Negotiating recovery in bereavement care practice in England: a qualitative study

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Abstract: This paper explores how 'recovery' from grief is negotiated in bereavement care practice in England. What constitutes recovery from grief remains contested in bereavement research and practice. In this paper, I outline some of the debates in the literature concerning what constitutes recovery following bereavement before presenting interview data from bereavement counsellors and support workers to discover how practitioners negotiate recovery following bereavement in practice. The findings show mixed responses to the use of the term recovery. I highlight six components that emerged across the accounts and that the participants agreed were important to the success of bereavement counselling. However, rather than provide an empirical basis for recovery, the findings in this paper reveal the conflicts and ambiguities that exist in bereavement care practice.

Keywords: Bereavement counselling, grief work, recovery.

Introduction

Recovery remains a contentious term in bereavement research and practice (Balk 2008, 2004; Paletti, 2008; Rosenblatt, 2008; Sandler, Wolchik & Ayers, 2008; Tedeschi & Calhoun, 2008). Within bereavement research and practice, grief is commonly understood as 'normal' and 'natural' and not something from which one recovers but rather something that one lives through. Balk (2008, p.85) argued there was a 'widespread resistance' amongst bereavement practitioners to using the term recovery in bereavement, and a 'distaste' towards recovery that was 'at times visceral'. Researchers have stated a preference for terms such as 'adaptation', and 'resilience' over recovery and emphasised how recovery does not capture how people may experience growth following bereavement. (Bonanno, 2009; Tedeschi & Calhoun, 2008). However, Balk (2008) has expressed puzzlement at the dislike of the term 'recovery' and argued that recovery has much broader meaning than that associated with the medical definition of recovery, which implies a return to prior functioning. For Balk (2008, p.85), recovery does not refer to the retrieval of the lost person, or a prior way of life, but to the recovery of one's self, 'one's humanity'.

Balk's argument suggests there is a lack of clarity among bereavement researchers over what recovery following bereavement means or constitutes, and further whether recovery is a term with any relevance to grief. This is in contrast to a growing interest in recovery within UK national health care services, particularly mental health, where service users and providers are embracing a 'recovery model' of care (Slade, 2010; Department of Health, 2001). In terms of bereavement counselling practice, whether or not an individual client 'recovers', according to a chosen framework, can serve to prove or disprove the 'effectiveness' of a particular intervention. Some form of measurement is arguably necessary to evaluate a client's improvement

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following a series of counselling sessions. This suggests that an idea of what recovery might look like would be helpful, or is already in action, when appraising the role of the bereavement counselling process in aiding a person in his or her grief, even if this understanding of recovery is an ideal rather than a prescribed formula. Furthermore, recovery is the end point of certain models of grief commonly used in bereavement care practice, for example 'the grief wheel' (Grief Education Institute, 1986) features 'recovery' as the movement out of the cycle of grief and away from possible 'deterioration'.

The contested nature of the term recovery might be indicative of a divide within bereavement care between research findings and their implementation into practice. For example, a staged model of grief resulting in 'recovery' has been largely dismissed by bereavement researchers yet, as Breen (2010) discovered, such models are still utilised within practice in Western Australia, causing a 'misalignment' between grief literature and grief counselling practice. Moreover, Stephen and Wimpenny (2008), in their qualitative study, emphasised the need for more national and local co-ordination in bereavement services in the UK. The 'unevenness' of support across the country was also highlighted in a report that reviewed existing literature on bereavement care services commissioned by the UK's Department of Health (The University of Nottingham & Department of Health, 2010). However, the Bereavement Care Pathways Project, formed in 2007, aimed to bridge this 'gap' resulting in the publication of the *Bereavement Care Service Standards* (Bereavement Services Association and Cruse Bereavement Care, 2013) that detailed the 'Gold Standards' for bereavement care and established a clear 'bereavement pathway' to educate professionals and better connect up services and support. This included auditing and ensuring equality and governance across different services; enabling 'quality control measures' to be utilised within the field; establishing a more integrated approach to the delivery of bereavement care; and providing a helpful benchmark with which services can be compared across the country.

This aim of this paper is thus to unpack some of these contested issues around grief and recovery and how they are negotiated in practice. This paper draws on data from the author's PhD study (Pearce, 2016) that sought to explore the conflicting views and ambiguities concerning the use of the term recovery in bereavement research and practice. Semi-structured interviews were conducted with 13 bereavement counsellors and support workers working in four organisations across England to discover what constitutes recovery from bereavement in practice. In the next section of this paper, an overview of how recovery has been configured in grief literature is provided before detailing the methodology and methods of the study and the presenting of the findings.

