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GRIEF, COMPLICATED GRIEF AND COUNSELLING

BY

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With the increase in life expectancy more deaths occur in old age and it has become acceptable that if somebody has had ‘a good innings’ then it is ‘their time’. However if this pattern is not followed of there being an order in which death is acceptable, that is when we seem to have difficulties with coming to terms with death. We need to have questions answered at times of bereavement or we find it difficult to function as we ‘normally’ would. A lot of time is spent musing over the things we wish we had done while that person was alive. So it seems incongruous that, as the one thing we can be certain of is that we will die eventually, we hardly ever discuss it or prepare for it in the way we know will give us comfort when it occurs.

The focus of the research presented in this paper looks at the relationship between bereavement and counselling in general and the difference between ‘normal’ grief and ‘complicated grief’ in a counselling setting in particular.

The research had significant limitations. Because of access problems, I was not able to account for cultural and religious diversity in my sampling. The same applies for excluding the influence of mode of death from my research, although there is a strong evidence of correlation between the mode of death and grieving (e.g. Parkes et al., 1997; Silverman and Worden, 1992; Gerber, 1978). Although in the course of the fieldwork I came across with these influences, the way in which the research had been designed did not allow me to introduce them a systematic manner and thus I felt it was more reliable to exclude them completely.

First I will briefly review the literature on bereavement. It is relatively short as the bereavement literature, although vast in volume, in quality it is a well-defined, concise set of thoughts. Then I will present the method I applied in my fieldwork and will discuss the findings. The way in which the findings are presented is aimed at making the contrast between grief and complicated grief more visible.

Literature review

The literature on bereavement and counselling has become inseparable from Bowlby’s theory of attachment and, following from this, the way in which people react to the loss of this attachment. Not surprisingly then, there is a great deal of similarity

between various models and approaches to bereavement although the authors of the more recent model (while acknowledging previous models) claim the superiority of their model.

The first attempt to capture bereavement in psychoanalysis is generally attributed to Freud's 1917 paper on Mourning and Melancholy, although Bowlby (1980) pointed out that Freud formulated his hypothesis as early as 1897). In this Freud stated that "the bereaved was not grieving for just one object, rather that he/she was letting go of multiple layers of attachments (stored memories and symbols) that are involved in the formation of a relationship" (Humphrey and Zimpfer, 1996). Consequently, the feeling of bereavement is associated not merely with death, but a feeling that commonly occur with loss in general, thus with varied phenomena, such as redundancy, retirement, loss of a limb or other operation, children leaving home (Worden, 1991).

As I mentioned above, more recent approaches directly or indirectly relate to Bowlby's Maternal Deprivation Hypothesis¹. The assumptions on which these studies were based came from Piaget's early works when he demonstrated that at around six months old a child would actively search for something that is missing. The child now recognises this object as the same as before even though he has not seen it for some time. He is able to realise that although the person has disappeared from sight they are still the same on their return and will react accordingly. The child is now able to discern that 'out of sight' does not mean gone altogether. At the age of around fifteen months and beyond, children were able to discern that the object was indeed where it had been placed. It is during this time that a child is developing the ability to realise 'object permanence'. Piaget argued that this was also true of a child's reaction to people (Phillips, 1969). However, Piaget was only a starting point for Bowlby. On the basis of the empirical evidence he concluded that a mother-child attachment could not be broken in the first few years of a child's life without permanent and serious damage to that child's future development.

Critics of Bowlby's theory pointed out that as children may form many attachments to figures other than the mother, thus in the absence of the primary attachment figure (the mother, the child becomes attached to the other care givers. (Gross et al., 2000).

¹ Deriving from studies carried out in the 1930s and 1940s on children brought up places such as residential nurseries and orphanages. The ethics of his research has been called into question a number of times (Gross et al., 2000).

