

Making sense of loss and grief: the value of in-depth assessments



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Abstract: Research in a community-based bereavement support service has revealed a proportion of clients for whom an assessment session which focuses on meaning-making mitigates the need for ongoing professional intervention. We suggest that such in-depth assessment sessions may consolidate resilience by helping clients construct meaning in relation to their loss. We support our position with four case studies using assimilation analysis.

Key words: grief, bereavement, needs assessment, meaning-making, resilience, assimilation analysis.

Introduction

Bereavement needs assessment procedures in UK bereavement counselling services have commonly been associated with assessing for risk of complications (Relf, Machin & Archer, 2010). The revised Bereavement Care Standards Document published jointly by Cruse Bereavement Care and the Bereavement Services Association (2014) calls for assessment which identifies 'both risk and potential for resilience'. It states that best practice comes from an assessment tool or framework that identifies needs and formulates a plan of support (Cruse & BSA, 2014 p5). Much of the current emphasis in bereavement needs assessment is on determining a client's level of resilience; low levels being identified as a risk factor (Machin, 2013). We would argue, as others have done (Neimeyer, 2001) that psychological change following bereavement comes

also from making sense and finding new meaning in a world changed by loss. Keesee *et al* (2008) concluded that the ability to make sense of a loss 'emerged as the most salient predictor of grief severity' (p1145). Machin (2013, pp. 40-41) has recognised how the acquisition of new meaning can be instrumental in the process of becoming resilient. Bonanno and colleagues have noted that resilient individuals benefit from talking about a deceased spouse (Bonanno, Boerner & Wortman, 2008, pp 293-294). Our emphasis has been not just to determine risk and resilience, but to observe the client's construction of meaning, which the evidence cited above suggests, can foster potential resilience. Furthermore we propose the possibility of a serendipitous side effect; that the process of conducting an in-depth assessment actually fosters the client's meaning-making process; in some cases mitigating the need for bereavement counselling.

Defining resilience

Resilience, a term adopted from material science, is the property of being able to recover from stress without lasting damage. Resilient materials bounce back into shape, but Cooper and his colleagues point out the limitations of such simple definitions to human complexity. They highlight the debate as to whether personal resilience is a characteristic, a process or an outcome. In their review of existing literature, they found resilience was commonly described as an adaptation to stressful change (Cooper, Flint-Taylor & Pearn, 2013, pp14-15).

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In order to understand loss and grief, we would describe a person as resilient if they demonstrate an ability to successfully manage the loss and in time adapt to a life without the deceased. Machin's Range of Responses to Loss (RRL) model posited resilience as a characteristic that changes through the grief trajectory and that can be changed by counselling. This implies that resilience is both a characteristic and a process. Bonanno and colleagues (Bonanno, Boerner & Wortman, 2008; Bonanno *et al*, 2002; Bonanno, Wortman & Nesse, 2004) suggest that resilience is a personality trait, but that grief may temporarily have an adverse effect. Bennett (2010) explored patterns of resilience in older widowers in the years following the death of their spouse. Based on semi-structured interviews she identified four groups. The first were resilient throughout their loss, a second group slowly acquired resilience, a third group reported a sudden turning point, and a fourth group were seen to exhibit both gradual and turning point change. In one instance the turning point was quite sudden, with one man reporting that the change came when he met a bereavement counsellor: 'I got a phone call to make an arrangement and when Mr Anderson came he was absolutely brilliant' (p378). Bennett's study would indicate that resilience is both a characteristic and a process which can lead to a successful outcome. If resilience is defined as the ability to adapt, meaning making may play a key role in resilience, since the ability to construct meaning and make sense has been shown to be an important factor in successful adaptation to loss (Gillies & Neimeyer, 2006; Holland, Currier & Neimeyer, 2006). We would suggest that resilience is a trait that can be depleted by loss but that it is possible to build back up. One possible mechanism for this is the experience of reconstructing meaning following a loss.

The research setting

The co-authors are psychotherapists and academics, with an established background in published research and an interest in bereavement counselling. The lead author is a BACP accredited counsellor practising in a hospice which operates a community Bereavement Support Service working with clients bereaved from any cause. The service has five staff and twenty eight volunteers. The catchment area of the service is 1600 square miles rural and urban, with a population of 250,000. Most referrals are from health and social work professionals although one fifth of adult clients self-refer for support. All members of the team are referred to as 'Bereavement Supporters'. The service operates a person-centred counselling model of support for all clients, and subscribes to the British Association for Counselling and Psychotherapy (BACP) Ethical Framework for the Counselling Professions (Bond, 2015). Service standards are monitored by a questionnaire which invites clients to comment on their experience, including the assessment session.

Principles and practice in assessment

Clients who are referred by health professionals or who self-refer will include not only those at risk of complicated grief or depression, but also those newly bereaved but on a normal grief trajectory. Often such clients are referred by a general practitioner because during a routine consultation, the patient became uncontrollably grief-stricken. Typically these individuals experience the classic pangs of grief and periods of intense tearfulness (Bowlby, 1980, pp 42, 86). Although this phase of grief can be distressing such that there is little wonder that these clients present for assessment, the weight of evidence suggests that this 'normally grieving' group do not benefit from bereavement counselling and that professional intervention may even be harmful in some cases (Schut, Stroebe, van den Bout, & Terheggen, 2001).