Defining recovery in grief and bereavement theory

The lack of clarity around the use of the term recovery in grief may be connected to a wider critique of 'staged' models of grief that in general assume a linear, time-limited process of grief resulting in resolution or recovery. Within this view of grief, the route to recovery is through 'working through' one's grief, or doing 'grief work'. The understanding that grief work is integral to recovery following bereavement has its own history commonly accredited to Freud (2006, originally 1917, p.245). In his essay 'Mourning and Melancholia' Freud described his understanding of 'successful mourning' as achieved through a long and painful process of what he called 'reality-testing' where 'each single one of the memories and expectations in which the libido is bound to the object is brought up and hyper-cathected' leading to a detachment of the libido so that the 'ego becomes free and uninhibited again'.

Later theorists construed Freud's ideas to mean melancholia or the failure to mourn was largely caused by an inability to face the reality of the death (Worden, 1991; Kübler-Ross, 1970; Gorer, 1965). In turn, recovery from grief was achieved by 'working through' one's grief, understood as a cognitive process of confronting the reality of the loss, going over the events that occurred before and at time of death, focusing on memories and working towards a detachment from the deceased person. For example, echoes of Freud are clearly audible in the work of Lindemann (1979) who described grief as requiring work, where grief work was understood as involving 'efforts at extricating himself from the bondage of the deceased and finding new patterns of rewarding interaction' (Lindemann, 1979, p.147). This understanding of successful grieving, Walter (1999) argued, became 'clinical lore' adopted in the practice of bereavement counselling.

However, the orthodoxy of the stage model of grief has since been widely challenged (Hall, 2014; Rothaupt & Becker, 2007) by studies that have emphasised how people construct meaning from loss and how people continue rather than relinquish bonds with the deceased (Neimeyer, 2005; Klass, Silverman, & Nickman, 1996; Rosenblatt, Walsh, & Jackson, 1976). As Stroebe and Stroebe (1991) argued, the belief in the necessity of 'grief work' has become a 'truism' rather than empirically supported. In their empirical study of 60 widows and widowers, Stroebe and Stroebe found that, on the contrary, there was not a clear relationship between grief work and adjustment and that adopting a 'confrontational' or 'avoidant' approach made little difference to overall outcomes. Further studies have suggested that there is a weak or inconclusive empirical basis for certain counselling interventions, in particular those that focus on individual 'grief work' (Waller et al., 2016; Schut, 2010; Larson & Hoyt, 2009; Neimeyer &

Currier, 2009; Currier, Neimeyer, & Berman, 2008; Jordan & Neimeyer, 2003). Furthermore, different interpretations of grief work have been proposed in the work of Davidson (2008; Davidson & Letherby, 2014) who views 'griefwork' as an activity undertaken with other people, both lay and professional - rather than an activity engaged in primarily by the bereaved individual alone.

Studies of grief and bereavement have thus provided differing perspectives on what the process of grief and its 'recovery' should entail. Through the development of models of grief, recovery has largely emerged as something that involves work on behalf of the bereaved individual whether working through tasks or along a series of stages, and as something to be achieved within a given time period, though this view has been increasingly challenged. Studies of 'complicated' and 'prolonged' forms of grief, however, argue that grief can become 'derailed' from its natural course suggesting that, in some cases, people fail to progress through grief to recovery (Shear, 2012, 2010; Prigerson et al., 2009; Zisook & Shear, 2009). If it is possible to identify the derailing of normal grief into complicated or prolonged grief, it is reasonable to assume that it is also possible to identify what constitutes a 'normal' recovery from grief. In other words, the process of defining normal and abnormal courses of grief builds upon a shared understanding of what comprises successful and unsuccessful grieving. However, as detailed below, the findings of this study revealed a mixed picture of how recovery is achieved in practice, and indeed what that 'recovery' should look like at the end of a counselling intervention.

Methodology

The data presented in this paper was gathered for my PhD research (Pearce, 2016), which also included interviews with bereaved people and analysis of policy and lay literature on bereavement and recovery. In this paper, I present the findings from the bereavement care practitioners that participated in the study.

The methodology of the study was influenced by the work of Foucault (1984a,b; 1973, 1971, 1970,) and the aim of the study was to explore the societal discourses around grief and recovery and how they are enacted in the theory, policy and practice of bereavement care in England, including how discourses around grief and recovery are negotiated by bereaved people when making sense of grief. A qualitative approach was adopted. Qualitative methods aim to capture the experience of the individual or group and to discern what is happening in the practices, thoughts and feelings of people's lives (Silverman, 2005; Charmaz, 2004). A qualitative method was well suited to a Foucauldian theoretical stance in terms of providing the scope to think about how grief and recovery might be differently formed and articulated, as well as how definitions of grief and recovery emerge, thus challenging some of the dominant ideas around grief and recovery.

Qualitative interviewing aims to capture people's experiences, opinions and feelings in their own words (Rapley, 2001). In conducting the interviews, I was interested in how different individuals made sense of grief and their views on recovery. The aim of conducting interviews was not to capture the pure 'reality' of grief and recovery but to gather different interpretations of grief from a variety of viewpoints and to analyse how they agreed with, conflicted, or contradicted the broader public discourse around grief and with one another.

