somebody about the sudden death although she "didn't want to go too far into it" [00:20:00]

A new 'girls night out' had been planned and she anticipated that it would be okay this time although she was still not ready to be away from home overnight because this would feel like abandoning David.

She didn't believe she would ever again sleep in the marital bed in that house. To do so would "just feel weird" [00:44:18], although it no longer felt traumatic.

However she did spend time during the day when sometimes she "sat on the bed and had a little think." [00:44:07] Sophie thought it might change if she moved house.

Session 35

News of a neighbour's death had triggered a dream that David had died peacefully at home. Sophie wondered if this was her wish that it had been like that for them although she could say that a slow debilitating death would have been worse for David. She recalled his moment of death and wondered if he knew he was dying.

[00:26:20]

- C:** I still beat myself up that I could have done more. And I know I couldn't and I know I keep going over it, but I still think I could've.
- T:** It's like knowing that you couldn't but feeling that you could.
- C:** Yes and (pause) I suppose I've just got to learn to live with that.

Session 36

Sophie had been out with friends and had noted that she did not feel guilty when she returned home, as she had reported in session 22, six months earlier.

Sophie noted that she could now enjoy happy memories with just a slight tinge of sadness. Thoughts and memories around David's illness and death were not as intense, and the image of him collapsing was fading.

She was still unsure about ever returning to sleep in the marital bed.

[00:25:35]

- C:** It's just the thought of being in that big bed I think, and him not being there. I think it's maybe that. It's scary.

Sophie reflected with her counsellor that the recent pattern of monthly appointments seemed to be adequate for her needs. She said that although "I may have my moments" [00:56:13] compared to the first year, which had been a "horrible blur" [00:56:53]. She now accepted that "that's how it is and that's how it will be." [00:09:35]

Session 38

Sophie said that she was sleeping a little better but still went to bed late. She could hear David's voice telling her to go to bed.

Forthcoming parliamentary elections had caused her to think about David saying how important it is to vote. She had found it good to remember little things previously forgotten. Now she could think about these things without too much sadness.

She still got moments when looking at photographs when it was hard to believe that David was not still here. Sometimes she imagined what it would be like if it was here. She would try to think what he felt like. The smell of him on his blanket was fading, which she found sad but sometimes she would go into his room and sniff the pillow.

Revisiting his death was getting easier but she could still feel guilty about feeling better.

Recently she had written him an email; the idea came out of the blue.

Session 39

Sophie reported that she had been thinking about David a lot, but more than just about the day he died.

[0:07:04]

- C:** I've just been thinking a lot recently. Just a lot of things going on in my head thinking about David a lot and stuff like that.
- T:** Anything in particular?
- C:** No not really, just everything, just yeah, um, and not, and not all about like the day he died, but just anything, in general, anything really. And funny things that might have happened and you know, wanting to tell him about them. Stuff that he'd have thought was really funny, you know, or something like that. And then just for a fleeting second I think 'I'll tell him about that,' and then you think 'Oh, yes.' Just for a second you forget.

She noted that as long as she has things in place to keep busy it helped. Now she could smile when recalling things that they did together,

Session 41

Sophie reflected that nearly two years had passed since David was diagnosed with cancer. It was hard to believe, and she felt that she had "skipped a whole year".

To miss the year in which he died was a "strange peculiar feeling." She recognised how far she had come, and cited as an example, her ability to go out without feeling guilty.

Although some days could still be painful, when she thought about David now he was healthy.

She found that it helped to avoid pictures taken towards the end.

[0:46:58]

- C:** I'm not so keen looking at the picture of him that Michael took not long before he died and he looks really drawn.

[00:47:16]

- C:** Sometimes, it might be a bit odd, I try and sort of remember um parts of his face, like his ears or what his ears were like or, um what his skin felt like, trying to remember it so I don't forget. Is that a bit odd? (laughs).

At times, his death still did not feel real.

[0:49:00]

- C:** Sometimes things will like trigger things. Like there's a car parking outside and just for a fleeting second you just think 'Oh David's home' It's really weird. Just for a second.

Sophie reflected that she could now cope with down days.

[0:50:00]

- C:** It's okay to let myself be like that. It seems weird thinking that next year it will be two years, because it doesn't feel like two years.

The counsellor pointed out that Sophie had come a long way. Sophie said that she could not remember what she was like when she first presented for counselling.