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In light of this, how best can we screen, assess and support appropriately? Many UK bereavement services contact potential clients by telephone to determine risk and appropriateness. This is followed by a carefully structured face-to-face assessment (See for example Fish, 2014). Such assessment is both valuable and ethical if it separates those clients most at risk of future complications from those grieving normally. Yet to deny support for those who seek help yet are deemed at assessment to be grieving normally could appear to lack humanity. Burke and

Neimeyer (2013, p155) have drawn attention to the possibility that 'bifurcation of high-/low-distress respondents' may miss a grieving individual's perceived need for intervention. Relf, Machin & Archer (2010) have discussed the humanity that underpins ethical bereavement needs assessment. Rather than wait for a client's grief to develop into a prolonged grief reaction, they suggest that timely professional intervention may move the client from vulnerability to resilience before grief can become problematic. Our own position is that we address all referred clients' perceived needs through in-depth, person-centred assessments. For many, this experience proves to be sufficient.

The assessment process

A full account of bereavement assessment described here, including a sample form, can be found in Wilson (2014, pp182-199). The assessment is a collaborative process, with the onus on the service to ensure that the client's needs are met with appropriate intervention. Where this is unlikely to be bereavement counselling, every effort is made to signpost the client to alternative support. The information collected is used to identify any risk factors which may prolong grief (Burke & Neimeyer, 2013 ; Parkes, 1998; Shear *et al*, 2011). Assessors are BACP Accredited counsellors and psychotherapists highly experienced in working with grief, who can collect this information with minimal reference to written prompts. Notes are written up later on a double-sided A4 form. The client is given verbal feedback and options for ongoing support are discussed. Service information is given, including waiting times, confidentiality protocols and service provision. With the client's consent, the referrer is informed of the outcome.

The client is encouraged to tell the story, including the nature of the death, when it occurred, whether it was expected and any other details the client wishes to discuss. The assessor asks about coping strategies and assesses how successfully the client oscillates between loss and restoration (Stroebe & Schut, 1999). Open questions are asked about levels of social and familial

support, occupation, hobbies and interests. The client is asked about cultural, religious and spiritual beliefs. Any signs of trauma, including unwanted images or memories are recorded, along with any reported eating or sleeping difficulties and feelings of social isolation. A suicide risk assessment is carried out, and the client is asked about self-harm, alcohol consumption and substance misuse. Prescribed medication is recorded. The assessor ensures that the client is sufficiently motivated to be ready to change, has realistic expectations of a counselling model of support, and is psychologically minded. (Cooper, 2008, pp63-79). As part of the collaboration, the assessor asks what the client wants to achieve.

... the client is at the heart of the process and is encouraged to reflect; both on the story she is telling and on her thoughts, feelings and behaviour in relation to the loss ...

The assessment protocols are common to all clients regardless of the time elapsed since the bereavement. However if a client is reporting chronic grief symptoms after six months, the assessment will vary in emphasis. Prolonged grief may be a disorder as classified in The Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5) (APA, 2013) and in the forthcoming 11th revision of The International Classification of Diseases, ICD-11 (See Maercker *et al*, 2013). In such cases the assessor explores risk factors likely to contribute to prolonged grief, including the client's history. Clients in this group are assessed as being at NICE component 3 (National Institute for Clinical Excellence, 2004, p161) and are referred to experienced bereavement counsellors. Because assessors are cognisant of the limitations of counselling for normal grief (Schut *et al*,