Methods

Bereavement counselling organisations across England were approached to participate in the study. Potential participants were invited to participate on the basis of their role working with bereaved people as a counsellor or support worker. I recruited participants with the assistance of the participating organisations through advertisements in staff newsletters and mailing lists. The study was approved on ethical grounds by The Open University Human Research Ethics Committee, and by the research ethics committees at Cruse Bereavement Care and St Christopher's Hospice.

Participants

Semi-structured interviews were conducted with 13 participants. Details of each participant can be found in Table 1. All names have been anonymised. The participating organisations present examples of bereavement care at national and local level, each with different forms of public support and funding, training and methods. Further background on the participating organisations is provided below.

Cruse Bereavement Care

Cruse Bereavement Care is the largest national charity in the UK dedicated to the provision of bereavement counselling and the training of bereavement volunteers. Cruse was founded in 1959 and was originally dedicated to the support of widows but now offers mainly emotional support to adults and children who have experienced any form of bereavement. Cruse's support largely consists of one-to-one counselling: according to their figures 29,803 bereaved people received such support in 2014. At the time of conducting the study in 2014, Cruse had approximately 5,700 volunteers who delivered bereavement support.

CARIS Islington Bereavement Service

CARIS (Christian Action and Response in Society) is a charity that provides a bereavement service to those who live in the borough of Islington, in north London. The bereavement service was established in the early 1980s as a deanery project by the Anglican churches in

Table 1. List of participants.

Name	Role	Organisation
Wendy	Bereavement service counsellor/coordinator	CARIS Islington Bereavement Service
Linda	Bereavement service counsellor/coordinator	CARIS Islington Bereavement Service
Daniela	Bereavement counsellor	CARIS Islington Bereavement Service
Matthew	Bereavement counsellor	CARIS Islington Bereavement Service
Claire	Bereavement counsellor	CARIS Islington Bereavement Service
Kelly	Bereavement counsellor	CARIS Islington Bereavement Service
Sarah	Early Intervention Project Team member	Cruse Bereavement Care
Jane	Early Intervention Project Team member	Cruse Bereavement Care
Susan	Bereavement support worker	Cruse Bereavement Care
Marion	Bereavement support volunteer	St Christopher's Hospice
Tony	Trauma counsellor	St Christopher's Hospice
Ellen	Senior member	Grief Recovery UK
Pamela	Bereavement service co-ordinator	Local bereavement service in South-East London

Islington, managed by the deanery 'Social Responsibility Committee'. CARIS Islington resolved to become an ecumenical project, although most of its funding relies on the support of local churches. CARIS provides training for volunteer counsellors, all of whom are already undertaking or have completed other formal counselling qualifications. At the time of writing, the service CARIS provided was open-ended, maintaining around 40 counsellors, with approximately 180 referrals a year of which around half became clients.

St Christopher's Hospice

St Christopher's Hospice was founded by Dame Cicely Saunders in 1967 and is widely regarded as the first modern hospice. It is located in Sydenham, south east London. St Christopher's is a charitable organisation that relies on donations. St Christopher's bereavement services consist of one-to-one and group support delivered by volunteers who receive training.

Grief Recovery UK

Grief Recovery UK is a not-for-profit organisation which is the UK branch of the Grief Recovery Institute founded in the USA. The Grief Recovery Institute was born out of the *Grief Recovery Handbook*, which was created by John W. James who had developed his own unique strategy for recovery from loss following the death of his young son. The Handbook (James & Friedman, 2009) states it is an 'action program for moving beyond death, divorce and other losses including health, career and faith'. It comprises a series of trademarked steps and activities that promise 'completion' and recovery from loss. The steps involve a number of activities that must be followed in the stated order. The first step is to write a 'loss history graph' which details all the losses people have experienced in their life, loss being broader than death, encompassing 'the loss of hopes, dreams and expectations'. The second step is to write a 'relationship history graph' for the relationship people wish to find 'completion' with. This graph documents the key aspects of a relationship with the chosen person (deceased or alive) on a timeline. The final step is to write a 'completion letter' to the person. Grief Recovery UK actively trains 'Grief Recovery Specialists' and support is delivered in a group or one-to-one setting.

Conducting and analysing the interviews

Before the interview, each participant was given full details of the research in the form of an information sheet and asked to sign a consent form. The information sheet informed participants of their right to withdraw and what would happen to the findings of the project. Participants were assured in writing and in person that all research data, including participant details, interview data, and field notes and data analysis would remain confidential at all times. Storage of data followed the guidelines set by the Data Protection Act (1998) and the Freedom of Information Act (2000).

The interviews lasted for one and a half to two hours. The interviews took place either in a room arranged through one of the participating organisations or a public venue. Each interview was recorded on a digital recorder. The interviews were structured around questions about the participant's professional background and training, their approach to grief in their practice, details of treatments and therapies used, including frequency, duration and intensity, and their understanding and definitions of recovery. To gain a more detailed understanding in the interviews, I constructed hypothetical vignettes or scenarios to illustrate and contextualise the questions and to seek a clearer picture of what is done in different situations. For example, I would ask a bereavement counsellor what course of action they would take with someone who was struggling to recover several years or more after bereavement.

