How helpful is counselling for people bereaved through a substance-related death?

Peter Cartwright*
BACP Registered and Accredited Counsellor with an interest in substance-related bereavements.
p.cartwright@talktalk.net

Abstract: *Background:* The research investigated how helpful counselling was for people who self-identify as being bereaved through a substance-related death. *Method:* Semi-structured interviews were conducted with twenty bereaved participants. Interview data underwent a thematic analysis using Iterative Categorisation (Neale, 2016). *Findings and conclusions:* Participants' needs were many, varied and changed over time. They used many types of support to meet these needs. Both one-to-one and group counselling were helpful and each was used to meet different needs. Significant needs regarding the substance-related characteristics of these bereavements were often not recognised by participants and seemingly also their counsellors, so were not worked through. Unhelpful experiences of counselling occurred through poor practice and a lack of specialist knowledge about these bereavements. *Recommendations:* Nine are given to improve the helpfulness of counselling for these bereaved people, including recognising and working with the substance-related characteristics of bereavements or referring clients to other services for these.

Keywords: Drugs, alcohol, bereavement, counselling, support, helpfulness.

Introduction

Little research has been conducted with people bereaved through an alcohol or drug-related death (hereafter substance-related death), despite these typically being severe, complex and disenfranchised bereavements (Valentine, 2018).[1] One finding from the largest known research study into these bereavements, conducted in the United Kingdom, was that people were more likely to experience help from professionals and other workers as a negative rather than a positive intervention that could adversely affect their grieving process and prevent them seeking support (Valentine, 2018). The findings from that research informed the first good practice guidelines for all those whose work brings them into contact with those bereaved by substance use, although these guidelines do not specialise in counselling (Cartwright, 2015).

This research has therefore investigated an area not specifically addressed before: 'How helpful is counselling for people bereaved through a substance-related death?' The objectives were to:

- Gather demographic information to ensure the research broadly represents the diversity of people bereaved this way in the UK.
- Establish whether counselling helped with grieving and if/when it did, how it actually helped.
- Subjectively score how helpful counselling was for grieving.
- Establish what, if anything, did not work or could have been better.
- Establish what may have been needed or wanted and was not received.
- Record anything else participants considered important.

The terms 'counsellor' and 'counselling' have been used for convenience to refer to all types of emotional and

* This is independent research and not affiliated to an organisation.
1 Disenfranchised bereavement is a loss that is not socially sanctioned, openly acknowledged or publicly mourned.

© 2019 Cruse Bereavement Care DOI: 10.1080/02682621.2019.1587869

psychological support, and most was actually provided by counsellors.

Method

Data collection

Participants were recruited through third parties including the team who conducted the UK study mentioned above, and organisations supporting bereaved people, black and minority ethnic (BAME) people, and those who identify as GSRD.[2] Posters, e-mail, phone and social media were used to reach people who self-selected as being bereaved through a substance-related death, who then voluntarily contacted the author directly.

Data was gathered through semi-structured interviews by telephone or Skype, using six open questions based on the six research objectives. Also, participants gave a subjective score, between one (very poor) and ten (excellent), for each type of counselling they received. A comprehensive written record was made during these interviews, including extensive verbatim quotes. Some participants e-mailed further information that was added to their record with their consent. Post interview support was offered by the author at the end of the interview and again the following day, and for one participant offered again after several months. This support was a phone session where a participant could share their thoughts and feelings, plus assistance with referral to others for further support if needed (this was not needed in the end). This support followed the same ethical guidance used for the research. No new data was gathered through this support.

Ethics

The research followed the British Association for Counselling and Psychotherapy guidelines for research (Bond, 2004), and data collected and stored according to General Data Protection Regulation (Council Regulation, 2016) requirements, such as the use of codes to anonymise interview records, secure data storage and all data being destroyed at publication. All participants received an information sheet about the research and what was involved in participating, and gave informed consent.

Analysis

The data was analysed using a thematic analysis, as this method enabled repeated themes and patterns to be identified, analysed and recorded, in order to answer the research question. The technique of Iterative Categorisation (Neale 2016) was used, because it is simple, rigorous and transparent. Every interview record was typed into a document, where each line was an individual piece of data. The first iteration involved comprehensively reading all records and identifying initial codes for the data. This approach ensured that participants' actual reality was described and recorded, rather than being interpreted. Next, every line of data was coded, for all records, with some data given more than one code as necessary. This included the subjective scores for counselling which were coded by type of counselling and recorded in a table for easier comparison. During this process changes were made to the codes to clarify them and provide more detail, so they accurately reflected the content of the entire data set. These changes were recorded on all records to ensure consistency. Each piece of coded data was given the participant's unique number to ensure an audit trail to its source. Next all the data were re-organised by each code.