Furthermore, Harlow demonstrated that newborn rhesus monkeys can develop attachment to baby blankets (Harlow and Zimmerman, 1959).²

Research by Ainsworth (1967) and by Ainsworth et al. (1978) strongly supported the basic tenets of Bowlby's attachment theory though made the approach to attachment significantly more differentiated. The Strange Situation study (Ainsworth, 1967) enabled Ainsworth to differentiate among types of attachment (securely attached, insecurely attached and not-yet attached). Later studies of the Strange Situation provided insight in the quantitative aspects of the situation (Ainsworth et al., 1978) and reclassified the types of attachment: secure, avoidant, ambivalent, disorganised.

George et al. (1985) investigated attachment in adult life using a structured interview schedule with questions about their childhood, parents, feelings of rejection and major losses they had experienced. Their replies were then marked giving particular emphasis to how they described their attachment figures and attachment related events that had occurred in their lives. Further emphasis was placed on the way in which they recalled if these events had been good or bad. As a result of these findings four categories were found in adult attachment; secure/autonomous, dismissing, preoccupied, and unresolved/disorganised – strikingly similar to Ainsworth's categories.

Theories of grief and bereavement do not only rely on attachment theories, but Bowlby himself moved on developing his theory on loss and mourning. He gave a special recognition to Lindemann's work (Bowlby, 1980). Lindemann on the basis of his work with friends and families of victims of a single disaster proposed six characteristics of acute grief which were:

- a) Somatic distress
- b) Preoccupation with thoughts/images of the deceased
- c) Guilt related to the deceased or the death event
- d) Hostile reactions
- e) Loss of function
- f) A tendency to assume traits of the deceased's behaviour

² While Bowlby admitted the existence of multiple attachments, he insisted on the unique attachment to the mother. This assertion became highly politicised as the inevitable conclusion is that working mothers cause damage to their children.

He encouraged the bereaved to consider grief as work and gave them specific tasks to accomplish in order to work through their grief (Humphrey and Zimpfer, 1996). During his research he found that there was evidence in such cases for an over anxious attachment which was termed ‘overdependency’.

While Lindemman’s methodology was criticised on the basis of lack of transparency and his conclusions on the basis of insufficient grounding (Parkes and Weiss, 1983), these seem to have little effect on the citation of his works and on methodology used today³. In this sense, Kubler-Ross’ stages model is a natural continuation in the theoretical development. Kubler-Ross (1970) states that having worked with dying patients for over two years she used this as an experiment to ask the patient how they felt about the treatment they received. She interviewed terminally ill patients every step of the way as they entered hospital.

The Stages model consists of five distinct parts⁴:

- a) Denial and Isolation
- b) Anger
- c) Bargaining
- d) Depression
- e) Acceptance.

The use of counselling was for her very important as it gave the terminally ill patient an outlet for their very special needs that sometimes went unnoticed. However, one has to have a certain attitude towards death and dying to be able to work with the terminally ill without appearing anxious. The patient has to know we are not going to shy away from the very topic they need to talk about and as a counsellor I have to know that my anxieties will not prevent me from hearing the client.

³ Probably this methodological heritage explains the sharp criticism Holmes and Rahe attracted as they tried to introduce a pure quantitative method in their research with their Schedule of Recent Experience (Worden, 1991). The findings of studies using this method suggested a relationship between life-change events and the possibility that someone will then experience an illness or possibly death but this is not true of everybody. Therefore it suggests that it is a person’s ability to cope with changes that determines the outcome. The main problem with this method is the interpretation of causality. Firstly, although it gives an appearance of being objective, it relies on retrospective subjective interpretation of events. Secondly, being a statistical method, it is unable to say anything about individual elements of the population, though it gives the appearance as if it could.

Worden (1991) takes the stages approach further by setting tasks of mourning as a way of operationalising the outcomes of the stages model. Worden's Tasks are as follows

- a) To accept the reality of the loss
- b) To work through to the pain of grief
- c) To adjust to an environment in which the deceased is missing
- d) To emotionally relocate the deceased and move on with life.⁵

As Worden perceives loss as a deep traumatic experience, similar to physical trauma, thus healing needs to take place and the completion of the tasks of mourning represent the full healing process provided in a counselling setting. He also felt that counselling in this topic was specialised and set about providing training in the form of two day grief counselling seminars for health care professionals. The fact that these people already worked in a health environment, he felt, ensured that they already had certain skills and understandings as mental health practitioners. Worden claimed that there was a difference between grief counselling and grief therapy, because of different types of grief.