In qualitative grief and bereavement research, the 'situatedness' of knowledge is more pertinent when the fact of death and mortality is something 'we' are all 'inside' and part of (Woodthorpe, 2009). Rowling (1999) suggests grief

and bereavement researchers should strive to be neither too 'in' nor 'out' but 'alongside' participants. Being 'reflexive' does not promise objectivity, it is rather a strategy that helps to reduce harm to the participants, and being clear about one's position as researcher.

One example, during the course of the fieldwork, highlights the fluid nature of the boundaries despite how many frameworks are adhered to. During a conversation with the organiser of the Grief Recovery UK workshop I disclosed that carrying out the fieldwork was causing me to reflect on my own experience of grief. She invited me to attend the personal Grief Recovery workshop. As I was attending as a participant, I did not use the responses or experiences of other attendees as data. However, I was also introduced to the group as a researcher and so I was there with a dual purpose of 'working through' my grief while learning of the techniques and methods of Grief Recovery UK that would inform my thesis. I participated in three days of activities where I fully participated as a fellow griever – despite my introduction as a grief researcher. I carried out exercises in which I had to draw up a timeline of my 'loss history'; I had to be open and speak about my losses in front of the other attendees. In this example of attending the Grief Recovery workshop I only gained access to the workshop by being 'inside', through my mention of the struggle I was having with my own feelings during the fieldwork. But being 'inside' meant that at times it was difficult to measure my distance from my research object. This reflexivity was something that required constant renegotiation in the fieldwork process, and was integral to achieving transparency in the influences on the data. This also involved monitoring my own emotional response to the interviews. In order to maintain reflexive awareness I kept a fieldwork diary and also had regular meetings with my supervisors.

The interviews were analysed following the principles of thematic analysis by coding the content of the data (Braun & Clarke, 2006). During analysis of the interviews I noted connecting themes that began to build up a particular picture around grief and recovery. I read and re-read the transcripts several times noting down repetitions and recurrences to construct an initial long list of themes and ideas. I was aided by the four questions Hollway and Jefferson (2000, p.55) suggest all researchers should consider when analysing qualitative data: what do I notice?; why do I notice what I notice?; how can I interpret what I notice? and how do I know if my interpretation is the 'right' one? With subsequent readings of the transcripts, the long list came to be refined to overarching themes that were then separated into sub-themes.

Findings

Negotiating recovery following bereavement: 'a really difficult dance to do'

The findings revealed mixed responses to the use of the term recovery, with the majority of bereavement practitioners interviewed in the study shying away from making prescriptive statements about what constitutes a 'successful recovery'. Counsellors and those who work with bereaved people have an investment in helping them to find relief from their grief. Yet, in bereavement counselling there is no resolution of the initial problem, as Wendy explained:

> If you come to a counsellor with a phobia you can just get over the phobia, or come to the counsellor with some childhood issue and work through it, but actually you can never bring back the person who died and so actually what the counselling is about is coming to terms with the fact you can't mend it, there's no mending this issue. (Wendy)

It is around this problem that bereavement counselling and care is positioned as providing different but never quite complete solutions to grief. Data from bereavement counsellors and support workers therefore did not provide a unified vision of what recovery looked like. The participants preferred terms such as 'integration' or more subtle explanations that grasped at ideas of 'movement' and the client 'inhabiting' new identities to recovery. Participants described the processing of finishing with a client as a 'long process' that involved 'constant reviewing'. CARIS counsellor Claire described it as 'very sort of drip, drip, drip' and 'not anything like a clear road'. Many counsellors and support workers described a mutual intuitive sense of knowing when the 'work is done' and 'it's time to say goodbye' by a change in the 'feel' of the counsellor-client relationship.

There were, however, markers that practitioners observed and looked for. These involved recognising that the client was taking an interest in their own life again and had started talking more about her or himself than the person they had lost. It could also be evidenced by practical things such as thinking about going back to work, taking up hobbies, doing new things, and meeting people. These new activities were often described as ways of internalising the lost person into the client's new life. The participants often drew on particular cases to elucidate their ideas, avoiding generalisations where possible, and emphasising the individual context. Further, they appreciated that ways to recovery were individual and idiosyncratic and there was not a 'normal' way, as Wendy explained:

> If a client is going to the grave every day and happy to do that and finding it supportive and not intrusive, then good for you and who cares if you do that for the rest of your life if that's good for you. But you might get another client who feels that going every fortnight is too much and is getting in the way and they can't stop themselves and they feel like its unhelpful and so, who can decide what's normal and not normal, only the client can. (Wendy)

There was acknowledgment that societal norms had levels of restriction on expressions of grief and recovery, and permitted certain behaviours over others. Recognising the normative requirements on emotional expression, Daniela described the process of recovery as 'a really difficult dance to do' one which 'nobody knows what the steps are, nobody knows what the bloody music is'.