The second iteration was a line-by-line descriptive analysis of each code retaining illustrative quotations and participants' unique numbers. The third iteration identified themes within codes and between similar codes, along with initial interpretations of the analysed data. Therefore every piece of data was used, organised together and traceable to the original interview. Themes were identified phenomenologically from the data *and then* their meaning was interpreted to ensure the analysis truly reflected participants' experiences of counselling. The final iteration cross-referenced the analysed codes to find explanations for existing themes and to identify new themes, still noting the participants' unique numbers. Particular attention was given to associations between the helpfulness or unhelpfulness of counselling and the different characteristics of people, and the type, duration and specialisation of their counselling. Additional analysis was then undertaken following peer review, covering the substance-related aspects of the data and the duration of participants' counselling.

Participants

Twenty people were interviewed. They self-defined their characteristics (Table 1), and the characteristics of the deceased (Table 2).

Findings

Support scores

Participants used a range of types of counselling. Table 3 lists these, briefly describing each service, and gives participants' scores for them. Scores are presented by the duration of counselling for short, medium and long-term work. Everyone accessed at least one form of one-to-one counselling and over half also accessed group counselling.

2 GSRD refers to Gender, Sexuality and Relationship Diversity. This acronym is used because it better reflects the diverse, non-binary and inter-related nature of these aspects of people than Lesbian, Gay, Bisexual and Transgender (LGBT) (Barker, 2017).

© 2019 Cruse Bereavement Care

Table 1: Participants	
Gender	16 women 4 men
Age	29 to 71, average 53
Relationship to deceased	7 mothers of sons 2 fathers of sons 2 women of different gender partners 1 man of a same gender partner 2 sisters of brothers 1 half-sister of brother 1 brother-in-law of brother 1 sister-in-law of brother 2 daughters of mothers 1 daughter and different gender partner
Race / Culture	14 white 6 BAME, including 3 dual heritage 1 American by birth 1 lived abroad
Social class	10 gave a social class, all as middle class
Religion	4 Christian 2 Muslim 1 Hindu 1 omnist 1 no particular religious affiliation
Other information	3 worked as counsellors 2 had mobility difficulties 1 gay 1 bisexual 1 illegal drug user
Knowledge of problematic substance use before death	16 knew 1 knew but not appreciated the seriousness until the death 3 did not know
Time between death and interview	9 months and 15 ½ years, average 5.4 years

Table 2: Participants' relatives who died	
Gender	2 women 18 men
Age	22 to 64, average 38
Cause of death	7 overdose 6 long-term health difficulties related to substance use 3 suicide associated with addictive substance use 2 murder for non-payment of drug debts 1 life support switched off following road traffic accident resulting from alcohol use 1 recorded as 'misadventure' because body badly decomposed, although it was surrounded by drug-using paraphernalia
Substances used	About two thirds regularly used more than one substance and most more than three, in order of prevalence: heroin; alcohol; cocaine; crystal methamphetamine; ketamine; crack cocaine; Ambien; amphetamines; barbiturates; gamma hydroxybutyrate; mephedrone; and methadone. The other third used a single substance, mostly alcohol or heroin.
Other information	2 men were gay

One-to-one counselling

Those offering specialist help scored highly, for example, DrugFAM with substance-related bereavements and The Compassionate Friends with the death of a child. Scores for other types were more variable, particularly bereavement counselling services. Those participants who were also counsellors tended to score their poor experiences lower than other participants (although they scored their other experiences highly), because they better understood what counselling could provide.

Group counselling

This was generally scored higher than one-to-one counselling. Participants used single events for bereaved parents, for example, weekends by The Compassionate Friends, or long-term participation in specialist groups, for example, Bereaved Through Addiction.

What helped and what did not?

Referral and accessing counselling

Participants valued good information about counselling from those who referred them and being able to start when needed, which was usually a few months after the death. Those who had experienced an unexpected death valued receiving help with contacting sources of counselling and valued starting when they needed to more than those participants who had anticipated the death. Other participants had poor experiences, such as not being given referral information, and one half-sister of a brother said:

> *'My GP freaked out…said take this and call Cruse'* but she was too bereft to call.

