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Bereavement and the effectiveness of counselling

by

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Introduction

Research has shown that bereavement is the biggest cause of stress, on the Holmes and Rahe Social Readjustment scale the death of a spouse is the highest stress factor scoring 100 points, whilst the death of a close family member rates 60 points as does divorce (Holmes and Rahe, 1967).

Although bereavement means many types of loss such as divorce, health, finances, employment, loss of limbs, loss of organs, loss of senses, in this paper only death-bereavement will be discussed.

Death is something we have no control over and this lack of control can leave the bereaved person feeling helpless and unable to function as they did before their loved one died. The strong emotions can be overwhelming and even seem life-threatening and truly unbearable. In this paper I will argue that counselling is beneficial to the bereaved person.

A bereaved person often finds it difficult to talk about or cry over the deceased in front of family or friends for fear of upsetting them. Quite often the bereaved will put a lot of energy into trying to hide their grief and put on a brave face. But at some point the grief needs to come out and can possibly bring on a pathological illness if repressed. Although immediately after the death and a couple of months later family and friends will gather around and give support, as time goes by well-meaning others expect the bereaved person to be getting over it and support is withdrawn. This is often the time when the bereaved most needs support, when the impact of the death is now being realised.

Counselling provides the opportunity to talk to someone outside their normal circle of family and friends who isn't emotionally involved. Quite often, well meaning others are so desperate to rescue the bereaved from their pain that they will make unhelpful platitudes such as: 'You'll get over it', 'You'll meet somebody else', 'You can have another baby'. This can make the bereaved person feel even more isolated as if no-one understands, therefore, they give up trying to explain what they are going through. By showing understanding and being empathic a counsellor can help alleviate the isolated feelings. The bereaved person often has a need to tell the story of the death, what

happened and events leading up to it, and how they were told the news. A counsellor can facilitate this by listening, encouraging and providing a safe environment to explore the strong and confusing emotions, and also to allow the client the environment in which to cry without fear of upsetting anyone.

Rogers (1967) stated that the conditions of congruency, unconditional positive regard and empathy should be present in the counselling relationship for the client to be helped. For the counselling process to be effective, the counsellor needs to be congruent - that is open and genuine and fully present with the client. Furthermore, the counsellor has to convey to the client a non-judgemental, accepting attitude. Rogers also sees empathy as vitally important, and being able to communicate that sense of understanding to the client.

Because of these characteristics, the problem of counselling and bereavement will be discussed in the context of the person-centred approach.

Mourning is often described as stage-by-stage process, based on different principles: attachment (Bowlby, 2000), acceptance (Kubler-Ross, 1999), etc. Consequently, bereavement is a process in which the bereaved person has to complete tasks (Worden, 1991, Tschudin, 1997). He has to accept the reality of the loss, to work through to the pain of grief, to adjust to an environment in which the deceased is missing, and to emotionally relocate the deceased and move on with life.

Literature review

John Bowlby's (2000) Attachment Theory is renowned to be relevant to the study of bereavement. His views on attachment and personality development were considered quite controversial in the 1960's when he first developed them. According to Bowlby a baby became attached to its mother not because she provided food as Freud had said in the past but because she provided safety and security. Bowlby and his co-workers, notably Mary Ainsworth did extensive observations of babies and how they react when separated from their 'attachment' figure- usually their mother but whoever is their primary care giver (Ainsworth, 1967).

As an evidence of the prominent role of attachment he also cited the studies of baby rhesus monkeys undertaken by Harry Harlow (1958). The baby monkeys were taken from their mothers at a very early age and put in a cage with two wire mother models, one of the models having a nipple that produced milk for feeding and the other was covered in a terry towelling cloth that felt more like the monkey's own fur, and was easy to cling on to. When a mechanical toy that was noisy was put into the cage, the baby monkeys always ran to the terry towelling mother for safety, not the feeding model.

Bowlby concluded that we as mammals have an in built fear of the unknown and unfamiliar, so it is in our genetic makeup to run to mother for security to be protected from predators, - for our individual protection and also to protect the species from becoming extinct (Bowlby, 2000). It is in our best interests to become attached to main care-giver. It follows that a baby will be content in the presence of its mother and distressed in her absence. When attachment figure is absent, babies will show separation anxiety, and make angry protests for her return.

Mary Ainsworth, devised the 'Strange Situation' to study separation anxiety (Ainsworth et al. 1978). Infants were put into a room with their mother and some toys, then a stranger would enter the room, after a few minutes Mother would leave the room. Leaving the baby alone with the stranger. Ainsworth observe three types of significant behaviour and labelled some infants as 'securely attached' and some 'insecurely attached'. Securely attached infants continued to play with toys and explore while stranger was present as long as mother was still around, they did make angry protests when mother left the room and greeted her with great enthusiasm when she returned. Insecurely attached infants however showed different behaviours. Ainsworth split them into two groups – Anxious/resistant and Anxious/avoidant attachment behaviours. She observed anxious resistant infants as not exploring even when mother was present and becoming very anxious and upset when she left. On her return they acted ambivalent towards her, not knowing whether to be angry or loving towards her. The third group, Anxious avoidant, seemed to be distant and aloof, not really bothered when mother leaves and ignoring her when she comes back. In Ainsworth's studies of middle class American children she found 65 percent of one year olds to be securely attached. While her studies on Israeli children on a Kibbutz (where child rearing is communal) only 37 percent showed secure attachment behaviours (Ainsworth et al., 1978). The middle class children in the early

1960s probably had mothers who stayed at home with them and so provided one secure attachment figure. Ainsworth observed that securely attached infants had sensitive caring mothers while insecurely attached infants had less sensitive mothers. Also mothers who were playful and responsive and enjoyed breast feeding had more secure babies.