Furthermore, there were differences in the methods and approaches used to facilitate recovery from grief. In the Grief Recovery Method (GRM), that sets out a clear path to recovery through their method of 'completion', there is no scope for ambiguity. Completion is gained through the writing of a letter that has a very specific format. The letter was written to the person with whom clients wanted to get 'complete', to rid any 'unresolved communications' they might have. The letter then had to be read in front of another person in order to become complete. In the GRM, recovery can only be achieved through a specific activity without which people are incomplete. Yet, even completion does not provide the permanent recovery it promises. Completion letters could be written a number of times to the same person. When asked whether completion was then a temporary thing, senior member of Grief Recovery UK Ellen replied 'Inevitably it almost is', 'but you can be as complete as possible'. The purpose of 'getting complete' was to communicate all the 'unsaid' things you needed to say. Yet, even for Ellen, new thoughts and feelings emerged that needed communicating, and so completion became an ongoing process. The act of completion was emphasised as crucial but it was a misleading term to describe a process that did not appear to have an end point.

The findings therefore show mixed responses to the use of the term recovery. However, across the interviews there was an emphasis on six components which the participants agreed were important to the success of bereavement counselling. These components were described as aiding success in the bereavement counselling setting yet they were interpreted and implemented differently. Rather than provide an empirical basis for recovery, the findings in this paper reveal the conflicts and ambiguities that exist in bereavement care practice.

Components of bereavement counselling practice

In what follows I highlight six components that emerged across the accounts and that my participants agreed were important to the success of bereavement counselling. The six features I discuss are: the types of counselling approaches and method employed; the practitioners' personal experience of loss; how clients are assessed to receive treatment; the importance of safety; normalising grief, and working with emotions.

The type of counselling approach and method

My data showed that the approach employed by the majority of counselling practitioners was a client/person-centred model derived from the work of Rogers (1951) drawing on an eclectic approach. The person-centred model was central to Cruse's volunteer training. Rogers' (1951) person-centred approach emphasises the client as expert. It is a non-directive approach that holds that the client knows her or himself best. The role of the counsellor is to be skilled in empathetic understanding and non-judgmental listening in order to allow the client to express their feelings. Some counsellors demonstrated an integrative approach that touched upon a number of different theories and techniques including Bowlby's attachment theory (Bowlby, 1980, 1979): a theory that considers grief as a separation response shaped by one's experience of separation from one's primary caregiver as a child. One of the counsellors at CARIS, Matthew, described his approach to bereavement counselling as influenced by mindfulness practices. 'Mindfulness' is a term used to describe a form of meditation derived from Buddhist practices (Kabat-Zinn, 1994). In brief, mindfulness has come to be understood as way of thinking that focuses on the present without judgment. Studies have shown mindfulness has some effectiveness when used in bereavement counselling practice (Cacciatore & Flint, 2012). A number of counsellors also referenced psychodynamic approaches and utilisation of concepts such as transference and counter-transference, the unconscious, and an emphasis on childhood experiences (derived from the work of Freud, 1917).

The participants also drew on grief models, making reference to the dual process model (Stroebe & Schut, 1999) (nine out of twelve participants), along with Worden's (1991) tasks (three participants made explicit reference), continuing bonds (mentioned by five participants) and the stages of grief (mentioned by five participants). Also popular were the ideas of 'growing around grief' conceptualised by Tonkin (1996) and the 'grief wheel' (Grief Education Institute, 1986). The models were often referenced by practitioners as useful tools to measure where a client was in the process, who also stated they were helpful for the client to 'normalise' their emotions. CARIS counsellor Wendy told me that she found Worden's tasks model useful when dealing with clients who 'seem quite stuck' and the stages model as helpful for someone 'who's got some sort of abnormality in their grieving'. Here models were used in a pick and mix fashion depending on 'the individual and their pathway'.

By way of contrast, the Grief Recovery Method states it is not counselling or therapy (James & Friedman, 2009). A senior member of Grief Recovery UK, Ellen, appeared quite dismissive of bereavement counselling. Ellen was critical of

the lack of choice in bereavement care and described it as a 'disservice to the bereaved'. The GRM does not reference any of the grief theories and research in their method. The GRM is against 'intellectualising' grief declaring that grief is a matter for the heart (Ellen). The GRM therefore promoted quite a different way of treating grief in comparison to bereavement counselling that Ellen believed provided an alternative for people who, like her, may find counselling is not suitable for them. The difference in methods and approaches found in the data also shaped how the practitioner described their own role in helping someone following bereavement, as described next.

