Identifying levels of vulnerability in grief using the Adult Attitude to Grief scale: from theory to practice

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Abstract: A key challenge for service providers and practitioners in the field of bereavement is to match clients' varied needs with equally diverse approaches to care. In order to provide these appropriate and effective interventions, it is crucial to have a reliable means of assessing levels of vulnerability in bereaved clients. The Range of Response to Loss model (RRL) and Adult Attitude to Grief scale (AAG) have evolved as practice tools able to profile the variable nature of client grief by identifying the initially instinctive reactions to loss alongside more aware coping responses. This paper describes the theoretical concepts which underpin the AAG, and recent research which confirms the factor structure of the scale and its capacity to identify varied levels of vulnerability. The application of the AAG to practice as an assessment/outcome tool and guide to intervention are set out and future developments such as potential inclusion in the CORE IMS discussed.

Keywords: Range of Response to Loss, Adult Attitude to Grief scale, vulnerability, resilience, outcome measures

Introduction

Central to both the theoretical and practical perspectives which shape care for bereaved people is the search for clarity about the nature of normal grief and the characteristics of complex grief. The attempt to reconcile tensions between these is often problematic, as seen in the discussion about the way in which grief and its complex variations have been defined in the DSM-5 (Parkes 2014). Alongside the 'theories debate' has been the growth in counselling as an increasingly established form of non-medical intervention, which has impinged significantly on less formal forms of bereavement care and the services which provide it. The question raised for both theory and practice is: how can we determine the needs of individual

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bereaved people and respond to them with an appropriate level of intervention?

This paper describes the development of a *model* and a *measure* that:

- enable vulnerability to be identified and categorised (from severe to low)
- contribute to a tailored approach to intervention, determined by the clear establishment of individual need.

In part 1, foundational theoretical perspectives, alongside an account of the concepts which characterise the Range of Response to Loss model (RRL) and the associated Adult Attitude to Grief scale (AAG), are considered. In part 2, a summary of our research identifying vulnerability using the AAG, is outlined, and the clinical evidence of the nature of severe and high levels of vulnerability set out. Part 3 provides a rationale for varied levels of intervention consistent with the diverse level of client need.

1. Theoretical perspectives

Before exploring the Range of Response to Loss (RRL) model as a framework for practice, it is important to look at the perspectives that have shaped the changing theoretical landscape of grief, and contributed to the concepts which have influenced practitioners in the field of bereavement care. The early grief theorists, in identifying the characteristics of disordered mourning (Bowlby 1980; Kübler-Ross 1970), created perceptions about the nature of grief which prompted the care professions towards a primary focus on the pathological variants of grief. However, the pathological bias has been challenged by the field of positive psychology (Seligman 1998; Joseph & Linley 2006) and the insights derived from studies of resilience (Bonanno 2004). This has contributed to the now widespread belief that only 10-20% of people are likely to suffer from 'complicated grief', generally understood as those who experience such features as difficulty in functioning in work and social relationships, a sense of meaninglessness, prolonged yearning for the deceased, and disruption in personal beliefs, with consequent increased risk of depression, generalised anxiety and panic disorder, alcohol abuse and use of medications, sudden cardiac events, and suicide (Parkes & Weiss 1983; Stroebe & Stroebe 1987).

This specific population of bereaved people has become firstly the subject of extensive contemporary research (Prigerson & Jacobs 2001) – central to the debate about the classification of grief within the DSM manual of disorders (Prigerson & Maciejewski 2006; Stroebe & Schut 2005); and secondly a practice focus – addressing how to provide appropriately targeted interventions to those most vulnerable (Shear 2010; Shear, Boelen & Neimeyer 2011). Translating notions of both vulnerability and resilience into effective bereavement care demands a clear bridge between such research, theory and practice.