He considered normal grief the one that occurs more frequently among a group of bereaved people. Just as Lindemann, Worden defines the type on the basis of behavioural manifestations. They are as follows: sadness, helplessness, anger, shock, guilt and self-reproach, yearning, anxiety, emancipation, loneliness, relief, fatigue, numbness. In addition, the bereft person may experience sleep disturbance, appetite problems, absent mindedness, social withdrawal, dreaming of the deceased, avoiding reminders of the deceased, searching and calling out, sighing, restless over-activity, crying, visiting places and carrying objects to remind of deceased, treasuring objects belonging to deceased.

While the first set of manifestations is considered normal reactions and the second set of behaviours parts of normal grief, if they continue for long periods of time or remain very intense they would be considered complicated grief reactions (Worden, 1991), which requires grief therapy as usually other unresolved issues are also present e.g. when the bereaved suffers from excessive depression or anxiety.

⁴ Interestingly, hope does not feature among these stages, even though Kubler-Ross mentions that she was always impressed when even the most realistic patient held out some hope of a last minute cure being found (Kubler-Ross, 1970).

⁵ The similarity of the Kubler-Ross' stages and the tasks of mourning is not accidental as both fits the general tendency of the use of stages in bereavement research. Parkes (1972) in effect uses six stages. Rando (1993) also uses six, though their names of the stages are different.

A number of empirical studies demonstrated that the grief (and hence the manifestations of grief) is dependent on a number of factors (e.g. Parkes et al., 1997; Silverman and Worden, 1992; Gerber, 1978)

As a result of these studies the following categories were offered as the most important factors determining the grief experience:

- a) Who the person was
- b) Nature of attachment: strength of attachment, security of attachment, ambivalence in relationship.
- c) Mode of death: natural, accidental, suicidal, homicidal. (referred to in literature as NASH categories). Where was the death, close to home or far away.
- d) Historical antecedents: were there any previous losses still unresolved that may lead to complicated grief.
- e) Personality variables.
- f) Social variables: ethnicity, religion
- g) Concurrent stresses: relationship, economic.

The brief review of the literature above suggests that counselling the bereft is a complicated and challenging task for the counsellor. The factors are not simply unique to the client, but the number of potential factors is daunting and likely to be interlinked (for example, e), f) and g) of the above determining factors.

Furthermore, although the theory of bereavement counselling appears to be well established and solid, it is, in effect, a highly structured and formalistic generalisation of clinical cases evidence that have varying degree of reliability.

Methodology

To explore the research question, I chose a combination of research techniques: questionnaires, interviews and a case study. The introduction of qualitative techniques is justified by the likelihood of bereaved people finding it difficult to give a numbered response to a feeling or emotion felt by them after such a loss. The pilot of the fieldwork fully justified this consideration – research techniques had to be introduced that allow for qualitative responses without stopping the participant from elaborating on how they were feeling. It was clear that it was not easy to put feelings and behaviours into any semblance

of order and maintain my theory that everybody reacts differently at times of bereavement. Research has established the likelihood of certain behaviours being present. That is not to say that every person would experience the same pattern of behaviours.

The questionnaires were based on closed ended questions using tick boxes to provide quantitative responses with the provision for more in-depth replies at the end of the questionnaire. The sampling was quasi-random in an accessible population of people who have accessed counselling as a result of their bereavement. Twenty questionnaires were sent out and fifteen were returned. Two of the respondents were male and thirteen were female. The majority of the respondents (11) experienced more than one bereavements. Over half of the respondents aged between 35 and 49, six respondents were older than 50 years of age and one respondent was between 25-34. Eight respondents lost their parents and seven lost children. Those respondents who experienced more than one bereavements, three lost sibling, five lost grand-parents and two respondents lost partners. Two of the respondents clearly demonstrated indications of complicated death⁶.