Waiting too long to start counselling most often occurred with bereavement counselling services.

One-to-one counselling

Participants received counselling through either a bereavement counselling service or private/workplace counselling, with only two people using both. Counselling helped participants with general aspects of grieving: making sense of grieving; practical ways to cope with grief; talking about the loss; expressing emotions; and

© 2019 Cruse Bereavement Care

Table 3: Scores by type and duration of counselling

Type of counselling	Scores for up to 5 sessions	Scores for 6 to 12 sessions	Scores for more than 12 sessions	Mean score	Number of participants
One-to-one					
DrugFAM phone support[a]	10		9, 10	9.7	3
Bereavement counselling service	1, 2-3, 6-7	3, 4-5, 6, 8	9.5, 10	5.7	9
General counselling provided by employer	7-8, 8	6, 9-10	8	7.8	5
Private counselling	2, 5	2, 5, 9, 10	5, 7, 9, 9.5, 10, 10, 10	7.2	7
Psychic counsellor[b]	8			8	1
The Compassionate Friends bereaved parents network peer phone support[c]			10	10	1
Child Death Helpline[d]	10			10	1
Police Liaison service[e]			9	9	1
Averages for one-to-one by duration	*6.1 (7.9*)*	*6.3 (7.3*)*	*9*		
Group					
Bereaved Through Addiction[f]			8, 10	9	2
Bereavement counselling service	2			2	1
Bereaved Parents Network one-day event[g]	10			10	1
The Compassionate Friends Meetings			7, 10	8.5	2
The Compassionate Friends weekend event	7, 9, 10			8.7	3
Al-Anon meetings[h]			10	10	1
General therapy group			10	10	1
Support after Murder and Manslaughter website forum[i]	6			6	1

Scores: One (very poor) to ten (excellent)
* Average when scores removed for participants who prematurely disengaged, see Discussion.
[a] Voluntary sector organisations providing support to people bereaved through a substance-related death.
[b] Described on practitioner's website as: tracing current problems to their source, to understand associated lessons and identify actions needed to move forward.
[c] Voluntary sector organisations supporting parents bereaved by any death.
[d] Voluntary sector organisations supporting parents bereaved by any death.
[e] Role includes facilitating care and support for relatives of people who were murdered.
[f] Voluntary sector organisations providing support to people bereaved through a substance-related death.
[g] Voluntary sector organisations supporting parents bereaved by any death.
[h] Peer led groups supporting people affected by someone else's alcohol use, using the 12-step model.
[i] Voluntary sector organisation supporting people bereaved through murder or manslaughter.

having their grief validated (that was more likely for BAME participants):

> *'Made it more real and less like I'd imagined it'* (daughter of mother).

How participants experienced their counsellor was important, especially for women: forming a good first impression; competent; having ethical boundaries; a good therapeutic alliance; and non-judgemental (more common for those who had experienced a drug, as opposed to alcohol, related death). In addition, women participants valued counselling being separate from the rest of their lives, where they did not worry about their emotional impact on others. Participating men often spoke more about a practical focus to their counselling.

Unhelpful experiences concerned a lack of knowledge or experience about working with bereavement, substance use and addiction, and substance-related bereavements. Problems with the therapeutic frame (Gray, 1994) were important for some women participants, such as a workplace counsellor having a second role in the woman's work life, and endings, breaks and cancellations handled in a distressing way.[3]

3 Therapeutic frame is 'how the work will be conducted' (p. 6) and covers setting, times and duration, cancellations, breaks, fee, confidentiality, etc.

© 2019 Cruse Bereavement Care

Some participants disengaged from counselling, which occurred mainly with bereavement counselling services, but this was also highlighted by some who had private counselling. This often happened for a combination of reasons: practical difficulties, such as the location or timing, and poor practice, including perceived stigma, a lack of empathy or warmth, not explaining how to use counselling, and for one mother:

> *'I needed to go into my depression and anger about the paedophile who'd abused my son* [and was the cause of his drug use] *but she avoided difficult stuff.'*

Whilst no participant reported explicit stigmatisation from their counsellor, some experienced them as incongruent or sensed judgement:

> *'I felt subtly judged, nothing was said, just that he didn't approve and was shocked'* (man who used drugs with his male partner who died).

Group counselling

Participants valued being with others who had similar experiences and the bond they felt. This helped grieving through mutual support, sharing difficulties and 'normalising' experiences:

> *'Meeting other bereaved parents was critical, they know how you feel'* (father of son).