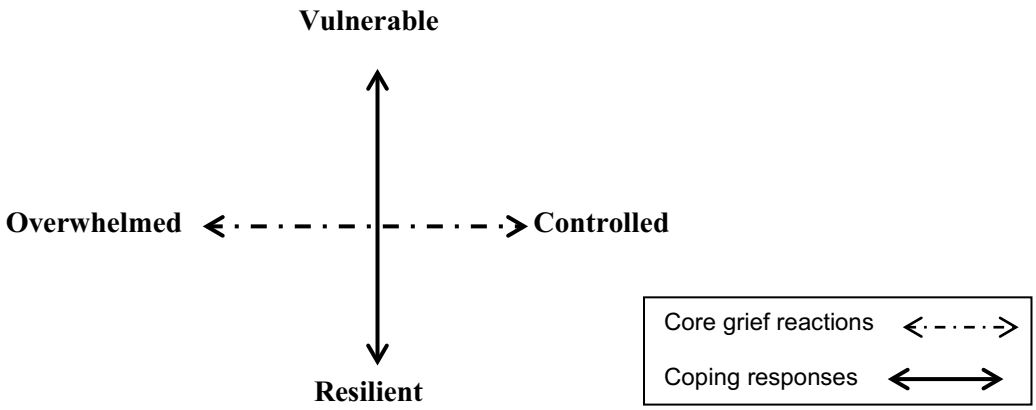
The Range of Response to Loss model was developed to reflect observed variability in expressions of grief in both research and practice (Machin 2001). It is important to emphasise that the RRL, unlike other theories, is based on terminology which has emerged from listening to grieving people themselves describe their lived experience of loss. This being so the model has strong face validity with practitioners and clients in a way that some theories do not (Machin & Spall 2004; Machin 2007). The RRL conceptualises grief as a stressful state, generated by loss, in which there is tension between reflexive **'overwhelming'** distress, and the instinctive mechanisms for remaining in **'control'**. The model suggests that the ability to find a balance between these competing reactions is characteristic of **'resilient'** coping.

There is a conceptual fit between these notions of grief and those identified in a number of other models, for example:

- attachment theory (Ainsworth *et al* 1978) – an overwhelmed reaction is comparable to anxious/ambivalent attachment, a controlled reaction is comparable to avoidant attachment, and a balanced/resilient response fits conceptually with secure attachment;
- the Dual Process Model (Stroebe & Schut 1999) – being overwhelmed parallels loss orientation, being in control reflects restoration orientation, and the balanced/resilient state reflects the capacity to oscillate between the two orientations.

In addition to identifying the conceptual parallels with these and other theories (Horowitz 1997; Martin Doka 2000), research has tested the validity of the three categories in the RRL model using a specifically devised measure, the Adult Attitude to Grief (AAG) scale, along with other psychometric tests (Machin 2001). Additionally, in this study the model was examined against other psychometric tests for depression (Beck *et al* 1961), Impact of Events (Horowitz, Wilner & Alvarez 1979) and detachment from the deceased (Cleiren 1991). The AAG scale consists of nine self report statements designed to reflect the three perspectives in the model (see Table 1. NB: This version is to help provide the practitioner with a quantitative indication of vulnerability alongside the wider appraisal of their clients' grief. It is desirable to use an AAG version which does not include scores for use with clients who might perceive the scores as providing cues to 'right' answers, rather than giving their responses and qualitative reflections spontaneously).The factor structure of the RRL was supported in the 2001 study, and it became evident that a picture of individual grief could be accessed through the permutations of possible responses to the items in the AAG scale. Since then, the

Figure 1: The Range of Response to Loss Model



nine-item scale has increasingly been used in practice as a measure to profile individual grief (Machin & Spall 2004; Machin 2007; Agnew *et al* 2009; Machin 2014). The full development of the model and its use are discussed in *Working with loss and grief: a theoretical and practical approach* (Machin 2014).