Bowlby, then came to the conclusion that any separation or disturbance of a child's initial attachment would have a profound affect on his or her mental health and personality development in later life. He claimed that babies go through a cycle of behaviours when separated from their mothers: protest, despair and detachment.

Protest was shown by tears and anger but hopeful that mother would return. Despair was shown as a quieter behaviour but observations noted that the infant was still preoccupied with absent mother, looking for her, watching the door, yearning for her return but hopes beginning to fade. Detachment - child acts as if he has forgotten mother and is uninterested on her return.

Bowlby stated that these separation anxiety behaviours and emotions in babies were the same as in bereaved adults. He believed that our instinctual behaviours have evolved in such a way that we have strong automatic responses to the loss of an attached person, always searching for them and scolding them for leaving us. Thus he developed his phases of mourning.

The first phase of numbness, shock and the second phase of yearning and searching relate to the angry protests and calling out and hoping for the lost person's return. So it is apparent that anger towards the deceased is a normal grief reaction. It also becomes much clearer as to why a bereaved person searches for the deceased and thinks they have seen him or her on a crowded street, becoming very preoccupied with finding the deceased. It may seem irrational as the bereaved person knows there is no hope of recovering the lost person, but in fact Bowlby argued that because these instincts are built-in we react to every loss in the same way without discriminating between the ones that are retrievable and those that are not.

The third phase of despair and disorganisation is probably the lowest point in the bereavement, when the searching and calling out and angry protests have all been

fruitless and the bereaved person begins to admit defeat much like the babies in the 'Strange Situation'.

The fourth phase of greater or lesser degree of organisation relates to the detachment phase the babies in the study went through. The bereaved person accepts the fact that the deceased is not coming back and will hopefully be able to form new attachments. However this phase of detachment can just be an act as although it may appear that the bereaved person is coping well and moving on, they could in fact be repressing feelings and using the detachment as a defence mechanism. This repression could lead to more complicated grieving later on. Bowlby suggested this occurred when the feelings of anger, sorrow and guilt were not expressed healthily and these phases were skipped over (Bowlby, 2000)

Bowlby's theory on bereavement was that securely attached people would cope better with their loss than anxiously attached people. For the anxiously attached, he noted that normal grief reactions were more intense and persisted longer. The anger towards the deceased was directed inwards, also the reproach that was meant for the lost figure becomes self reproach. His studies on personality development also showed that a high percentage of his patients with psychiatric disorders had suffered the death of a parent at an early age.

It is worth noting the era in which Bowlby did his research, that is post war Britain. It has been suggested by others that his research was part of a propaganda campaign to keep women at home with their children to free up the jobs in the factories for the unemployed men. Others, through their own research, concluded that high quality day care at a nursery is in fact beneficial to the child, increasing the child's confidence and ability to mix with peers (McKenzie, 1998).

In Elisabeth Kubler-Ross's five stages of grieving (Kubler-Ross, 1999) the stages of Denial, Anger and Bargaining are very similar to Bowlby's phases of numbness and shock, and yearning and searching. Kubler-Ross, in her observations of terminally ill patients and their relatives, noted a stage of Bargaining, this was when the patient was going through a futile attempt to postpone death. Offers were made to donate body parts if a cure could be found for their illness. Bargains were made with God: for

example: 'I'll go to church more often, be a good Christian, give to charity, if you stop me from dying'. Although at first it might seem that this bargaining cannot be connected to Bowlby's phases, it can be argued that it is in a way searching and yearning for what can never be. The Depression stage obviously is very similar to Bowlby's phase of Despair which Bowlby describes also as the period for depression and sadness. Her final stage of Acceptance is also similar to Bowlby's fourth phase of organisation. Although the obvious difference is that Kubler-Ross was writing more about the terminally ill patient accepting the fact that they were dying, whereas Bowlby's phase of organisation implies that the bereaved person has accepted his loss and is ready to move on, reorganise his life without the deceased. The 'moving on' would obviously not apply to the terminally ill patient, unless this can be interpreted as the patient accepting the fact that he is dying.

Kubler-Ross, however, was criticised both by theologians claiming (incorrectly) that she plagiarised the model from Nighswonger and for interfering with the jobs of hospital chaplains, and by scientists for absence of detailed research method, the model does not withstand scientific criticism and her later attachment to spiritualism.

Worden (1991) also starts from the stages approach, however, he strongly argued against the perception of automatic cycles, stages that are not affected by the bereaved person's action. This gives an emphasis to his practice-oriented approach: the bereaved person certain tasks that they must complete to adapt to their loss.