Personal experiences of loss

> A lot of us have got backgrounds with personal experiences, which has led us to do what we do now. So you get a connection - it's not formal counselling, it's professional we are all properly trained and its professional - but at the same time there's lots of empathy. (Susan)

Like Susan quoted above, the majority of bereavement care practitioners I interviewed spoke in some capacity of their own experience of loss and how the knowledge of loss either provided them with the incentive to become a bereavement counsellor or how it enhanced their work. Susan described how at Cruse 'a lot of the counsellors and supervisors' were drawn to the work at the organisation because of their own experiences. Many of the participants told me of their own personal experience of loss in order to explain why they became engaged in bereavement work. Getting involved in bereavement counselling was a way to 'give something back' and do something 'positive' following their loss. They also told me that having such experience meant that they had something to offer as counsellors, even without formal counselling training. This, some of the participants claimed, was because the mutual experience of loss was considered to produce a 'connection' where the potential counsellor could 'understand how it feels'. A personal experience of grief was considered to complement the person-centred approach to practice that encouraged the counsellor to imagine and feel the world of the client, despite the Rogerian approach encouraging empathy rather than sharing the experience.

Being aware and reflective about one's own 'loss background' was included in the bereavement counselling training, albeit in different measures. At CARIS, for example, counsellors would create their own 'grief map' of losses experienced in their own life. This was understood as part of the necessary personal development of the counsellors that would bring to awareness any 'unconscious' thoughts and feelings around grief and bereavement that might become problematic in the counselling encounter and prevent the counsellor from listening to the client. A background or experience of loss might be a key incentive to getting involved in bereavement counselling, but the personal experiences of the counsellor should not enter into the counsellor-client encounter.

Grief Recovery UK explicitly embraced the practitioner's personal experience of loss in the training of their 'grief recovery specialists'. In fact, personal experience was considered key to being able to train others. All trainee grief recovery specialists have to undertake the 'personal workshop' that had to be completed in order to receive their certification. Further, being able to speak about one's own experience is key to the method. As Ellen, senior member of Grief Recovery UK, described:

> We don't use a professional mask in grief recovery we don't make our faces blank, we show our human emotions and we share our personal stuff which is a complete no-no [in other methods]. (Ellen)

Ellen here was highlighting the difference between the GRM and counselling where personal disclosure is not standard practice; indeed disclosure from the counsellor goes against the counsellor/client contract. In the GRM the idea is that the 'leader goes first'. Speaking about one's loss history was thus used to reveal the 'authenticity' of the GRM in contrast to the 'masks' of counsellors. Yet arguably, the 'mask' of counsellors is a means to create important boundaries between counsellor and client. For example CARIS counsellor Wendy describes the importance of boundaries of the counselling setting:

> My view on it is the boundaries only became confused if the counsellor is confused about what counselling is. And you can be in a consulting room because someone else set the room up, you can appear to be a counsellor much more, but actually fundamentally if the boundaries are confused in the home setting then that's because the counsellor is confused (…) so there has to be an ownership on the counsellor's side about what boundaries matter and what one's don't. (Wendy)

However, as the GRM does not claim to be counselling, the parameters were quite different. The role of the specialist is to 'teach the steps' of the handbook. 'We're not messing about with your head, we're not analysing anything' declared Ellen. Subsequently, the potential specialists need not undertake formal training or an application process. Instead they were required to attend a four day workshop, and have 'an open mind and open heart'. Following the workshop, people were then 'licensed' as 'Grief Recovery Specialists' to either set up their own one-to-one or group sessions using the GRM. The GRM is also endorsed by the British Association for Counselling and Psychotherapy

(BACP) to be taken by trained counsellors and psychotherapists as part of their continuing professional development. This endorsement by the BACP might appear contradictory considering the GRM's opposing beliefs on counsellors sharing personal information with their clients.

Client suitability

It was not only the training and background of the practitioner but also the suitability of the client that was important before undertaking bereavement counselling. Clients were given different forms of assessment to judge their eligibility for counselling. At CARIS, Linda carried out the assessments on all potential clients and described the process:

> What is it I need to know about this person? (...) I need to make a sound assessment that takes into account risk factors, that takes into account history and how the history of that person would be indicator of how they manage grief now. (Linda)

Along with a list of questions around the bereavement, Linda's assessment sought to estimate the 'risk factors'. Risk factors included suicidal thoughts, self-harm or 'risky behaviour'. These forms of 'risky behaviour' were elucidated further in completing the CORE-10 (Clinical Outcomes and Re-Evaluation) screening measure that is commonly used in mental health care practice to screen for signs of depression and suicidal thoughts. Thus assessing eligibility was also about assessing potential risk. Cruse's Early Intervention Project (EIP), established in 2013, was a service designed specifically to target 'those most at risk of developing prolonged grief disorder'. It aimed to be a 'fast-track service' to avoid the long waiting lists Cruse sometimes has. To qualify for the service, the client had to be no more than six months bereaved. The EIP assessment sought to identify any risk factors that suggest someone might develop 'prolonged grief disorder'.