The RRL model has evolved conceptually through continued practice reflection and the incorporation of new theoretical considerations. This has led to vulnerability being integrated as a fourth component. Vulnerability represents the opposite end of the spectrum to resilience and is a dimension of *conscious* coping with the loss, while the overwhelmed/controlled reactions are activated at a less conscious level in the face of loss (Attig 2011). These distinctions provide definitional clarity to the complex nature of grief and have led to the RRL becoming redefined as a two dimensional schema; made up of the interface between a spectrum of core reactions (overwhelmed to controlled) and a spectrum of coping responses (vulnerable to resilient) (Figure 1). Vulnerablity is included in the model as a state in which personal/social/circumstantial factors are problematic and contribute to difficulty in coping ie. managing loss and its consequences at an emotional, social and practical level. Conversely positive personal/social/circumstantial factors can contribute both to the resourcefulness needed to balance the competing demands of grief, and to resilient coping (Machin 2014).

The revision of the RRL model raised the question as to whether the capacity of the AAG scale could be extended to identify the additional component, vulnerability. A proposition was developed to address this, and was the key hypothesis in research carried out in 2011–2012, and discussed in part two of this paper (Sim, Machin & Bartlam, 2013). The proposition was that by combining the scores of the overwhelmed and controlled reactions (scoring on a 5-point Likert scale, in a range from 4 for 'strongly agree' through to 0 for 'strongly disagree', providing a range from 0-36) and reversing the scoring of the resilient responses an indication of vulnerability could be calculated:

Overwhelmed score + Controlled score – Resilient score = Vulnerability Indicator

2. Research evidence for the ability of the AAG scale to identify vulnerability

The research sought to test the key psychometric properties of the AAG scale by examining the factor structure of the scale, its internal consistency, its construct and criterion-related validity, and optimum cutoffs for classification of vulnerability. The study received approval from Keele University's ethics review panel. Full details of the methods, analysis and findings of this work have now been published (Sim, Machin & Bartlam 2013) and are summarised here.

Three bereavement services already routinely using the AAG were partners in the research. Clients who gave consent for their anonymised data to be released to the research team were included in the study. Data collection began in March 2011 and concluded in September 2012.

An indication of vulnerability was calculated from responses to the AAG scale and tested for validity and reliability, through psychometric testing with other widely used clinical instruments:

- a measure of prolonged grief disorder, the PG-13 (Prigerson & Maciejewski, 2006)
- a brief depression severity measure, the PHQ-9 (Kroenke, Spitzer, Williams, *et al* 2001)
- a brief measure for assessing generalised anxiety disorder, the GAD-7 (Spitzer, Kroenke & Williams, 2006).

168 clients participated (128; 76.2% female and 40; 23.8% male). 95 were clients were from a community based bereavement service and 73 were from hospice-based bereavement services. Ages ranged from adults under 25 to

Table 1: Adult Attitude to Grief scoring and comments sheet

Client number…….. Date …….. Session number……

Vulnerability indicator scores: R = Resilient C= Controlled O = Overwhelmed

Adult Attitude to Grief scale	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Additional responses/ comments
R 1. I feel able to face the pain which comes with loss.	0	1	2	3	4	
O 2. For me, it is difficult to switch off thoughts about the person I have lost.	4	3	2	1	0	
R 3. I feel very aware of my inner strength when faced with grief.	0	1	2	3	4	
C 4. I believe that I must be brave in the face of loss.	4	3	2	1	0	
O 5. I feel that I will always carry the pain of grief with me.	4	3	2	1	0	
C 6. For me, it is important to keep my grief under control.	4	3	2	1	0	
O 7. Life has less meaning for me after this loss.	4	3	2	1	0	
C 8. I think its best just to get on with life and not dwell on this loss.*	4	3	2	1	0	
R 9. It may not always feel like it but I do believe that I will come through this experience of grief.	0	1	2	3	4	

© Linda Machin 2010 (modified 2013)* (resilient scores reversed to allow for a simple addition) Vulnerability indicator scores = total score for the 9 items

86+, with 64% falling within the 36 to 65 age span. The median age category was 46-55. The need to replicate this work in areas of ethnic diversity is clearly indicated as the sample was wholly white British or Irish.