His first task is to 'Accept the reality of the loss'. If the bereaved person is still in denial and searching for lost figure what is the point of a counsellor or therapist working on depression? The counsellor's involvement here would be to help the bereaved client to accept that the death has occurred, to talk about the death and events leading up to it. This makes it more real for the client, it may seem like rubbing salt in the wound but it is a very necessary part of the process. Also, the client may be receiving unhelpful platitudes from well meaning friends and relatives or worse still, nobody mentions the deceased as if they never existed out of fear of upsetting the bereaved person. So the counsellor is the only person the client can talk to about the actual death and what occurred.

The second task is 'Work through to the pain of grief'. This is about acknowledging the pain and feeling it, the counsellor's job here would be to facilitate this most painful process. Bowlby stated (2000) that those who didn't acknowledge their pain would sooner or later break down with some sought of mental illness, usually depression. This comment links in with those he observed as being anxiously avoidant, they would appear ok then maybe need psychiatric help much further down the line when they couldn't cope with the 'stiff upper lip' façade any longer. Worden has taken Bowlby's comments as a source of inspiration for this particular task.

The third task 'To adjust to an environment in which deceased is missing' can be a very difficult task, especially if the bereaved person's whole sense of identity revolved around their relationship with the deceased. The counsellor's task would be to help the client look at new roles and a new way of living without the person they were so closely attached to. If the bereaved person was highly dependant on the deceased this can also cause a more complicated grief and relates to Bowlby's theory of insecure attachment. The bereaved could feel completely helpless and unable to make any kind of decision, when a decision is made it's likely to be what the client thinks the deceased would have done and not what he or she would do. This client may have never been autonomous throughout their lives.

The fourth task 'To emotionally relocate the deceased and move on with life' is similar to Kubler-Ross's fifth stage of Acceptance, that is accepting the new situation and it is also similar to Bowlby's fourth phase of organisation- also about accepting the new situation and moving on. This task can be left undone if the bereaved person chooses to hold on to the past attachment, sometimes out of a sense of loyalty, sometimes refusing to make new attachments because they are scared to become attached again as loss was so painful for them. It has also been stated that a bereaved person may choose to hold on to their grief as a way of receiving help and attention from other people, the pay-off being they never have to do anything much for themselves. People who succeed best at the completion of this task are Bowlby's securely attached ones. This may seem odd at first, after all if the relationship was a strong, loving, secure one wouldn't the bereaved be in the most excruciating pain at losing that relationship? However, the more securely attached person is better equipped to cope and go out and find other people to love. The securely attached person has a positive sense of self.

Tschudin's four question model (Tschudin, 1997) is widely used in bereavement counselling. Her first question - 'What is happening?' is very similar to Worden's first task in that it is to encourage the client to talk about the deceased and events leading to the death, so working on accepting the reality of the loss. This question is conveying to the client that it matters what the client has to say and that the counsellor is listening.

Her second question 'What is the meaning of it' – that is what the loss means to the client's life, would tackle more the client's pain and anguish and so is similar to Worden's task of working through to the pain of grief.

The third and fourth questions: 'What is your goal' and 'How are you going to do it' are helpful questions for any counselling situation really but for the purpose of bereavement counselling these questions would be useful for getting the client to look at ways of completing Worden's tasks of Adjustment and Moving on.

It can be argued that these approaches, to a larger or lesser extent, start from the basis of Bowlby's attachment theory and consequently, there is an agreement on the assertion that the relationship and strength of attachment the bereaved had with the deceased is of great significance to their grieving process, and that a person only grieves when they are attached, it is the loss of that attachment figure that actually causes the grief.

However, a number of research demonstrated that ways in which people mourn and react to a particular loss vary significantly. The Harvard Child Bereavement Study, a highly standardised, longitudinal research (Worden, 2001) identified the following six determinants of grief.

The mode of death. Deaths have been catalogued into four categories: natural, accidental, suicidal and homicidal. Worden argued (1991) that a sudden death is more difficult to deal with than an expected death. When an accidental death occurs, the bereaved has to deal with thoughts of whether their loved one suffered at the time of the accident, injuries could be horrific, as with homicidal death. A person could be prevented from being able to go through a grieving process in the circumstances where a body has not been found as in war or disasters, they could remain in denial and grief will never be dealt

with, without some kind of professional support. When the death has been a suicide, the bereaved has great difficulty handling their grief. Suicide is the most unspeakable of deaths, especially if it is not certain as to whether the death was accidental or suicide. This 'not speaking' can cause the bereaved to feel totally isolated. Death can be seen as rejection even when the bereaved knows in his rational thinking that the deceased hasn't left deliberately. Therefore suicide can seem like the ultimate rejection. When the mode of death for a baby is due to SIDS (Sudden Infant Death Syndrome) the surviving parents are seen in the medical field as particularly needing support. The guilt can be overwhelming for a number of reasons such as they wish they had not been asleep when death occurred or if the baby was ill why didn't they detect this. There is often no explanation for this death and leaves questions unanswered. Also because of the nature of this death there could be legal as well as medical investigations, all adding to the stress. The divorce rate for couples experiencing cot death is high (Rando, 1985), a reason for this could be that the husband finds it difficult to cry and feels he should be the strong one and support his wife, the wife could perceive this as him not caring.

Who the person was. Where did the deceased fit in to the hierarchy of the family and what was their role? For example the loss of a spouse can mean the loss of companionship, financial security, intimacy, practical support, emotional support, status.