Session 42

Sophie said that Christmas had passed without great difficulties. She said that she felt positive.

[0:15:40]

C: I feel quite positive at the moment. I don't know if it will last but I feel quite positive going into 2015 I feel like I'm getting myself in control.

She also reflected that she felt positive about getting in control of her health.

Sophie said that now she could think about things that they had done or talked about that now felt comfortable. For example, she and Emily had been into a television shop and had talked about how Dad would have liked one of the big screens. **[0:17:00]**

"I get changed in our bedroom, but I still couldn't sleep there. Having the empty space makes it more noticeable compared to sleeping in a single bed." **[0:25:00]**

Session 43

This session was the second anniversary of being told that David was terminally ill. Sophie said that it was hard to believe that it was two years. She noted that some people had not remembered.

[0:15:15]

C: Cos you sort of feel like cos it's two years now, people will have forgotten and people won't remember, which you know if they've got their own life they won't remember and stuff. And because it's two years you think that people might think I should be getting over it or whatever, you know? But it's not that easy is it?

Half way through the session Sophie reflected on the short time between diagnosis and death which had deprived them of the time to "think and talk." As she considered her thoughts and feelings today, she reflected that she was going to be like this every anniversary.

[0:30:30]

C: The first year is all just like a big blur, and then like the second year is almost like you're grieving again but you're understanding it. I recently went through David's hospital letters and looked at his Twitter page. I don't know why I did that.

She said that she wished they had talked more about the situation, but "everything that he ever did was always to protect us." **[0:39:25]**.

Sophie turned to thinking about her future.

[0:40:45]

C: I think it's like I feel like 'Where do I go from here now?' stage again. I know I had that before (sighs). But I don't have to do anywhere do I? Just carry on.

Session 44

The day before this session had been the second anniversary of David's death. Sophie reflected, as she had on previous occasions, that "the build-up was worse than the actual day." Others in the family had been "teary".

[0:05:08]

C: But I find I'm not. Sometimes I think, 'God they must think I don't care.' or something, because I don't break down and cry at you know, the graveside as it were. But I don't seem to do that. Maybe it's, I don't know, and I think 'Maybe they think I'm okay (laughs), but it's not that; I just don't feel able to somehow, I don't, I'm not trying to stop myself or anything,

Sophie described it as "a bit annoying" that some friends had remembered the significance of the date but others had forgotten. She reflected on a friend also bereaved of a husband but who has recently got engaged.

[0:21:24]

C: I'm really happy for her, *really* happy for her (pause) but it's almost, I almost feel like we're in a different category now. And I almost feel a little bit abandoned, I don't know if 'abandoned' I don't know what the right word is, I just feel like I'm the only one in that situation now sort of thing whereas before I thought 'Oh yes she's like a little ally.'

She said that she felt she needed other friends, and wondered again about joining the WAY Foundation.

[0:23:25]

C: I don't want it to be like something that's going to rake it all up, I just want maybe some friendships that understand, but I don't want it to be all morbid.

Session 45 – Final session

Sophie described her mood as "a little bit up and down" [0:04:21] but not too bad. She could find herself thinking about David "absolutely loads, like not purposely, just thinking about him loads, all the time then that weans off a bit" [0:04:33]. Sophie said that this involved not just thinking about happy things.

She said that next week would have been David's Birthday, followed days later by their 21st wedding anniversary. With friends and family, both days were to be marked with a celebration. Sophie said that she had been dreading the days since Christmas (4 months earlier) but that "Now it's nearly here it's just another day."

[0:33:47]

C: I can't believe how, it seems like ages, it seems like a long time and short time again you know, and I feel like people feel, people around me, I feel they should know when things are, you know anniversaries, they should know.

And of course they don't, they're not involved in it. I don't know; it's weird really. Cos I just feel like I'm in this (pause) plateau of nothingness really. And then sometimes I think I miss David *more* now than, (pause) obviously I miss him all the time but I feel like I'm missing him more now because I want to be able to do things, everyday things with him and things like that. It's weird really, but I feel I've just got to get on with it, can't do anything about it. I have joined the WAY Foundation.

With her counsellor Sophie reviewed the work done together, and there was mutual agreement that the counselling could come to an end. Sophie recognised that although her grief would continue, she now had an understanding of the nature of her grief and emotional resources to cope without professional support.