Analysis broadly supported the factor structure of the AAG, but identified item 8 as one that could profitably be reworded to make the fit with the concept of 'control' more robust. (Consequently, item 8 has been changed from *'I think it's best just to get on with life after a loss'* to *'I think it's best just to get on with life and not dwell on this loss'*) (Table 1).

Internal consistency of the three subscales – ie. the extent to which they consistently measure the relevant domain in the scales (resilient (R) controlled (C) and overwhelmed (O)) – was found to be acceptable. Construct and discriminative validity were supported, respectively, by correlations with allied constructs (depression via the PHQ-9 and anxiety via the GAD-7) and by a significant difference between scores on the AAG between clients with prolonged grief disorder and those without.

A correlation with counsellors' own clinical ratings of vulnerability demonstrated the criterion-related validity of the scale for identifying the new measure of vulnerability. Using receiver operating characteristic methods, it was possible to identify optimum cut-off scores on the scale for the classification of different levels of vulnerability:

Severe vulnerability	>24
High vulnerability	21-23
Low vulnerability	<20

Characteristics of vulnerability in this study sample

In addition to the psychometric validation of the AAG (Sim, Machin & Bartlam 2013), associations between the identified vulnerability of study participants (a little over 40% of the study sample was in the severe category with the rest of the sample equally divided between high and low levels of vulnerability) and demographic and grief characteristics was examined.

Heightened vulnerability was found amongst the oldest and youngest ages; with those who had experienced the death of a child, the death of a spouse and, for adult daughters, the death of a parent; and where the death was sudden. It is important to note that there were low numbers within each of these sub-groups and the findings are not statistically significant.

However, the data indicates that complications arose for over half the sample related to either the deceased's last illness (n=86; 51%, of whom 35 were severely vulnerable) and/or the death (n= 100; 59%, of whom 42 were severely vulnerable). Relationship difficulties were an added complication for over a quarter of the sample (n=44; 26%, of whom 14 were severely vulnerable). Respondents having difficulty dealing with stress were also likely to be severely vulnerable (n=42; 25%, of whom 23 were severely vulnerable). The number facing financial difficulties was small but this factor had the greatest negative effect on the AAG vulnerability

Table 2: Grief reactions and responses and the incidence of severe vulnerability

	AGREE responses Total sample N (%)	**AGREE responses** Severe vulnerability sub-group as % of total sample N (%)
Grief Reaction		
Inability to accept the death	81(48)	42(25)
Powerful expression of distress/despair	97(58)	45(27)
Strong feelings of anger, guilt, blame	77(46)	33(20)
Disturbed intrusive thoughts	80(48)	38(23)
Difficulty in day to day functioning	61(36)	30(18)
Loss of/change in previously held beliefs	20(12)	10(6)
Anxiety about the normality of grief	77(46)	27(16)
Coping Responses		
Difficulty coping with feelings	139(83)	61(36)
Difficulty in coping with day to day life	106(63)	49(29)
Difficulty coping with other people's feelings	57(34)	25(15)
Difficulty coping with the meaning of the loss	110(66)	59(35)
Social factors		
Socially isolated	41(24)	21(13)
Perceives social support as lacking	42(25)	17(10)
Makes poor use of social support	47(28)	20(11.9)

Table 3: AAG responses of 168 study participants at the first support/counselling session

AAG items	**Combined strongly agree and agree**		**Neither agree nor disagree**		**Combined strongly disagree and disagree**	
Overwhelmed						
2. For me. it is difficult to switch off thoughts about the person I have lost	136	81%	15	8.9%	17	10.1%
5. I feel that I will always carry the pain of grief with me	138	82.2%	16	9.5%	14	8.3%
7. Life has less meaning for me after this loss	105	62.5%	23	13.7%	40	23.8%
Controlled						
4. I believe that I must be brave in the face of loss	129	76.8%	13	7.7%	26	15.5%
6. For me, it is important to keep my grief under control	136	81%	17	10.1%	15	8.9%
8. I think it's just best to get on with life and not dwell on this loss	85	50.6%	30	17.9%	53	31.5%
Resilient						
1. I feel able to face the pain which comes with loss	69	41.1%	24	14.3%	75	44.6%
3. I feel very aware of my inner strength when faced with grief	78	46.4%	38	22.6%	52	31%
9. It may not always feel like it but I do believe that I will come through this experience of grief	121	72%	29	17.3%	18	10.7%

indicator scores (n=14; 8.3%, of whom 8 were severely vulnerable).