The degree of the attachment. If the attachment was strong and the love intense then the grief will be intense. For example a woman who deeply loved her husband would grieve for him differently to how she would grieve for an aunt whom she did not have such a strong attachment to. The bereaved may have had a highly dependent relationship with the deceased, this could cause complicated grief as the bereaved cannot see him/herself as an individual, unable to make decisions and unable to adjust to new circumstances and their own new found role. Although feelings of helplessness are common in the newly bereaved and seen as normal, in the highly dependent person these feelings can continue to be very desperate and overwhelming with no ability to go through the grieving process. This is when the grief can turn into abnormal or complicated grief and could require specialist help. An ambivalent relationship with the deceased can also determine how a person will grieve. Ambivalent feelings will not die with the person and this can cause tremendous guilt and anger. Conflicts with the deceased can cause difficulty and complicated grief, any chance to resolve conflict is seen as lost. So even though the grief

is intense because the love was intense, if it was a secure relationship then as Bowlby postulated the bereaved will be better equipped to cope and work through the grief and form new relationships. As with the anxious/avoidant and anxious/resistant babies in Ainsworth's study, the more insecure and ambivalent the relationship the more difficult it will be to resolve the grief.

Historical antecedents. Previous losses can effect the grieving process of a current loss. If past losses were not adequately resolved then when another death occurs, the bereaved is grieving for past loss as well as the most recent.

Personality. Personality also plays a role in the mode of grieving. If a person perceives himself as the strong, brave one in the family, he may feel unable to show his true feelings and 'bottle up' his emotions, putting on a 'brave face'. So the very people who appear on the outside to be coping are the ones who may need the most help. A person who has difficulty forming relationships will struggle to cope with their loss, and also those with a personality disorder, notably a narcissistic personality disorder (Beverley Raphael, 1985). A highly narcissistic person can only see the deceased as an extension of themselves, so to deal with the loss would mean dealing with the loss of part of themselves, so the loss is often denied.

Social Context. If the bereaved person has a good social support network from family and friends, this is said to alleviate the stress and adverse effects of bereavement (Worden, 1991).

From these determinants then it can be deducted that bereaved persons who have a number of these conditions such as lack of social support will be in need of counselling or more specialist help, although it is unwise to presume this. High risk factors can also be that the bereaved has a physical or mental illness, has financial difficulties, lacks coping mechanisms.

Grieving could become a border-line personality problem or illness (Worden, 1991) and it is often called complicated grief. Complicated grief has been given many labels such as unresolved, exaggerated, delayed and pathological – when it is seen as an illness. Although depression is seen as a normal grief reaction, when the feelings are exaggerated

and the person falls into complete despair, this can lead to clinical depression and is seen as pathological grief, requiring special help. The grief can even manifest in the bereaved developing similar symptoms to those the deceased had before they died (Deutsch, 1937). However it is worth noting that this can also be seen as a normal grief reaction, and can be seen as abnormal depending on the intensity and duration of the symptoms. Sigmund Freud (1917), described mourning as the "Reaction to the loss of a loved person, after a lapse of time it will be overcome" but melancholia as a pathological illness "Marked by inability to recover from the loss, the complex of melancholia behaves like an open wound that refuses to heal". Freud described feeling pain as pathological grief whereas today it is seen as a normal grief reaction.

Research methodology

To explore the research question, I used questionnaire survey as the main method. The sample size was 20. The participants who answered the questionnaires are mainly from a widowed group of people, although not entirely. To improve the validity of findings from the small survey sample, I undertook ten interviews of bereaved people, five who had counselling for their bereavement and five who hadn't. For the interviews I chose seven participants who had lost a parent, two who had lost a partner and one who had lost a brother-in-law. I did this to achieve a balance of relationships with the deceased, so that not all participants were widowed. I treated the questionnaire results quantitative and the interview proceedings as qualitative data.

The questionnaire established the demographic data of the respondents.

For the bereavement specific questions I used the theoretical assumptions discussed above (e.g. relationship with the deceased, feelings and behaviours). To deal with the function of counselling in the bereavement process, I asked respondents to rate their counsellor's competencies.

For the interviews, I asked about feelings, thoughts and behaviours to establish similarities to the literature and answers to questionnaires. It was also important for me to know what people who had not had counselling found to be helpful for their grieving process, to compare to those who had counselling. I also wanted to establish if people

considered being able to talk freely about the deceased as helpful to them and important for the grieving process.

Discussion

Grief, while shows universal similarity, differ from culture to culture. What is considered to be pathological grief in one society is seen as normal in another, for example in the slums of Cairo, Egypt, a mother locked in deep depression for years over the loss of a child is behaving normally by the standards of her community, and a Balinese person who seems to 'laugh off' the death of a close one is also behaving normally by the standards of her community. (Parkes et al., 1996). What may seem barbaric to some cultures will be normal behaviour in others. The Yoruba of Nigeria dispose of the dead body of a baby by throwing it into the bush, this may seem bizarre to the western culture but to the Yoruba people to bury a dead baby would be deeply offending the earth shrines that bring fertility and ward off death. (Parkes et al., 1996)

The participants of my research are all white British. While this may bear influence on my findings, it is important to point out that my professional experience is that minority ethnic communities do not access the bereavement counselling services. I was assured that the services had been offered to these communities, but had largely been refused as there was no need for such services amongst them. Staff at the Alder Centre in Liverpool[1] also reported that they had not had a great deal of success in offering their services to these minority groups. It appeared to me then, that these communities had their own ways of dealing with grief and we would be more respectful to not intrude and not presume that they 'needed' counselling. However, we are living in a multicultural society, and some would say we should adapt our services to make them more accessible to the minority communities by finding out what it is they need. Some would call the 'not intruding' as 'not finding the time or effort to find out'. So perhaps there is a misconception that communities 'sought themselves out'[2].