Unhelpful experiences included: stigmatising comments from other group members; feeling inhibited as the only partner in a group of parents; joining too soon to be able to cope with hearing others' experiences; and for one mother:

> *'I should be further on as newer people are less emotional'* (mother of son)

Participants from BAME groups were less likely to use groups.

Duration and changing needs

Some participants did not remember exactly how many sessions of counselling they had received. Duration varied from single sessions or weekend events; most participants received six to twelve sessions of time-limited counselling and were about equally divided in terms of whether they thought that was enough or not. Some participants had received extended counselling over many months or even years. Mothers were slightly more likely to have extended counselling. Participants' need for counselling changed over time, but counselling did not need to be continuous.

Counselling and the substance-related characteristics of bereavement

Participants spoke at length about their diverse substance-related experiences of before the death, the actual death and their experiences of bereavement. A few participants had counselling for these experiences which that they found very helpful. However, for most these experiences were not worked with, their associated needs went unmet, and participants often highlighted their counsellor's lack of this specialist knowledge.

There were five substance-related characteristics that potentially affected participants' bereavement. These were usually interconnected, creating a complexity to the whole bereavement, e.g. being poorly informed about addiction could result in more unresolved difficulties from the past, make the death harder to understand; addictive use increased the risk of stigma, and there was more to cope with during bereavement. Also these characteristics were influenced by and varied between participants' individual differences, for example, with parents tending to feel more guilt, and participants from BAME groups reported more stigma outside of counselling.

1. Substance use

Participants were often poorly informed or confused about their relative's substance use, especially if addictive, and of any co-occurring mental-health difficulties. Typically, participants did not see this as a need and it had not been worked with in counselling. The few who already understood it, perhaps through their work, had significantly less confusion.

> '[Substance use] *is not something I have spoken about or explored, but… want to understand what he went through'* (mother of son).

2. Unresolved difficulties from the past

Most participants had difficulties from their relationship with the deceased that arose through substance-using behaviour, for example, domestic abuse. These difficulties had often impacted participants' physical and mental health, which could be compounded by a lack of support:

> *'I had a breakdown before the death'* (woman partner)

When worked with, counselling helped, such as making sense of what had happened before the death:

> *'First time I'd spoken about what happened before the death, its impact and feelings'* (daughter of mother).

© 2019 Cruse Bereavement Care

Commonly associated with these difficulties was guilt: believing they caused substance use; failing to stop it; assisted using, such as buying alcohol; guilt for their own substance use; and feeling guilty despite believing they did not need to. These experiences were reported most by parents and by those whose relative had used drugs as opposed to alcohol. Participants' guilt often came with unrealistic expectations about what seemed to be beyond their control. However, those who understood substance use and addiction, such as through their work, were much less likely to feel guilty. Counselling helped a few:

> '*See the bigger patterns than me, see the wood for the trees* [that helped to reduce guilt]' (father of son).

Although for most their guilt was not worked with and remained unresolved:

> '*Guilt is a feeling that I had and still have in a big way. It really doesn't matter how much someone tells me that it wasn't my fault, I still feel bad about so many things*' (mother of son).

Anger and blame were also common themes: for substance use and associated behaviour, and for the perceived failings of treatment agencies. Counselling was valued as somewhere to express anger.

> '*He had a different worker every time he had treatment and they were naïve about his lying*' (sister of brother).

For participants who were adult children a further unresolved difficulty was the impact of parental substance use on their childhood and personal development.

> '*As a child I tried to make her better and I failed*' (daughter of mother).

3. The actual death

Participants' relatives often died in distressing circumstances, which were sometimes unexplained. Deaths could evoke blame, guilt and/or confusion, particularly if participants felt responsible or if the death was unexpected, for example, from overdose, suicide or road-traffic accident.

> '*Is it me?*' (sister of brother-in-law, questioning herself about the cause of his death through suicide).

Counselling helped by making sense of the death, particularly if unexpected or if substance-use had not been seen as problematic before the death, when counselling was scored higher. For others needs were unmet:

> '*She* [the counsellor] *missed the trauma*' (mother of son).

4. Stigma, disenfranchised bereavement and a lack of support

Participants spoke of being stigmatised outside counselling, which was experienced more by those from BAME groups, and by those whose relative had used drugs as opposed to alcohol. This evoked anger, shame or uncertainty about how to respond. Group counselling could reduce stigma through 'normalising' participants' experiences. However, stigma was rarely worked with directly in counselling and it helped when it was:

> '[Substance use] *defined me and my life was ruined, but it doesn't define me now*' (woman child and partner).