Interviews were used to supplement the information gained from the questionnaires. I conducted three in-depth, semi-structured interviews, two with people who have received counselling after bereavement and one interview with people who did not. The participants of one interview had lost their son by suicide, one participant had lost her husband through illness and one had lost her sister also through illness. The interviews were then transcribed and their content was analysed.

The case study was chosen to demonstrate counselling issues in complicated grief. The subject of the case study, **B**, is a wife and mother of three children. Her first child was born days after her mother's death. The death of her mother occurred twenty-two years previously. B was still struggling with her feelings after a loss then used counselling to help her come to terms with her grief. The first interview took place before she had accessed counselling. The second interview took place three months later after person-centred counselling had been accessed.

⁶ One of them discussed the loss of her dog that she now viewed as a substitute for the daughter she lost, while the other indicated loss of home and stability as causing further complications alongside the death of somebody close.

Findings and Discussion

One of Bowlby's conclusions from his research was that the majority of subjects are grateful of the opportunity to express their feelings of sorrow to someone who shows understanding (Bowlby, 1980). This would then also suggest that counselling should provide this opportunity and indeed the empirical evidence strongly supports this.

All but one of the questionnaire respondents were contented with their counsellor (the one changed her counsellor and was satisfied with this second one)⁷. Of the qualities of the counsellor, the respondents put the greatest value on being approachable, understanding, respectful and friendly. It is probably expectable from counsellors, but importantly qualities such as wise, unflinching, empathic, caring, supportive were graded lower. After this very strong appreciation of the counsellor, it is not surprising that all respondents claimed that counselling helped them. These results correspond to the interview evidence. The two interviewees who accessed counselling stated that it was a nice relationship. Both clients had felt they could cry and be themselves and one also stated that she felt that the counsellor accepted her, respected her and listened to her⁸.

In addition, the social environment can also provide the opportunity of expressing feelings. More than half of the survey participants received support from family and friend and four from professionals (among them GPs). Five respondents did not answer this question. This could indicate that they had nobody to turn to – they were dependent on themselves and on the counsellor.

The empirical evidence from this research called for the use of the models put forward by Bowlby, Kubler-Ross, and Worden. The survey results, interview proceedings and the case study content could be easily classified under various headings of the stages proposed by these authors. As I mentioned in the literature review, the dominant theories and models in the field agree on the feelings and behaviours at times of loss and the differences are only about the sequences of these feelings and behaviours and the time they emerge. This, of course, also suggests generalisation problems, that is, the unique

⁷ Four of the respondents were already in counselling at the time of bereavement, seven almost immediately. The remaining 4 people accessed at a later date, 2 at the advice of their G.P. and 2 as a result of visiting local voluntary organisations. Nine of the respondents received person-centred counselling, two received psychodynamic counselling, while four could not identify the approach.

⁸ It has to be added though that one of the female interviewee thought that as her counsellor was male, she may have held back, which led her to claim that in future she would ask more questions about the type of counselling she was accessing. Although it is a single piece of data, hence problematic to generalise, but it suggest that for the client the core conditions of person-centred counselling is contextualised.

experience of mourning varies sample by sample, and a formalised deduction would inevitably result in different models.

Phase one, numbness, along with Kubler-Ross' first stage, denial and isolation and Worden's first task, to accept the reality of the loss were all described in the participants of this research.

To gauge the feelings and behaviours the respondents felt during bereavement I used Worden's manifestations of normal grief as guidance. Figure 1 and 2 show the distribution of responses. These feelings and behaviours were confirmed in the interviews. The interviewees talked about feeling shock and devastation. One felt "like a zombie", the other felt her-self losing control. Both described the feeling of being unable to share their grief for fear of upsetting the people closest to them. One said "it was so big.....I didn't want to upset them" while the other was "conscious of the fact that they were also grieving". The first stage of denial is the place where numbness is the only way the interviewees felt able to continue at that time.