Many services warn against people accessing them too soon after bereavement. However, Grief Recovery UK took a different approach by helping people immediately after bereavement. In the GRM the only qualifying criteria was a 'broken heart'. Within the GRM 'fresh' grief was actually favoured for people who had not yet 'pushed down' the grief. The hesitancy around encouraging people into counselling too early is the general hesitancy in bereavement care to medicalise 'normal' grief. The GRM assumes that all grief needs some level of work and help and can find 'completion' through the method.

Overall, my data show a key criteria of eligibility for undertaking bereavement counselling beyond the risk factors was simply the client being 'ready to do the work'. The assessment procedures documented the observations of the counsellor and their judgment of the client's suitability, but the appropriateness of the intervention also depended on the client's apparent willingness 'to make the journey', as described by CARIS counsellor Claire. However, as Claire acknowledged, while working through grief may be like a journey, it's a journey that's 'not for everyone'. Embarking on counselling was a choice, but one bounded by a set of rules and the counselling method. This can be seen as part of the contract between counsellor and client where counselling also aims to 'give people the opportunity to make choices' (Wendy).

Normalising grief

> And it was almost when I gave her permission, to say look it's completely understandable and it's completely normal that you would be upset (…) It's completely normal to be feeling the way you're feeling (…) and so to be able to dispel that myth, to help to normalise feelings, because I think that's a big part of bereavement counselling: it's about normalisation. (Linda)

As Linda described, my data show that a significant part of bereavement counselling is about 'normalisation' and 'normalising feelings'. However, there was some ambiguity around how 'normal' and 'abnormal' were defined. Grief was described as individual and unique but then also a 'process' that was 'natural' and 'normal'. Normal and natural were often used interchangeably and when I explored with participants what was meant by 'normal', many of the practitioners had difficulty providing an easy answer. It was emphasised that normal could be quite broad. Describing the activity of 'normalising' grief was intended to make people experiencing grief feel better, rather than to state there is a 'normal way' to grieve.

As Daniela put it 'When I talk about normalising emotions it's more about being in a world where it's okay to feel like all you want to do is lie on the ground and stare at shoes'. But normal was also a measure aided by models of grief, or as Susan mentioned 'photocopies of all the emotions' that she would use so that clients could 'see them all written down' and learn that what they were feeling was normal 'it gives them something concrete'.

Normal emerged as something to be achieved, as something that has been lost in grief, yet at the same time the grief process itself was judged as normal or not. The use of the term 'normal grief' implied some form of movement forward, in contrast to those who got 'stuck'. Cruse bereavement support worker Susan used the 'growing around grief' model to measure clients' return to 'normality'. Susan drew me a diagram to demonstrate, drawing 'the grief' as a circle in the centre and then circles that would expand around the grief, as she described:

> So that's the grief but (…) a person's got a little bit, is in the normal world (…) so even though that's their grief, there's a bit of normality going on, restoration if you like round there. (Susan)

Grief could be categorised into types, whether 'straightforward' and 'run of the mill' or 'complicated' and 'risky'. Cruse's Early Intervention Project, for example, aimed to identify 'complicated grief' even before it developed into 'prolonged grief disorder'. Thus 'complicated' grievers were separated out from the 'run of the mill' grievers. Participants' inability to express clearly what was normal highlighted the conflict that, at times, appeared when emphasising both the individual and unique feelings of the grieving client and the belief in a 'natural process' of grief.

The importance of safety

The building of a 'safe space' emerged as an important component. A safe space was created in a number of ways, crucially by the building of the client-counsellor relationship, so central to the person-centred approach. In all approaches, confidentiality formed an important part of the contract. Showing one's expertise as counsellor also created safety. In the GRM this was ensured by the 'leader goes or support worker first' policy but for Cruse clients viewing the counsellor or support worker as professional and 'properly trained' formed safety. Creating a safe space enabled clients to 'offload' and release previously hidden or unconscious emotions. The role of the counsellor was to be someone who could sit with the seemingly unbearable nature of grief, as Wendy described:

> So the client is actually in a relationship at last that allows them to cry or not cry. Can stand it if you do cry, can stand it if you don't cry and doesn't have an agenda about it. And that subtle something transpersonal or unconscious that goes on between the client and the counsellor because it's not so much what's said it's just, sometimes you're with a person and you know it's just alright if I burst into tears. (Wendy)

For Wendy, safety was often a subtle, unspoken and unconscious agreement between the counsellor and client, formed by the strength of the relationship. Adhering to boundaries and the contract of the counselling encounter developed a strong, safe relationship. Within the safe space the unconscious could be slowly allowed to 'perk up to consciousness'. As Wendy explained, the unconscious was normally kept guarded, but the barrier could loosen its grip and a 'flood' of thoughts could appear, thoughts the client may not have realised they had. It was as though the space formed between the counsellor and client allowed the release of emotions that could not find release anywhere else. The safety of the space also provided important boundaries that could hold the emotions of grief, and find room to undertake the crucial working through of the emotions.