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[1] The Alder Centre offers support and counselling to bereaved parents

[2] These communities are changing in the UK. The traditional community values and the individualistic values of the society as a whole are manifest in generational and other conflicts. Counselling, partly because of ignorance of other values, partly because of this conflict, is often culturally irrelevant to members of the minority. In particular, in the case of bereavement counselling it is imperative that the counsellor has knowledge of the religion, beliefs and rituals to be of any assistance. The task of

80 percent of the respondents were female. This roughly corresponds to the fact that women are more likely to use counselling services more so than men (cf. University of Hull, 2003).

The bias in the sample for women was also a result of demographic characteristics. As the target group was the widows, 37% of the respondents were 60 and 70 years of age. Considering that at that age group there are 50% more women than men (ONS, 2002), the bias is justified. Because of the bias of widows in the sample, the relationship to the deceased is biased to (70%), namely spouse. However, as the death of a spouse gets maximum points on the stress scales, it is more likely that widowed people will seek and need help to some degree. The loss of a spouse can mean the loss of a whole way of life. The bereaved may be unable to perceive any future life without their loved one.

20% of the respondents suffered the death of a child, this particular loss is seen as requiring special help. The loss of a child is considered unnatural, as we do not expect our children to die before us. It is the loss of a planned future, hopes and dreams, the loss of parental role, the loss of someone to nurture. It can cause great strain on the marriage, the husband and wife could find talking about the death to each other too painful and may be fearful of upsetting each other, so counselling may be the only place they can vent their true feelings. Anger is a common feeling for this particular death as it seems so unjust, the parents can direct their anger at each other or siblings of the deceased.

Respondents were asked about their feelings at the time of the deceased's death. Most participants reported that they felt devastated, shocked and numb when first getting the news. One participant said 'As though my life had stopped, as though I was going to die, frozen, devastated' this statement captures the total shock and numbness the bereaved person first feels. A fifty-year old woman whose husband died stated 'My whole world has collapsed', this shows that the death of a spouse can feel like the death of one's

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reaching out to minority groups however is huge. The people in the communities who are already helpers with regard to bereavement need to be identified and willing to allow counsellors to work alongside them. Also, the powerful families in each community should be identified, for example there could be a number of powerful families in each community, if only one family was approached the others would possibly see this as a snub and not get involved.

'whole world' or way of life. The answers corroborate with Bowlby's first phase of mourning-numbness and shock.

These concrete feelings, sadness (90%), shock (85%) and numbness (80%) are closely linked to depression. A high percentage (75%) experienced a sense of disbelief, this also ties in with Bowlby's first phase as part of the shock is the inability to accept the news. It also confirms Kubler-Ross's first stage of denial. One couple reported that after the accidental death of their eight-year old child, they kept his bedroom as a shrine to him and also all his personal belongings were left just as they were, in case he returned. This is denial but normal behaviour when death first occurs, however if this denial continues for years it is said to be abnormal grief. This also indicates that to be of help to a client in a counselling situation, Worden's first task of accepting the reality is significant.

Loneliness also scored a high percentage (65%), loneliness links with feelings of isolation and depression that the bereaved person feels, Bowlby's third phase of disorganisation and despair is the phase when these feelings surface. This is also the phase when a person can feel suicidal, a 61 year old woman reported feeling suicidal after her husband's death. These suicidal feelings can be due to depression or they can be a strong desire to be with the deceased, as many people believe they will be reunited with their deceased loved ones when they die. Kubler-Ross sees depression as the fourth stage of mourning. Worden's second task of working through to the pain of grief would be helpful at this stage.

60% of participants reported yearning as in Bowlby's second phase of mourning, desperately pining for their lost loved one. 55% reported feeling helpless, this also ties in with the stages of disorganisation, despair and depression. 55% also reported feelings of anxiety. Anxiety is usually brought on by fear. Fearful feelings when a loved one dies can be about feeling fearful of a future without the loved one, it can also be that the bereaved person starts to think about their own mortality, and becomes fearful of death. This can lead to a phobia developing in the bereaved person. This is generally seen as complicated grief. Counselling could be very beneficial to the bereaved person with a phobia, or who suffers panic attacks as a result of the anxiety, as quite often the bereaved person doesn't realise that the death of their loved one is what has caused this behaviour. So this can be explored through counselling, once the fears are recognised as the cause, the problem

can be alleviated. Worden's third task of adjusting to the environment in which deceased is missing would be helpful here.

Anger, confusion and guilt all scored 40% in the questionnaire. Anger and guilt, according to the literature are common and strong emotions a person feels when someone dies, so I expected them to score higher. However, it can be difficult for some people to recognise or even admit to these feelings. I noted that one participant (male) did not report guilt as one of his feelings on the questionnaire, yet when interviewed, it was evident that guilt was one of the main issues he was dealing with. A bereaved person can feel tremendous guilt when someone dies. Guilt can be due to the relationship, especially a highly ambivalent one where "Hate and love contend with each other" (Freud, 1917). In the counselling situation, guilt can often be alleviated by acknowledging it and talking through, then the client can realise that it is, in most cases, unfounded.