Figure 1: Feelings at the time of bereavement indicated by 15 respondents

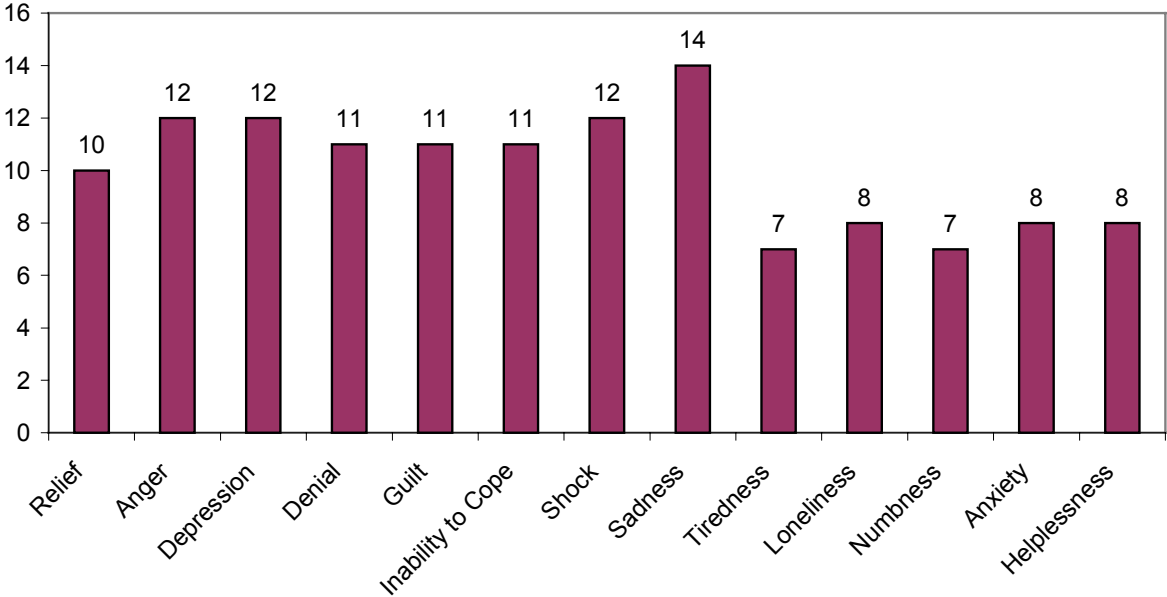
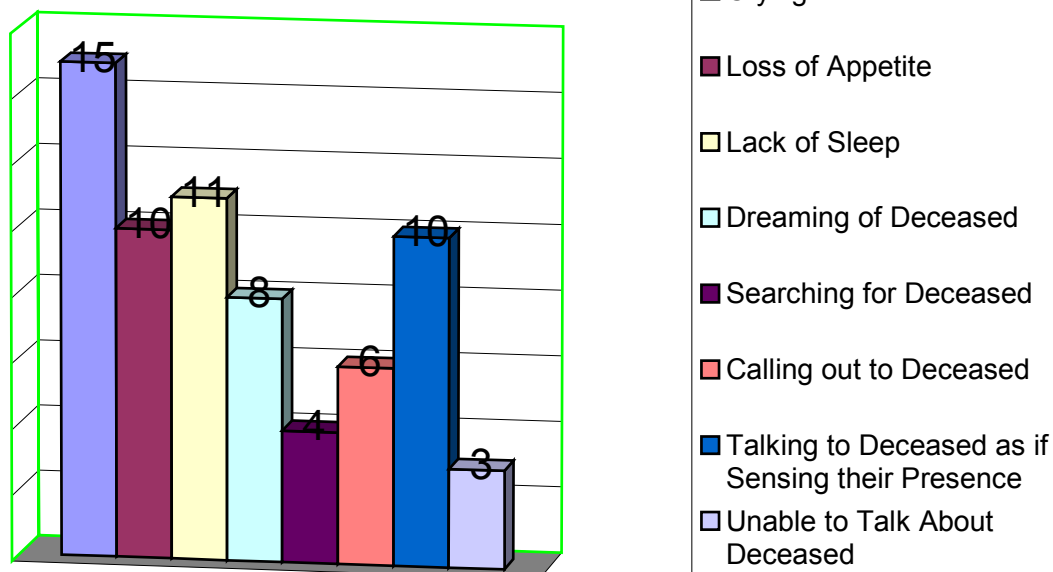


Figure 2: Behaviours during bereavement indicated by 15 respondents



Bowlby's phase two, yearning and searching, apart from the aspect of disbelief, did not feature prominently in the data, probably because adults are more aware that realistically the person they search for is no longer there. Nevertheless, the subject of my case study, **B**, recalled how, after learning her mum's death, she had followed her first instinct on reaching her Mum's home and had rushed to her bedroom and looked for her there.