Family, friends, colleagues and work managers could be experienced by participants as supportive, unsupportive, or both. At best others were of great support, valued most by women participants. Workplaces, particularly managers, were the most likely to be unsupportive, especially for those bereaved through a drug as opposed to alcohol-related death.

> '*My colleagues* [doctors and nurses] *were less than helpful and lacked empathy, that was surprising*' (mother of son).

5. Coping with specific difficulties

Participants spoke about the strain of coping with unexpectedly severe and prolonged grief (that could have begun before the death when it was anticipated), returning to work, official procedures like an inquest, and so on. For most, their counselling did not provide the practical help they needed to cope, although some did:

> '[Counsellor] *suggested helpful things… helped me quite a lot with coping with the demands of bereavement*' (mother of son).

Another mother was supported at her son's inquest by a bereaved mother from her counselling group.

Self-support

Most participants spoke about self-support, e.g. managing when to grieve, finding their way to live with the loss and the effective expression of grief emotions:

> '[Crying] *like being violently sick… that lasted for days… it was a massive release… I chose to stay with it, it's a natural process*' (father of son).

© 2019 Cruse Bereavement Care

They also spoke about their general ways of coping that they used during bereavement, including self-acceptance and compassion, positive reframing and spiritual practice. However, some spoke of things that could be interpreted as potentially unsupportive, e.g. critical self-talk, suppressing emotions and internet searches:

> *'Don't Google it, as it freaked me out!'* (half-sister of brother).

Discussion

The findings suggest that several experiences shaped how helpful counselling was for grieving a substance-related death. However, the number of participants using most of the types of counselling was too small to draw meaningful conclusions between types. Meaningful conclusions can be made by comparing one-to-one and group counselling, and for some other conclusions where the data support it, as discussed below.

How helpful was counselling for people bereaved through a substance-related death?

One-to-one counselling

Counselling often helped with general aspects of grieving as described above. This was also found by Simonsen and Cooper (2015) who studied the helpful aspects of counselling following all kinds of death. Also, it sometimes helped with grieving the substance-related characteristics of these deaths, but not always (see below).

When the scores are removed for participants who disengaged prematurely because of poor experiences, the average scores imply counselling helped even in short-term work, although participants often still had substance-related bereavement needs they were not aware of, as discussed below. Long-term counselling had the highest scores, as did organisations specialising in substance-related bereavements or the death of a child, because more of participants' needs were met. Bereavement services had the most variable scores, with the most poor scores and some of the highest; this variability in experience was found by Ford, McKell, Templeton, & Valentine (2018) and discussed by Adfam (2011) which attributed this to the lack of specialist knowledge about these bereavements.

One-to-one counselling of any type that scored poorly happened because of: counsellors' perceived lack of empathy; lack of specialist knowledge, that Templeton, Valentine, McKell, Ford, Velleman, Walter, Hay, Bauld, & Hollywood (2016) found to be likely in any service these bereaved people encounter; probably an associated lack of information about how to work with these bereavements, as discussed by Adfam (2011); and possibly the plurality of methods used by bereavement counsellors (Munday, 2013). Also, lower scores came from, but were not exclusive to, participants who were gay, from BAME groups, had lost a partner, or lost someone to drug as opposed to alcohol use. These occurred when participants experienced stigma, poor practice, or a lack of specialist knowledge or empathy, for example, not understanding why someone chose to stay with a partner who was addicted to drugs. Practical difficulties accessing counselling are inevitable, like needing to wait, as is the offer of time-limited counselling, particularly for bereavement services with limited resources and high demand. However, often this was not mitigated by referring participants to other help.

Group counselling

The group counselling used by participants was more specialised in a particular aspect of bereavement than was one-to-one, although there were too few of each type to make meaningful comparisons between them. Group experiences scored higher than one-to-one counselling. This was reported as due to the bonding, sharing and 'normalising' effects of being with others experiencing a disenfranchised bereavement (needs that one-to-one counselling could not meet), and expectations that were specific and straightforward to meet. The helpfulness of group support was also found by Adfam (2011) and Ford et al (2018). However, such group experiences can produce a 'them and us' perspective setting those bereaved by substance-related deaths apart from those bereaved in other ways and this may hinder re-integration into society (Parkes & Prigerson, 2010; Vlasto, 2010). Participants' unhelpful group experiences were to some extent inevitable in group work, but some imply poor group facilitation.