Anger is a normal grief reaction, however it is sometimes very difficult for a bereaved person to admit to feeling angry at the deceased for leaving so the anger can be directed at others – such as medical staff. Sometimes the bereaved person will turn the anger inwards and this can lead to a pathological illness such as clinical depression if not recognised. Counselling can help the bereaved person to acknowledge they are angry at the deceased, although it is worth bearing in mind cultural issues, as depending on a person's cultural and religious beliefs, admitting to being angry with a dead person could be completely inappropriate and taboo.

Respondents reported confusing feelings and behaviours (40%), they are usually preoccupied with thoughts of the deceased and of what the future holds, there is an inability to make decisions and think rationally, these behaviours are common for people in Bowlby's first phase of numbness and shock and also second phase of yearning and searching.

30% reported feeling fatigued, the fatigue is usually brought about by constant thoughts and dreaming of the deceased, sleep disturbance and pining. The impact of the death can effect the bereaved physically, so the body can feel real pain and totally lack energy. Fatigue is also a symptom of depression, Kubler-Ross's fourth stage of grief.

5% reported feeling relief, this is usually when the deceased was in a lot of pain and it is unbearable for loved ones to cope with this. However the relationship with the deceased could also be a factor, for example if the deceased was abusive in the relationship. None of the respondents reported feelings of freedom, although this could be that this is not a feeling easily admitted to when someone dies. Feelings of freedom can occur if a person has found looking after their ill loved one a heavy burden and after the death the burden is lifted. Guilt is likely to accompany this feeling.

All participants reported crying. Crying is considered to be a good release of built up emotions and a way of relieving stress. Research is currently being carried out as to the healing value of tears, researchers hypothesise that tears caused by emotional stress have a different chemical content to tears secreted through eye irritation and that tears released emotionally may contain more mood altering chemicals (Worden, 1991). When someone dies, friends and relatives expect the bereaved to cry, however as time goes by well meaning friends and relatives can become uncomfortable with the tears and can avoid the bereaved, adding to feelings of loneliness and isolation. A counsellor may be the only person the bereaved person feels comfortable to cry in front of. A high percentage (70%) reported sleep disturbance and 50% appetite disturbance. These two are closely associated with stress. Stress can cause chemical imbalance in the body (Worden, 1991), so this can lead to physical symptoms such as lack of appetite. Sleep disturbance can be as a result of constant preoccupation of thoughts of the deceased and how death occurred.

30% of the respondents reported Social Withdrawal, the person recently bereaved will find it difficult to function socially, may feel that no-one understands their pain and so it is easier to avoid others. 25% experienced dreaming of the deceased. When a person is in the phase of yearning and searching, dreaming and preoccupied thoughts of the bereaved are common, as are hallucinations (also 25% reported). 15% claimed sensing the presence of the deceased, this also links to the yearning phase and still feeling very much attached to the deceased. 10% experienced screaming and 5% experienced being bad tempered.

Turning now to the role of counselling, Equal numbers of respondents were referred to counselling by their doctor as people who self- referred. This is a positive result as it

shows that doctors are willing to acknowledge that counselling helps with bereavement and not necessarily just medication such as tranquillizers. In self-referral, the most important trigger seems to be loneliness and the need to talk.

Counselling seems to be effective in bereavement – 80% of the respondents considered counselling helpful, while only 10% gave a negative answer. This was clearly correlated by the fact that most respondents who considered counselling helpful thought it was easier to talk to a counsellor about their loss than to somebody else. Not surprisingly then, listening was the highest ranked counselling skill in this sample, followed by accepting and understanding. While openness and responding also ranked high, compared the previous skills, they were of minor importance. This confirmed my initial hypothesis that the core concepts of the Rogerian approach would be helpful in bereavement counselling.

People were relieved after counselling, stating that they felt better after counselling and counselling helped them to come to terms with their bereavement. This positive experience is confirmed by the fact that 85% of the respondents would recommend counselling to others.

My interviews not only confirmed these findings, but allowed a more detailed exploration of the process itself and the effects of the mode of death and social factors.

Slow death, due to an illness may be perceived as a relief, while sudden death brings about shock and disbelief. One of the interviewee related his mother's death:

> *"It was different from when my Dad died because he was dying slowly, he was deteriorating, we were wanting him to go and not be in any more pain. It was a joyful thing when Dad died because we had seen him struggling, he was really ill. Well, he's at ease now, no more pain."*

However he stated that his mother's death – a sudden heart attack, affected him very badly, and in a very different way to his father's death, mainly feeling shocked, angry and anxious.

Another interviewee, when describing the death of her 30-year old her brother-in-law due to a car accident, said:

> *"I remember punching the bathroom wall in frustration and thinking-why him? If he'd been ill it would still be a shock but at least you'd think well at least he's not suffering now. It was so final and so sudden".*

Again, this suggests people can accept death more when it follows an illness, almost justifying it by believing the deceased to now be out of pain and suffering. She also stated "he was so young", again this is an unacceptable death because of the age of the deceased. It follows that people are more able to accept the death of an elderly, sick person as this is seen as the way life is. It is not the way things 'should be' when a young person dies, many hopes and dreams for the future are also seen as lost, this is why the literature clearly states that the death of a child is seen as the worst death possible.