Between one fifth and up to 27% of respondents who reported coping reactions such as anger, intrusive thoughts, inability to accept the death and despair were also categorised as severely vulnerable through the AAG measure. More than one third of those agreeing that they had coping difficulties – ie. coping with feelings, day to day life and the meaning of the loss, were also assessed as belonging to the severe vulnerability group.

Social isolation, perception of inadequate support and inability to make use of support are experiences of about a quarter of those presenting for bereavement support; of the sample one tenth who experienced this were also classified as vulnerable.

Table 2 compares the responses of the severe vulnerability subgroup to the whole sample.

Cross-tabulating the categories derived from the AAG vulnerability score with the demographic and clinical data, identified factors associated with severe vulnerability that were consistent with other research findings: on risk (age – very young or old, sudden death, death of a child, mental health problems, concurrent crises eg. financial problems, relationship difficulties, limitations in social support; Sanders 1993), and on complicated grief (inability to accept the death, powerful emotions of distress and despair, disturbing intrusive thoughts, difficulty in day-to-day functioning, difficulty coping with the meaning of the loss; Prigerson *et al* 1995). This provides additional support for the AAG as a valid measure of vulnerability and its appropriate use in practice.

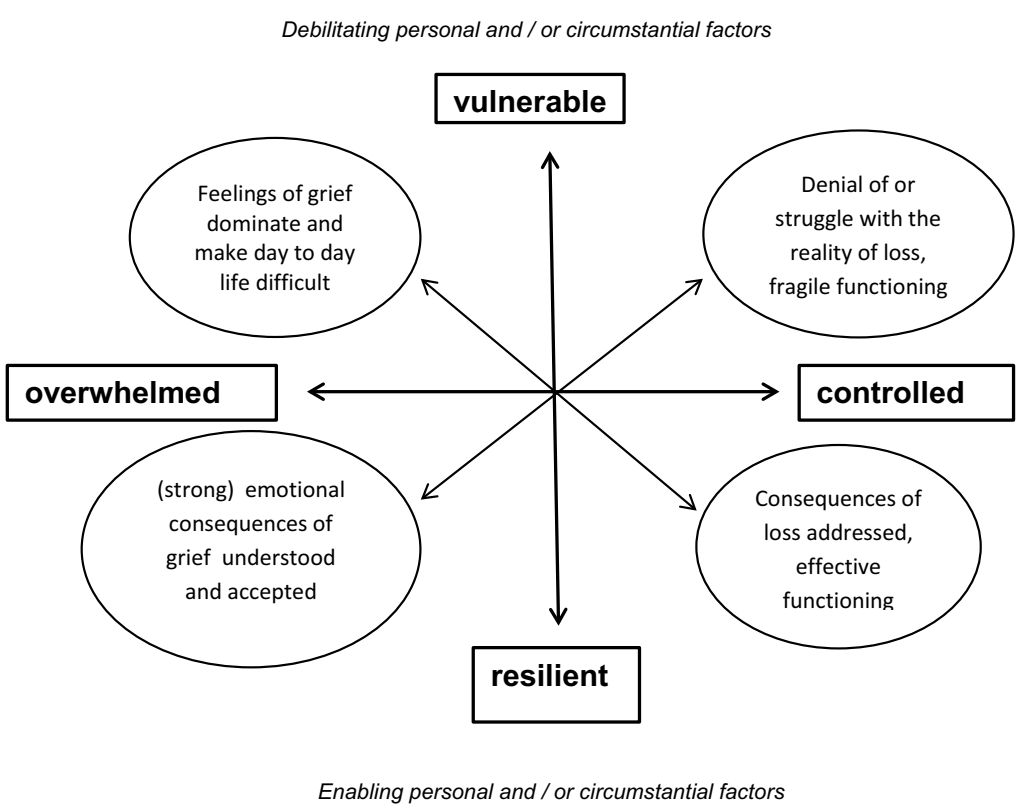
3. The AAG – applying the research findings to practice