Other conclusions

Many participants used one-to-one and group counselling. This need for multiple support reflected the diversity, severity, complexity and long-term reality of these bereavements, as well as how participants' needs changed over time, and for many a lack of local specialist counselling for substance-related bereavements that could meet all their needs rather than these types duplicating help – a tendency also identified by Vlasto (2010) for all bereavements.

Participants disengaged from counselling if they experienced potential stigma. Drug use was more stigmatised than alcohol use, as also found by Walter & Ford (2018). For others their experiences may have been a projection onto the counsellor.[4] However, as projection is a co-created phenomenon, a client's projection needs

4 Projection refers to a disowned part of the self that is projected, out of awareness, onto another person so they are experienced as being that disowned part (Joyce & Sills, 2014).

© 2019 Cruse Bereavement Care

a 'hook' on the counsellor to land on. Ford et al (2018) reported how people bereaved through substance-use could feel stigmatised by their counsellor, and Walter, Ford, Templeton, Valentine, & Velleman (2017) found they could potentially experience stigma from any service. Additionally, these bereaved people can experience a lack of compassion and support from any service they encounter (Ford et al, 2018).

Many participants had lived with the stress and strain of substance-using behaviour; research has confirmed this type of experience (Orford, Velleman, Natera, Templeton, & Copello, 2013). Templeton and Velleman (2018) suggested that this can continue after the death, such as bereaved people experiencing ongoing stigma and lack of support, as described by participants in this research. In addition, participants' needs associated with the substance-related characteristics of bereavement were often not met because their counselling lacked specialisation in this area. When these needs were addressed it tended to be via long-term work, by services specialising in these bereavements, and/or through peer-support.

Unmet needs

In addition to these reported unmet needs, participants often spoke during the interviews about difficult substance-related experiences that sounded like other unmet needs – which they agreed with when this was raised with them. These unmet needs typically arose from the same five, interconnected, substance-related characteristics described above, characteristics very similar to those described by Ross (1996) and Valentine (2018). Having unmet needs occurred across all types of counselling, including those that scored highly. However, participants who were also counsellors had fewer unmet needs as they were better informed about counselling. Other participants did not recognise their experiences as being needs that counselling could help with, for example, feeling guilty might be a need to work on guilt in counselling sessions. Many counsellors did not help with these needs, nor refer participants on to those who could. Participants were unable to say why this occurred, although they spoke about counsellors lacking specialist knowledge. Also, most participants did not have the longer-term counselling that some other participants felt was required to meet these needs.

Potential further help

Therefore, there seems to be much potential for further help with the five substance-related characteristics/needs associated with these bereavements. As these are interconnected they probably need addressing together. For example, understanding addiction potentially leads to a better understanding of the death with less guilt about not being able to have stopped someone's substance use. This supports the bereaved in being able to challenge some assumptions behind stigma and thereby leads to better coping.

However, some substance-related themes went beyond what was possible in bereavement counselling services, for example, psychotherapy for a participant's early development that was impacted by parental substance use.

Difference and diversity

Much attention was given to finding a diversity of participants, with limited success, so again it is difficult to draw firm detailed conclusions.

Women participants spoke a lot about the characteristics of their counsellor and the nature of this relationship. This might be in part because women tend to cope more through sharing and expressing emotions (Parkes, 2009), and often have more distress than men in the first year of bereavement (Parkes & Prigerson, 2010). Therefore, possibly they gave more value to having an emotional connection and feeling secure with the person helping them. Many women did not get help with their practical needs, so may have benefited from gender opposite problem-focused help (Schut, Stroebe, van den Bout, & de Keijser, 1997). Women valued counselling being separate from the rest of their lives, where they did not worry about their emotional impact on others. Men's counselling tended to be more practical and they hardly spoke about the relational aspects of counselling. It is possible they approached counselling as a task, possibly reflecting how men sometimes tend to grieve (Parkes, 2009).

Participants' relationship to their relative who died affected their bereavement, such as parents being more likely to report guilt; these differences between relationships were also found by Templeton, McKell, Velleman, & Hay (2018) for substance-related bereavements and are typically found in all bereavements (Parkes & Prigerson, 2010). Some mothers needed counselling for longer than other participants, this may reflect how 'the loss seems to create a permanent vacuum in their lives' (Cleiren, 1993, p. 253).