Death by suicide is a particular difficult death to come to terms with. One interviewee had experienced this when her partner had taken his own life. Twelve years after the death she still found it necessary to go to counselling. She states

> *"the third time I went (to counselling) I didn't realise it was about him, I thought it was something else to do with the relationship I was having at the time. Then once I got going, it was him who kept coming up again so it was him underlying everything".*

This suggests delayed or unresolved grief. It is said that suicide is the ultimate rejection to those who are left behind and can leave them depressed and suffering from low self–esteem. This is borne out in the interviewees comments

> *"If anybody said anything vaguely critical about me I took it really personal and questioned everything I was doing, it (counselling) helped me calm down about that sought of thing, so for all aspects really not just the bereavement".*

Thus counselling helped her to work on her self-esteem and self worth and not just the issues of her loss. Shame is also a feeling that comes up for people bereaved by suicide as

there is a stigma attached to suicide in our society, people do not know what to say to be of comfort. So people will say nothing or act as if the death has not occurred (Worden, 1991). The interviewee stated:

> *"People seemed to be acting strangely towards me. So the biggest thing was I just felt so on my own about it. Totally isolated. People just didn't know what to say."*

I found from the interviews that it is also important for people to have the chance to say their goodbyes, which is not possible with sudden death. Guilt is a strong emotion that comes up when others in the family have had their chance for goodbyes, also anger and resentment.

Relationship and nature of attachment to the deceased clearly plays an important role in the grieving. One of the interviewee's narrative illustrates how conflict with the deceased can cause a lot of anger and guilt for the bereaved:

> *"From the age of seventeen, when I was becoming my own woman, that's when the conflict started between my mum and myself… Looking at it now I wish I'd gone down to see her more… I should have done more, I should have done this, I should have done that, I should have been there for her. I just wish. I do feel even now and it's seven years ago that I could have been there, I could have done a lot more."*

The anger she feels is directed at her father and her siblings. She said:

> *"In a way I blame my Dad, if he had called the doctor at the time I don't think she'd have suffered the way she did… I got very annoyed and angry with my sister because she went to my Mum's friends for help in organising the funeral."*

This particular participant would rate quite high on Parkes' Bereavement Risk Index (Parkes et al., 1997) as needing help as she has high anger, high self reproach and young children at home at the time. I noted that her personality could also be a factor, she states:

"It was as though I was the only one who had suffered a loss as big as this, nobody could understand what I was feeling, the upset, the hurt, the guilt. I felt like I was the only one entitled to suffer like this. I didn't give a second thought to what my brothers and sister were going through, it's like I was the only one who mattered."

This suggests unresolved grief.

People try to cope with grief in various ways. My interviewees reported receiving support from their partners, family and work colleagues. Two participants who did not have counselling reported that they were the ones giving the support, one to her mother and one to her sister. A theme that came out of the interviews with both these participants is that they 'kept busy' and did practical things to help. It is notable that what was helpful for them was being close to the 'chief mourner':

"I think being there for my Mum helped me to come out of myself, my Dad had been very ill".

Or the participant who's brother-in-law died said:

"My grief wasn't as important as my sister's, I had to keep mine under control. My boyfriend couldn't get his head around the fact that I felt better being with her because he couldn't bear to see her the way she was. I'd wake up in the morning feeling panicky and anxious until I got to her house then I'd feel better. They were such horrible feelings, I'd do things like make the babies' bottles up and that made me feel better because I was being useful. I was the one giving the support"

From the interviews it is clear that social factors are important and that the bereaved feel better when receiving support and having others around them.

All this help and support, however, can be unhelpful to the bereaved. The main factors that came out were regrets at not being there at the end. Platitudes were also identified as being unhelpful. A significant theme that came up during the interviews was sibling rivalry when a parent dies, interviewees stated arguments and siblings making decisions

without consultation as very unhelpful. Not being able to talk about the deceased or the circumstances surrounding the death was also seen as very unhelpful.

Conclusions

The empirical research demonstrated that in general and majority, counselling helps the bereaved and it is beneficial for the coping with bereavement. Furthermore, while I have no means to compare approaches, the core concepts of the Rogerian approach is particularly suited for bereavement counselling.

Bereavement is a process and people go through stages, each stage being characterised by particular symptoms, feelings, thoughts and behaviours. As Bowlby postulated a bereaved person who was securely attached to the deceased will cope better in their bereavement because of their positive sense of self. So it follows that a bereaved person having difficulty in coping with their bereavement or unable to work through the grieving process possibly because of insecure attachment, would benefit from person centred counselling, as this approach very much centres on the client working on her own self esteem, self-worth and becoming the autonomous person she really can be.