Assessment

The three levels of vulnerability (severe, high and low) identified by the AAG scores (>24, 21-23 and <20 respectively) provide an indication of the type and level of intervention needed to address a client's grief. However, the scale has a wider assessment function. The individual items and the clustered groupings of the overwhelmed, controlled and resilient categories on the scale provide a picture of grief being expressed and experienced by the client. The grieving characteristics of those presenting for bereavement support can be seen in the summary of the validation study sample in Table 3 (Sim, Machin & Bartlam 2013).

Over 80% of the sample agreed with items 2 and 5 (overwhelmed items), identifying the pain and persistence of distress, and a similar number agreed with item 6 (controlled item), believing grief should be under control. This represents the tension between the presence of forceful emotions and the instinct to remain restrained. Less than half the sample agreed with the resilient items (1 and 3) relating to an ability to face the pain and feel resourced in dealing with grief. However, 72% agreed with item 9,

Figure 2: The RRL model as a template for assessment



suggesting that there was a basic hopefulness coexisting with the other grief reactions which may be associated with the expectation of a positive outcome from the support being sought.

Clearly more research is needed to test this proposition and to explore the wider characteristics of vulnerability in the 10.7% who did not feel that they 'would come through this experience of grief'. However, it remains essential that the components underlying all responses are explored appropriately within any therapeutic intervention(s), and that practitioners are adept at understanding and interpreting the significance of specific item responses within the context of all nine items.

Exploring the scale for consistencies and tensions/contradictions through the qualitative comments as well as the scores helps identify the confusions and complexities of grief and the aspects most troubling to the client, providing a nuanced and comprehensive understanding of the clients' grief in terms of resilience and vulnerability. A general sense of the nature of grief (Figure 2) supported by fully understanding the distinctive aspects of client grief through careful assessment is an important pre-requisite for identifying the most appropriate and effective intervention(s).

The AAG as an indicative guide for intervention

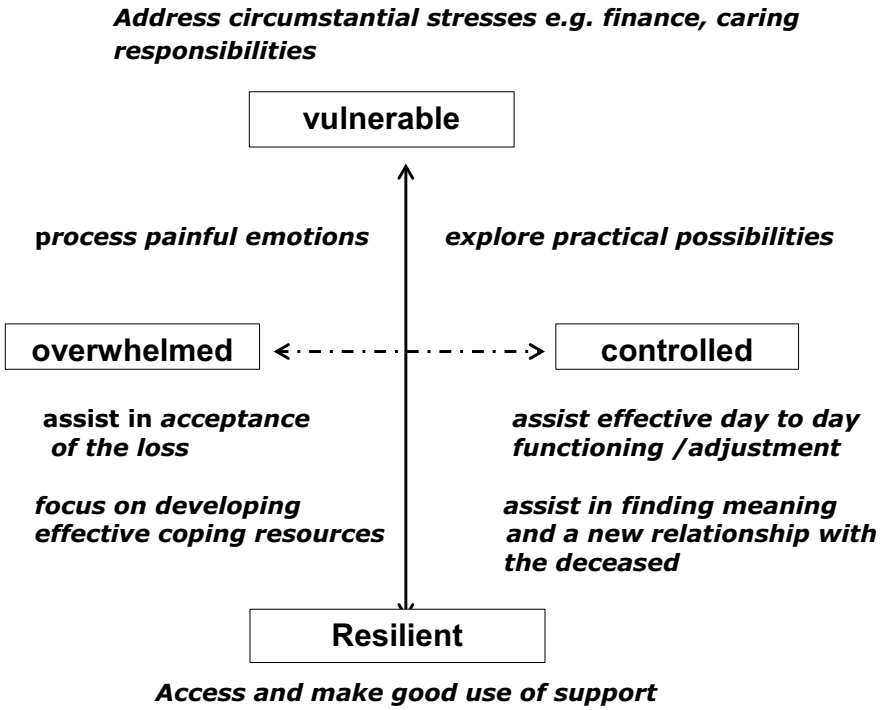
As outlined, conceptually the RRL model captures the diversity of loss response and the AAG permits the mapping of grief. Those characteristics which tend to resilience and are captured by a low vulnerability score on the AAG indicate minimal levels of intervention are needed. These may consist of components 1 and 2 bereavement support (NICE guidance):