Worden's task two, working through to the pain of grief and Kubler-Ross's second stage of anger were present in all cases. Anger featured highly in questionnaire responses and was used by all interviewees at some point as to how they felt. The interviewees discussed how angry they felt at the time of bereavement. One was angry at the hospital although it actually was not at fault and two were angry at the bereaved for leaving them, while appreciating that the husband who was ill had no choice and the son who took his own life felt he had no choice. The third interviewees discussed how angry they felt towards their son "*that he should leave us and not ask us for help*" and described how they still feel anger four years later towards the funeral director, the landlord of the bar where they went after the funeral and towards themselves for not knowing how their son felt.

The behaviour that was experienced by all questionnaire respondents and two of the three interviewees reported on crying (of the third interviewee couple, the wife recalled

keeping control so that everybody else would be ok while the husband cried during the interview). In this context it is worthwhile to remember Worden's discussion on the chemical effects of tears on imbalances in the body and his argument on suppression of tears is causing further problems (Worden, 1991).

The case study shows these feelings and behaviours in a very detailed way. **B** used the words sad and angry frequently and she went on to say how she felt the hospital were at fault for not acting with more care. It is common to feel anger when a loved one dies and if the anger is not directed towards the deceased it may be displaced onto someone else, in this case the hospital for not realising her mum's illnesses sooner. As a result of this guilt may be felt for choosing the wrong doctor, wrong hospital etc. It is more beneficial that the anger be used in this way otherwise it may be retroflected – turned inward and show itself in the form of depression, guilt or lowered self-esteem or even suicide (Worden, 1991). B, although not intentionally, clearly turned anger outward, for example, when telling her husband that he was horrible as he told her of her Mum's death. Crying may have also helped, as she spoke about crying all the time.

Although B has rationalised much of her behaviours from that time, she still cannot speak to her father about mother. Every time her Dad mentions her Mum she will change the subject⁹. This is partly due to the fact that she holds him partly responsible for the way she was towards the end of her life, and ultimate death. She went on to defend her Mum's drinking habits when her own husband referred to Mum's drink of choice as "*an alky's drink*". Still the rationalisation is present as she defended her Dad for his actions and had already come to understand why he acted as he did.

On the other hand, the rationalisation has not yet been completed. **B** was convinced that she was going to die young. Her argument to justify this was that her mother and aunts had all died young. She lives her life in a completely different way to her mother, but has this idea firmly fixed. Worden (1991) refers to a compulsion to imitate the dead person in his clues to complicated grief and I feel this appears to be in reverse at this point.

Bowlby's third phase of disorganisation and despair has similarities with Kubler-Ross's fourth stage of depression and also Worden's task three of adjusting to an environment in which the deceased is missing. Feelings at this time are of sadness, which

⁹ This was the main thing she wished to resolve by accessing counselling

all fifteen questionnaires agreed to. Worden adds to this that many ‘normal’ grief behaviours seem like ‘manifestations of depression’ in which symptoms such as sleep disturbance, appetite disturbance and intense sadness may be present. The interview proceedings supported these depression-like symptoms. One interviewee said that after her counselling session she would have the best nights sleep (that is before entering counselling, she had sleep disturbance) and the other said that when she felt at her lowest she couldn’t get out of bed for a month. Finding a way to fill the gap left by the deceased may have huge implications on family dynamics physically, emotionally, and sometimes financially. Coming to terms with these implications may not be doable while the bereaved is at this place.

Bowlby’s fourth phase of greater or less degree of reorganisation suggests that changes are being made and this would be present at Kubler-Ross’s fifth stage of acceptance and Worden’s fourth task to emotionally relocate the deceased and move on with life. There is a feeling in all cases that this is a place where the bereaved has found a way to move on.