Counselling is helpful to the bereaved, in particular because they have the ability to talk to someone about the bereavement. Being able to talk about the deceased and what occurred around the time of death to someone who is not emotionally involved (the counsellor) is very beneficial to the client, and how difficult some participants found it to talk to family or friends for fear of upsetting them and alienating them. Themes of not wanting people to worry were present. Empathy was also identified in the findings as very beneficial in the counselling situation. Participants reported that friends didn't understand what they were going through but their counsellor did. Congruence is also an important factor for counselling to be helpful. This proves that when the counsellor can show genuineness, and be open and honest, it encourages the client to do the same. Honesty, then, is a crucial factor in allowing the client to explore her feelings.

I was able to identify that participants who had counselling reported that counselling had helped them come to terms with their bereavement. This coming to terms links with

Bowlby's fourth phase of greater or lesser degree of organisation, also Kubler-Ross's fifth stage of acceptance and Worden's fourth task to emotionally relocate and move on. From the interviews of people who did not have counselling I was able to identify that people who did not have counselling had not come to terms with their bereavement as well as people who did have counselling. I found that Worden's theory on the tasks of mourning were relevant to my research, I identified that participants who had counselling had completed the first task to accept reality and the second task to work through to the pain. It was evident from the interviews that people who had counselling did not have such a great need to tell their story regarding the bereavement, indicating this had already been dealt with in counselling and so helping them to 'accept reality'. Whereas those who did not have counselling still had a need to tell of events leading up to and around the time their bereavement occurred. I observed that participants who had counselling were more relaxed about discussing the painful feelings they suffered at the time, linking with the task of working through the pain, linking with being more able to resolve their grief.

Although grieving in our culture is a unique experience to each individual, there are a lot of similarities as regards to feelings, behaviours and thought patterns that bereaved people will go through. I have learnt that it is unwise to presume that people from other cultures grieve the same way, and that counsellors may need to re-train in the future to be more accessible to the minority groups in our society.

A special interest may be focused on respondents who reported conflict with the deceased and also reported to being the 'same person' as the deceased, actually using the phrase 'same person'. One may wonder how anyone could see themselves as being exactly the same as another person. It is interesting that it was their parents who had died, and I wondered about this need to emulate a deceased parent. Although psychodynamic counselling is not discussed in the dissertation, it may prove particularly useful for such cases, when the grieving process is dependent on past relationships, childhood memories and transference to such a degree.

Another interesting sub-theme is the role of the family dynamics in bereavement, for example sibling rivalry when a parent dies. Although the word 'jealous' was not actually used in the interviews, it was clearly narrated. Participants were angry at being left out of decisions and argued over funeral arrangements. I also noticed a theme of wanting to

know who the deceased parent loved the most. Death can also affect the whole family dynamics, not just in relation to sibling rivalry but it is possible that roles will change and the place one thought they were in the family can shift, for example the woman whose brother-in-law had died, found herself as having to be 'the strong one' in the family.

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Appendix

QUESTIONNAIRE

The questionnaire is anonymous. Your answers will only be used in aggregated data.

1) Are you:

Male ☐ Female ☐

2) How old are you:

3) What is your ethnic origin:

4) What was your relationship to the person who died (e.g. your husband, wife, a parent):

5) Please describe your feelings you had when they died:

6) Did you experience any of the following feelings: (please tick as many as you wish)

Shock	☐	Guilt and self-reproach (e.g. I should have done This, I shouldn't have said that)	☐
Numbness	☐	Sadness	☐
Helplessness	☐	Anxiety	☐
Anger	☐	Fatigue	☐
Loneliness	☐	Yearning	☐
Relief	☐	Freedom	☐
Disbelief	☐	Confusion	☐

Any other feelings not listed? Please state:

……………………………………………………………………………………

7) Did you experience any of the following thoughts or behaviours: (please tick as many as you wish):

Crying	☐	Sleep disturbance	☐
Screaming	☐	Appetite disturbance	☐
Bad tempered	☐	Social withdrawal	☐
Searching and calling out	☐	Dreaming of the deceased	☐
Sensing the presence of the deceased	☐	Thinking you have just seen the deceased person (for instance in a busy shopping street)	☐

8) Did you make the decision to go for counselling or were you referred (e.g. by a doctor)

…………………………………………………………………………………………..

…………………………………………………………………………………………

8b) If you made the decision to go for counselling yourself, what made you do so?

9) Did counselling help you to cope with your bereavement?

YES ☐ NO ☐

10) Was it easier to talk to a counsellor about your loss than, say family or friends?

YES ☐ NO ☐

11) If counselling was helpful, please rank the following competencies of the counsellor on a scale from 1-5

Listening	----
Understanding	----
Responding	----
Open and Genuine	----
Accepting towards me (not judging me)	----

12) How do you feel now (after counselling) ? Please state in your own words:

……………………………………………………………………………………

……………………………………………………………………………………

……………………………………………………………………………………

13) Where you are at now, has counselling helped you come to terms with your bereavement?

YES ☐ NO ☐

14) Would you recommend Counselling to others?

YES ☐ NO ☐

INTERVIEW SCHEDULE

PEOPLE WHO DID NOT HAVE BEREAVEMENT COUNSELLING

1. Can you describe your feelings when (insert name) died?

2. Can you describe your behaviours, thoughts?

3. What support did you feel you got at that time (say from family or friends)?

4. What did you find helpful?

5. What did you find unhelpful?

6. Did you feel able to talk freely about (name)? If so, did this talking make you feel better or worse? Of not, did this make you feel better or worse?

7. Do you feel any further on in coming to terms with your bereavement?