1. Practical information.
2. Information about the normality of grief.
3. Sources of support.
4. Short term one-to-one support.
5. Group support.

The quality of the helping relationship, based on a person-centred way of being with the client (Rogers 1980) and primary attention to his/her 'story' or narrative of loss (Angus & Hardke 1994), is crucial to providing effective care at all levels. It enables the assessment process and the setting of goals to be mutually agreed and understood.

Where NICE component 3 (or where there are more complex needs) support is required (counselling/therapy) a pluralistic approach developed by Cooper and McLeod (2011) provides a theoretical rationale for engagement with individual client need by focusing on the **goals, tasks and methods** necessary for working with vulnerability and enhancing resilience (Machin 2014). The tasks developed by Worden and Winokuer (2011) have been widely integrated into practice and provide an important structure upon which counselling can focus, addressing the diverse individual need to:

Figure 3: The RRL as a template for practice intervention



1. Acknowledge the reality of loss
2. Process the pain of grief
3. Adjust to life without the deceased
4. Find an enduring connection with the deceased while embarking on a new phase of life.

These tasks can be integrated within the RRL model as the focus of intervention (see Figure 3).

Within the RRL model, the aim is to counteract the bias towards either the overwhelmed or the controlled end of the spectrum of reactions by a focus on the opposite.

- For the client whose distressed feelings dominate, an alternative approach may be used to address thinking and practical strategies for increasing effective functioning (Ellis 1962; McLeod 2003).
- For the client whose tendency is for control but who is struggling to find their normal capacity to deal with life events, an exploration of past relationships and experiences may helpfully provide insight, for the client and the counsellor/therapist, into the factors which undermine an inability to face and/or deal with the emotions of grief (Bowlby 1980; Dallos 2006).

This approach of working to counterbalance the usual reactions of a client where these are especially dominated by one end or the other of the overwhelmed /controlled spectrum has been shown to be effective (Schut *et al*, 1997) and provides a re-balancing of feelings and functioning.

When looking at the **coping spectrum of the RRL model** (vulnerable to resilient) there needs to be recognition that most people will demonstrate some degree of vulnerability immediately after a loss and this is not usually indicative of long-term complications. However, where there is persisting distress and there are complicating circumstantial or personal factors, attention to all these dimensions of vulnerability is necessary:

- Information/advice giving (practical guidance) may be necessary alongside therapeutic strategies (Ellis 1962; Dallos 2006) for engaging with factors that are undermining the capacity to cope with loss and its consequences.
- Exploration of social support, its availability and the use made of it may also be needed (Berne 1961; Stylianos & Vachon 1993; Shapiro 2001).

In moving to an acceptance of the loss, and finding increased equilibrium between feelings and functioning, restored or new-found resilience is likely to be more evident. This will suggest a new focus in which opportunities for growth are explored:

- Advanced processing of the experience of loss and adjusting to new life circumstances eg. where there is openness to explore more deeply the personal implications of loss (Neenan 2009).
- Attention to making sense of loss through evaluation of those cognitive, spiritual and social domains that need revision, by finding a way to re-order them into a meaningful life view (Neimeyer & Sands 2011).