Participants from BAME groups used face-to-face groups less than others; they spoke more of substance-related stigma outside of counselling, and all valued having their experiences validated in counselling. GSRD participants were the most difficult to recruit for this research. The one gay man who participated spoke of stigma from his counsellor, family and workplace. Understanding is emerging of the interconnected nature of factors such as gender, race, class, sexuality and how they create overlapping and interdependent systems of

© 2019 Cruse Bereavement Care

discrimination or disadvantage (Collins & Bilge, 2016). This may explain 'minority' people's reluctance to engage in counselling and research from those they identify as part of 'majority' groups.

Social and self-support

These additional sources of support were helpful, if they were available, a finding confirmed by Ford et al (2018). It helped when counsellors facilitated developing these and encouraged participants to use them.

Limitations of this research

This research has several significant findings and conclusions, as already described. However, it has its limitations too: The number of participants was small, particularly for sub-groups of participants using some types of counselling. The exact duration of counselling was estimated for a few participants. This research lacks insight into *how* counsellors gave participants the experiences they reported, because the aim was to study how helpful counselling was for participants and too few of them knew the therapeutic modality of their counsellor(s) to draw meaningful conclusions about how counsellors helped.

Recommendations for counsellors and services

1. Be informed about these bereavements. See Valentine (2018), useful articles in *Bereavement Care* (Ross, 1996; Lawton, Gilbert & Turnbull, 2016), the DrugFAM booklet (2013) and online generic guidance (Cartwright, 2015).
2. Refer clients to other services, including local, national and internet; suggest they consider what could help now and what could be useful for the future; and offer to help them take up referrals.
3. Consider allowing access to counselling when needed (not a set time after the death) and provide it for longer (that does not have to be continual).
4. Consider counselling practice, both one-to-one and groups, particularly regarding stigma and the therapeutic frame.
5. Services consider having a counsellor who specialises in substance-related bereavements.
6. Recognise the needs in the five, interconnected, substance-related characteristics that potentially affect these bereavements, and offer to work with them:
   - Make sense of substance use, especially addictive use.
   - Work through unresolved difficulties from the past, including any guilt and anger.
   - Work through difficulties associated with the death, including any blame, guilt, confusion and trauma.
   - Build social and self-support to cope with stigma and other specific difficulties.
7. Consider both the understanding of, and how to work with, difference and diversity:
   - Disenfranchised bereavements and associated shame.
   - How different relationships to the person who died affect the nature of bereavement.
   - Recognise both 'GSRD' and 'BAME' as umbrella terms for many different 'minority' groups, which may have different needs, not least in bereavement.
   - Consider how to counsel these 'minority' groups if from the 'majority' group.
8. Group counsellors consider client's readiness to join a group, and how to manage stigma and comparing between group members.
9. Supervisors consider how best to supervise counsellors working with these clients.

Conclusion and further research

This small study confirms some of the findings made by others about these under-researched bereaved people, draws new conclusions about the helpfulness of counselling for them and makes recommendations to improve their counselling. Further research could test these conclusions with a greater number and diversity of participants and could better study the impact of duration of counselling on helpfulness. Also, it could study exactly how counsellors can help with the substance-related themes of these bereavements. ■

Acknowledgements

I wish to thank the people I interviewed, who gave so generously. I also thank those who helped me to find these people. I am very grateful to Lorna Templeton who informed, guided and encouraged me, and to Carol Siederer and Carmen Joanne Ablack for their help.

Disclosure statement

I have no disclosures to make in association with this research article.

Adfam (2011). Learning from loss: Drug related bereavement. *Families Up Front* Issue 3, 6–7. Available from: https://www.adfam.org.uk/cms/fuf/doc/Adfam_Families_UpFront_Issue_3.pdf [accessed 17 February 2018].

Barker, M-J. (2017). *BACP good practice across the counselling professions 001: Gender, sexual, and relationship diversity (GSRD)*. Lutterworth, Leicestershire: British Association for Counselling and Psychotherapy.

Bond, T. (2004). *Ethical guidelines for researching counselling and psychotherapy*. Rugby, England: British Association for Counselling and Psychotherapy.

Cleiren, M. (1993). *Bereavement and adaptation: A comparative study of the aftermath of death*. Washington, DC: Hemisphere.

© 2019 Cruse Bereavement Care

Cartwright, P. (2015). *Bereaved through substance use: Guidelines for those whose work brings them into contact with adults after a drug or alcohol-related death* [online]. Bath: University of Bath. Available from: http://www.bath.ac.uk/cdas/documents/bereaved-through-substance-use.pdf [accessed 23 October 2017].