However, people may not be able to complete the process. The interviewed couple who did not have counselling still felt guilty. As Lindemann said “to be bereft by self-imposed death is to be rejected”. The husband said that he “*will not get over it. It’s going to be with me for the rest of my life.*” Although they claimed that they have moved forward with the help of the local self-help group in which they are involved, some of their other comments suggest that the ‘acceptance stage’ is not yet in their grasp. They referred to their son’s room as a “*shrine*” in which they retain a casket containing his remains. **B**, the subject of my case study, carried a bag around belonging to her Mum. These behaviours give these bereaved people great comfort¹⁰.

B’s case, however, also shows that people can find much more constructive, healthier solutions. As counselling progressed, **B** was able to admit to herself that her Mum was physically and mentally ill and felt no need to find somebody to blame any more. She said she had stopped beating herself up and for her, that was the best bit. She was about to ‘emotionally relocate the deceased and move on with life’ (Worden, 1991).

¹⁰ The most extreme reaction of this type is when a person literally keeps everything the same as it was before that person died. Gorer (1965) calls this ‘mummification’ and the most famous example is Queen Victoria who, after the death of Prince Albert still had his clothes and shaving gear laid out daily.

Now, 22 years after the death of her mother, for the first time, she has been happy to talk about her mother, which she hadn't done at length for twenty-two years. She felt empowered enough to go home and talk to her children about the grandmother they never knew. She was glad to talk about the good bits and the bad bits, feeling no compulsion to defend her as previously.

Counselling enabled her to see that as a role model her Mum was not the best and it was ok for her to admit this, to herself and others. For **B**, the most important quality of the counsellor was her congruence. She felt she was not permitted "*to get away with anything*" and stated that the counsellor was very observant. Naturally, congruence can work only if it is acceptable for the client, which, in turn, requires the client to feel being accepted. Indeed, **B** said the counsellor was accepting of her and she was able to discuss things that she would previously have felt embarrassed about saying for fear that she would be considered not "*a nice person*". Here, the counsellor was showing unconditional positive regard by being totally accepting and making the client able to discuss her innermost feelings. She went on to say that sometimes she would look across and see that something had "*really touched*" the counsellor and this made the client feel that the counsellor was not "*made of stone*". Here, the counsellor was showing empathy, putting herself in the client's frame of reference and feeling what the client is feeling.

Conclusions

The discussion of the findings shows that the question whether counselling helps the bereaved can be answered positively, and demonstrated that it is especially effective in the case of complicated grief. As the majority of the participants have received person-centred counselling, it can be further specified, without prejudice to other approaches, that person-centred counselling provides the necessary safe and secure environment in which such people can discuss their feelings with no fear of reprisal.

While many people can deal with bereavement relying on themselves and on their 'normal' social environment, many have to rely on other types of help. In this context it is important that three of the participants said that they have young children in their family circle who have suffered the loss of somebody close. All said that no support network seemed to be available. Although it is an important point (especially for those who are affected), it needs to be qualified.

A part of the support network is the self-organised self-help groups. While these fulfil an important task, they can become an obstacle. During the research I came across a self-help group that had been in existence for fourteen years relies on charity funding to maintain its status. People, who attended these groups only want to speak to somebody who has ‘been through what they’ve been through’ and when I asked the members of the group they said a counsellor would not understand. While they listened to the persuasion, they were clearly contented with each other’s company and discussed their loss without being able or willing to emotionally relocate the deceased and moving on with life.

As a nation we are much more aware today of the many reasons that death can occur in unanswered circumstances that previously would have been ‘blamed’ on somebody. Even as I complete this study there is a case at the High Court in which people who were imprisoned for ‘shaking their baby to death’ have had their convictions found to be unsafe and that is ongoing.

In his paper “Mourning and Melancholia” Freud (1917) said that he saw grieving as a natural process that should not be tampered with. However, historically we have seen grief worked through by using family, church or funeral rites to assist us in the grieving process. It was Freud, after all, who coined the phrase ‘grief work’. Not everybody handles grief well and indeed this just emphasises the fact that we all grieve and react to loss in a different way.