For those most vulnerable, the counselling process is likely to be lengthy (Shear *et al,* 2011) and it challenges conventional practice, where 6–8 sessions is the norm. No longer can grief counselling/therapy be seen as a one-size-fits-all process of care but must be regarded as one in which the matching of clearly-appraised individual need and appropriate interventions can effectively enhance growth through grief even in complex situations.

Outcomes

A subset (n= 54) of the research sample (described above) was analysed where the AAG scale had been used on a second occasion. In some cases this was for a mid-counselling review and for others at the end of counselling, as an outcome measure. The individual client details are not available to distinguish this variable usage or the nature of the interventions. However, the data does provide interesting evidence of the changes taking place in grief reactions and responses across this sub-set (see Table 4).

Table 4: Summary of changes in levels of vulnerability in a subset of 54 participants

Vulnerability category		No. clients	% of subset
Time 1 –	Severe	27	50%
	High	7	13%
	Low	20	37%
Time 2 –	Severe	7	13%
	High	7	13%
	Low	40	74%

Comparing the responses across the two assessment times in detail, it was seen that overall agreement with all the resilient items increased and, in the category as a whole, increased by 30.9% while all the overwhelmed and controlled responses in the 'overall agreement' category reduced, and collectively in those categories reduced by 21.5% and 13% respectively. In exploring change it is necessary to recognise that resilience does not cancel out distressing and difficult reactions but makes the acceptance of the loss and its consequences more sustainable.

Future developments

This paper sits within a policy and practice environment in which the context is a rapidly changing landscape. The publication of the Bereavement Care Service Standards document (Cruse Bereavement Care & Bereavement Services Association 2014) was the result of work by key representatives in voluntary and statutory care. It was a collaboration which came at the end of more than a decade of diverse initiatives across health and social care settings, and provided a joint initiative for setting strategic objectives and standards in bereavement care. Existing organisations like Cruse Bereavement Care and Child Bereavement UK together with two newer umbrella groups – the Bereavement Services Association and the National Bereavement Alliance – have set out clear objectives for quality service provision. This is the context of exciting but challenging times for service providers and practitioners: but the document makes clear that 'Whilst there have been some significant developments in bereavement care, the impact of these is as yet largely unknown and there is no tool to enable the quality of services offered to be checked or assessed with any degree of objectivity'. (Cruse Bereavement Care & Bereavement Services Association, 2014 p4)

Key to addressing this particular challenge is how we go about systematically auditing and comprehensively capturing outcomes. CORE IMS (Clinical Outcomes in Routine Evaluation Information Management Systems (www.coreims.co.uk)) has had a significant role in evaluating client care across psychological therapy services by providing tools and systems for collecting and analysing assessment data. The work of this organisation is widely used and the standards achieved by tracking interventions and client progress have contributed to improved outcomes. CORE has recognised the potential of the AAG as a grief–specific measure to contribute more widely to the field of bereavement care. It is supporting the development of an IT system capable of offering central data collection and processing of AAG responses, and is providing the base from which a network of practitioners might work together as a Learning Collaborative to maximise the practice and research findings to be gained from an extensive data source.

Conclusion

The Adult Attitude to Grief scale (AAG) is a validated tool shown to effectively give a comprehensive and nuanced picture of individual reactions and coping responses to loss and bereavement, capturing both quantitative and qualitative data in a form which is acceptable to both practitioners and clients. Its additional capacity to indicate levels of vulnerability is important for its use as an assessment and outcome measure. In practice it gives practitioners a structure within which to understand the grief dynamics of their clients and the level(s) of their need(s), as this changes over time, together with a framework for developing appropriate strategies and interventions for addressing vulnerability and nurturing resilience. The AAG has the potential to meet the challenge of practice and policy agendas for targeted, effective and cost-efficient interventions while remaining open to continued research scrutiny and development.

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