Collins, P. H., & Bilge, S. (2016). *Intersectionality*. Cambridge: Polity Press.

Council Regulation (EC) No. (EU) 2016/679 of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, and repealing Directive 95/46/EC (General Data Protection Regulation). Available from: https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32016R0679 [accessed 10 November 2018].

DrugFAM (2013). *Bereaved by addiction: A booklet for anyone bereaved through drug or alcohol use*. High Wycombe, England: DrugFAM [only available directly from DrugFAM].

Ford, A., McKell, J., Templeton, L., & Valentine, C. (2018). The impact of a substance-related death. In: Valentine, C. (ed). *Families bereaved by alcohol or drugs: Research on experiences, coping and support*. London and New York: Routledge, 43–66.

Gray, A. (1994). *An introduction to the therapeutic frame*. London: Routledge.

Joyce, P., & Sills, C. (2014). *Skills in Gestalt counselling and psychotherapy* (3rd ed.). London: Sage.

Lawton, H., Gilbert, J., & Turnbull, F. (2016). Bereavement through drugs and alcohol. *Bereavement Care*, 35(2) 48–51.

Munday, H. (2013). Making use of the vignette technique to examine methods of bereavement counselling: An exploratory study. *Counselling & Psychotherapy Research*, 13(2) 151–158.

Neale, J. (2016). Iterative categorization (IC): A systematic technique for analysing qualitative data. *Addiction* 111 1096–1106.

Orford, J., Velleman, R., Natera, G., Templeton, L., & Copello, A. (2013). Addiction in the family is a major but neglected contributor to the global burden of adult ill-health. *Social Science & Medicine* 78 70–77.

Parkes, C. M. (2009). *Love and Loss: The roots of grief and its complications*. Hove, East Sussex: Routledge.

Parkes, C. M., & Prigerson, H. G. (2010). *Bereavement: Studies of grief in adult life* (4th ed.). London: Penguin.

Ross, E. (1996). Alcohol and bereavement. *Bereavement Care* 15(1) 5–7.

Schut, H., Stroebe, M. S., van den Bout, J., & de Keijser, J. (1997). Intervention for the bereaved: Gender differences in the efficacy of grief counselling. *British Journal of Clinical Psychology* 36 63–72.

Simonsen, G., & Cooper, M. (2015). Helpful aspects of bereavement counselling: An interpretative phenomenological analysis. *Counselling & Psychotherapy Research* 15(2) 119–127.

Templeton, L., Valentine, C., McKell, J., Ford, A., Velleman, R., Walter, T., Hay, G., Bauld, L., & Hollywood, J. (2016). Bereavement through substance use: Findings from an interview study with adults in England and Scotland. *Addiction Research & Theory* 24(5) 341–345. Available from: http://dx.doi.org/10.3109/16066359.2016.1153632 [accessed 14 March 2016].

Templeton, L., & Velleman, R. (2018). Families living with and bereaved by substance use. In: Valentine, C. (ed.) (2018). *Families bereaved by alcohol or drugs: Research on experiences, coping and support*. London and New York: Routledge, 17–42.

Templeton, L., McKell, J., Velleman, R., & Hay, G. (2018). The diversity of bereavement through substance use. In: Valentine, C. (ed). *Families bereaved by alcohol or drugs: Research on experiences, coping and support*. London and New York: Routledge, 112–140.

Valentine, C. (ed.) (2018). *Families bereaved by alcohol or drugs: Research on experiences, coping and support*. London and New York: Routledge.

Vlasto, C. (2010). Therapists' views of the relative benefits and pitfalls of group work and one-to-one counselling for bereavement. *Counselling & Psychotherapy Research* 10(1) 60–66.

Walter, T., Ford, A., Templeton, L., Valentine, C., & Velleman, R. (2017). Compassion or stigma? How adults bereaved by alcohol or drugs experience services. *Health and Social Care in the Community* 25(6) 1714–1721. Available from: http://onlinelibrary.wiley.com/doi/10.1111/hsc.12273/abstract [accessed 2 October 2017].

Walter, T., & Ford, A. (2018). Managing stigma. In: Valentine, C. (ed.). *Families bereaved by alcohol or drugs: Research on experiences, coping and support*. London and New York: Routledge, 67–89.

© 2019 Cruse Bereavement Care