Working with emotions

> We are working with the emotions, grief is all about emotion. (Ellen)

As Ellen identified, grief was all about working with the emotions, and the participants drew on a variety of, sometimes conflicting, metaphors and images to describe the work of grief. Hochschild (1983) popularised the term 'emotional labour' to describe how waged labour was not only physical but required emotional work. In the bereavement counselling setting, the participants agreed that some level of working with the emotions was required on behalf of the client in order to work through one's grief. Grief was often described as a space to be worked through and moved out of 'You can't go round it, you can't go under it, you can't go over it, you have to go through it' (Ellen). But grief was also described as something that was 'inside' the person that needed to be 'externalised'. For example, this work was described as 'pulling', 'hoiking' and 'bringing up emotions'. Yet emotions and grief also had a life of their own and could be resistant to being managed. Emotions were viewed as 'fluid' and unable to be contained. Emotions could inhabit different bodies and be 'transferred' on to different people. Daniela described how in transferring feelings of grief, people may not recognise their feelings until another bereavement or loss:

> (…) say for example you had a mum and a dad, and the dad died and the mum and the dad had divorced and the kid was always, grew up with the mum and the mum would say oh that's a terrible person and then the dad dies. The kid's still not allowed to grieve for the dad because mum's still there and mum's still saying what a terrible person this was but when mom dies you lose your mom and then you also go, 'shit I lost my dad as well!' (Daniela)

For this reason, as trauma counsellor Tony described, emotions had to be 'worked through' and 'dealt with' otherwise they would 'catch up with you' and 'come back and bite you on the bum'. In these differing interpretations, grief was both something to be actively moved through but also something that moved the individual. Grief was something inside to get rid of or outside the person and in the way. The client was provided with different forms of agency in each interpretation, either as possessing the control to move out of grief or possessed by grief itself, unable to resist the emotional sway of grief. Emotions were not always visible to the person experiencing them, but they could be named and identified by the counsellor, in an activity Claire described as 'colouring in a picture together'. My data showed that what presented initially in the counselling encounter was not what was important, suggesting that the 'true' emotions could only come to light through the counselling process.

Conclusion

The purpose of this paper was to uncover whether there exists a common understanding of what constitutes

recovery from grief in bereavement care practice in England. This study found that the value of counselling work, and talking through emotions or following the steps in the Grief Recovery Handbook were considered effective means to relieving the pain and suffering of grief by the participants. However, what constituted recovery was not always made clear and overall the participants did not conceptualise the successful outcome of grief counselling as being 'recovery'. The practitioners explained their practice through reference to individual clients and emphasised that there was no universal way of knowing when the work of bereavement counselling was 'done'. Even for Ellen and the GRM, the notion of 'completion' was inevitably a temporary one that required continual work to maintain. Moreover, without including the perspective of the client, it is not possible to provide the full picture of what constitutes recovery.

Instead of supporting one particular model of grief, the participants in this study highlighted different components that play an important role in the counselling endeavour. I argue that these six components are used, to varying degrees, to facilitate the bereaved client through their grief. These components address the role of the bereavement counsellor or support worker and the methods they use, but also the suitability of the client and what happens in the counselling setting in terms of normalising grief, dealing with emotions and building feelings of safety. Rather than provide an empirical basis for 'grief work' the findings in this paper reveal some of the conflicts and ambiguities that exist in bereavement care practice.

In highlighting six components, the findings of this study demonstrate how the method and the role of the practitioner create the boundaries in the bereavement counselling setting where a safe space can be built to do the work of normalising grief and managing emotions. As this paper has shown there is room for ambiguity and differences in how these components are used. It is from this space that something that may or may not be described as recovery can emerge.

Investigating the role and meaning of the term 'recovery' has proven an illuminating lens within which to consider the goal of bereavement counselling practice, and revealed some divergent perspectives. The findings of this study are limited by the size and scope of the sample, yet the findings complement larger scale studies such as Stephen & Wimpenny, (2008) and provide an insight into some of the differences in local and national voluntary bereavement services, and the contrasting approach adopted by a non-profit organisation, working across England. Despite efforts to establish a 'Gold Standard' of bereavement care and promote co-ordination across local and national services, the findings of this study reveal unevenness in the delivery of bereavement support in England, and often conflicting approaches in how best to treat and manage grief and recovery. This unevenness also raises the question of who has the authority - if possessed by any one group or individuals - to co-ordinate the future direction of bereavement care practice.

The findings suggest that more work needs to be done in addressing this unevenness and developing a more consistent approach. It may be that a 'pick and choose' approach to accessing support is preferable for some bereaved people. Though a range of tools and approaches to dealing with grief can only be a welcome move away from a prescribed stage model of grief, there are potential risks in using interventions that are not evidence-based, not only in disregarding a wealth of research evidence and exacerbating the divide between research and practice, but to the integrity of bereavement counselling practice. ■

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