I feel the benefits of counselling have been illustrated by the responses from the participants in my research. Everybody who was asked confirmed my belief that counselling helped them through this difficult stage in their life. They all agreed that counselling had helped to give them the place to discuss their feelings and not feel judged or in the wrong for having what they had previously thought were adverse thoughts. Counselling has helped to facilitate growth in people at a time when they think their lives have ended. They feel empowered and this leads to personal transformation. Counselling shares with them the fact that their feelings and behaviours have a place in the grieving process and indeed the ability to respond to these feelings will only help them to eventually acquire skills to continue daily life where the deceased is no longer present.

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Appendix
QUESTIONNAIRE

1. Are you

- Male
- Female

2. How old are you?

- 16-24
- 25-34
- 35-49
- 50 + Over

3. How long is it since you suffered a bereavement?

- less than 1 year
- 1-4 years
- 5-9 years
- 10-19 years
- 20 years and over

4. Have you suffered more than one bereavement in the last

- up to 5 years
- 6-10 years
- 11-15 years
- over 15 years

5. How old was the person who died? If more than one bereavement was suffered please state ages of deceased.

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.....
.....

6. How old were you when you suffered the bereavement after which you accessed counselling? (if more than one bereavement please state your age at the time)

.....
.....
.....

7. What was your relationship with the person/persons who died? (e.g. Your mother, your father, your partner etc.)

- Mother
- Father
- Partner
- Sister
- Brother
- Friend
- Son
- Daughter
- Other (please state relationship).....

8. Were you already in counselling at the time of any bereavement you have mentioned?

- Yes
- No

9. Was counselling available after this bereavement?

- Yes
- No
- Don't know

10

(a) Did you take up the offer of counselling?

- Yes
- No

(b) How many sessions did you attend?

(c) What type of counselling was it?

- Person-centred
- Cognitive
- Psychodynamic
- Behavioural
- Other (please state)
- Don't know

(d) How long did you have to wait for counselling?

(e) Please indicate how you found the counsellor to be during your sessions-tick all of the following that apply in your experience

- Approachable
- Warm
- Friendly
- Understanding
- Respectful
- Chatty
- Distant
- Dominant
- Is there any quality that I have omitted-please describe further

.....
.....

11. Did you have to pay for your counselling?

- Yes
- No-see next question.

12. Who paid for your counselling.

13. Did this affect the choice you made?

- Yes
- No

14. Was there a reason you did not ask about counselling at that time? Eg. Too soon, unsure of what counselling was for, did not know how to access counselling

.....
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15. Did counselling help?

- Yes
- No-Please state briefly the reason if counselling did not help.

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16. Did you have support from other sources? (Tick those that apply)

- Family/Friends
- GP/Professional
- Help-line (Samaritans, Listening Ear, etc.)
- Other (Please state)

17. If you were offered counselling today would you accept it?

- Yes
- No
- Don't know

Please give your reasons for your reply

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18. Grieving is a unique experience and no two people will react in the same way. Bearing this in mind, please tick all of the following that you felt at the time of your bereavement.

- | | |
|-------------------------|-------------------|
| Relief..... | Sadness..... |
| Anger..... | Tiredness..... |
| Depression..... | Loneliness..... |
| Denial..... | Numbness..... |
| Guilt..... | Anxiety..... |
| Inability to cope | Helplessness..... |
| Shock | |

19. Which of the following do you remember experiencing at the time of your bereavement. Please tick all that apply.

- Crying..... Loss of appetite
- Dreaming of deceased..... Searching for deceased.....
- Calling out for deceased..... Talking to deceased as if sensing their presence.....
- Unable to talk about deceased

Are there any feelings you experienced which I have left out at questions 18 and 19? Please include anything you would like to mention about your particular case that you feel the questions above have not covered (continue over the page if necessary).

20. Would you recommend counselling to others?

We are training the counsellors of tomorrow.

Counselling Training Personal Development Consulting

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