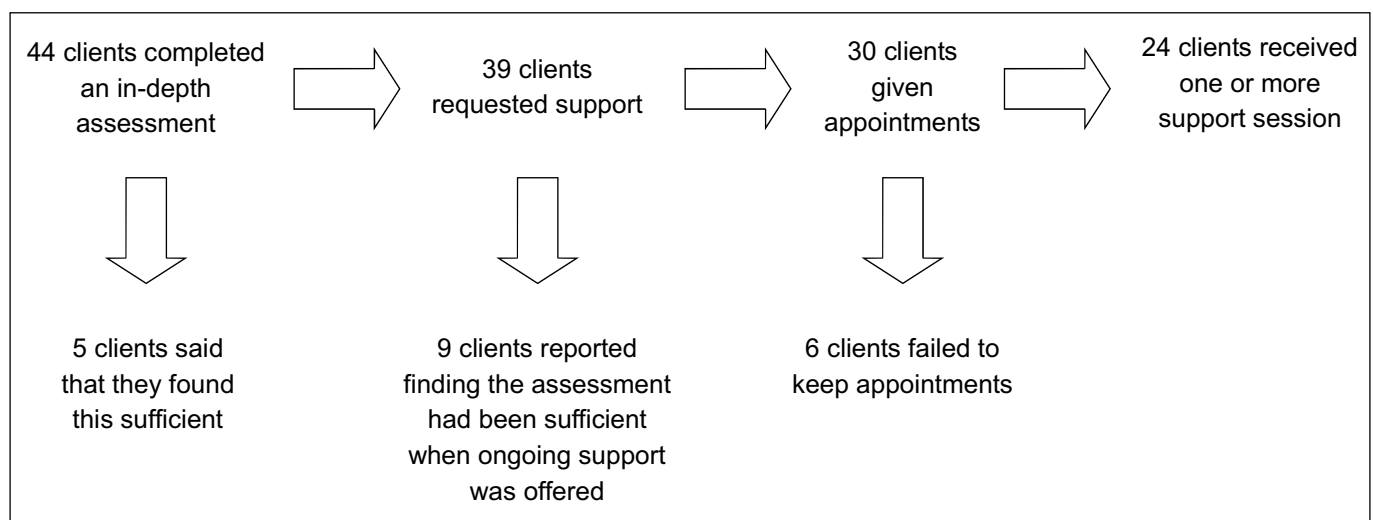


Figure 1: Audit trail

2001), clients assessed at component 1 are encouraged to seek support from family and friends. Although clients matching the features of component 2 are offered counselling support, some can be helped by the reassuring and normalising aspects of the assessment sufficiently to need little if any further support from the service.

Value of in-depth assessment

Written and verbal feedback from clients confirms that an in-depth assessment is for many a therapeutic experience. We define an in-depth assessment as one which has this potential to be therapeutic. A face-to-face meeting in a secure and confidential setting, it involves intense listening which closely observes the thoughts and feelings of clients and reflects them back. In our assessments we use the Rogerian core conditions of empathy, genuineness and unconditional positive regard so as to relax and encourage the client to tell the story of the loss. Emphatically, this is not just about the assessor collecting the information described above. The client is at the heart of the process and is encouraged to reflect; both on the story she is telling and on her thoughts, feelings and behaviour in relation to the loss. The assessor is able to collect this information through open questioning, summarising, paraphrasing and reflecting.

From our own experience and observation, we noticed that for some of these clients, in particular those on a normal but distressing grief trajectory, working in this way often means that no further professional intervention is needed. The lead author became curious to find out what is happening in these circumstances and conducted an audit. Of 44 clients assessed for bereavement needs by the lead author, only 24 went on to receive one or more sessions of counselling. Figure 1 illustrates the audit trail.

... Deliberate emotional avoidance may be a helpful strategy. However such avoidance strategies can be confounded by the confusion of disordered thoughts.

In most cases it is only possible to speculate why further intervention is not sought. After all, the intensity of normal grief naturally diminishes over time, and for some clients this will be contingent on waiting list times. Waiting times between assessment and the offer of ongoing support varied between 4 and 18 weeks, the mean being 11 weeks. However, since a number of clients referred specifically to the assessment when declining ongoing support, we wondered whether some observable psychological changes may be occurring either during the assessment session or as a result of the in-depth assessment. To this end we compared

two clients who declined ongoing support with two who requested and received further intervention.

Method

This paper is part of wider research on assimilation, accommodation and meaning construction in bereaved adults. It is predicated on the idea that clients in counselling and psychotherapy become more resilient by making sense of their confusion. This is achieved by assimilating the problems they are experiencing into new ways of thinking, feeling and being (Stiles, 2001). By recording and transcribing counselling sessions, it is possible to identify, analyse and sequence moments of assimilation as the client creates new meaning and makes sense of the loss (Varvin & Stiles, 1999).

The four bereaved adults who are the subject of this paper gave informed consent to be part of the research. Each assessment took one hour and was digitally recorded. At the conclusion, clients were given feedback which a) summarised his or her story, b) normalised the grief reaction and c) discussed the client's needs. Each client was invited to decide on counselling support. The stories which are told here are based entirely on the assessment; all four related an account in much greater detail than space permits here. The lead author, who was the original assessor, played back the recording twice: the first time to become re-acquainted with the case, and the second time to allow detailed notes to be made. From these notes, all verbalised moments of the client's meaning construction were extracted: meaning, both of the life and death of the deceased, and of the sense made of the client's thoughts, feelings and actions as an outcome of the loss. This included strategic avoidance of grief as well as movement between grief and restoration activities (Stroebe & Schut, 2000). Where confusion remained such that no sense could be made of the death, any helpful outcomes were noted concerning how the client perceived that they dealt with the loss (Davis, 2001). Moments of assimilation were replayed, sufficient times to ensure accurate transcription, and the case studies which appear below were assembled. Clients' verbatim words appear in speech marks.

Assimilation analysis

Assimilation analysis (Stiles, 1999) is a qualitative technique which allows the psychotherapy researcher to measure both processes and outcomes of an individual client in therapy. For other qualitative methods, process is usually described in brief therapeutic moments and outcomes are determined over weeks, months or even years. This technique bridges the gap between the two. Stiles originally related this to a Piagetian model of assimilation and accommodation (Stiles *et al*, 1990), but later it was also conceptualised as a community of the client's confused and opposing voices, which come together as successful therapeutic outcomes are attained.

Careful observation has enabled Stiles and his co-researchers to describe the client's sequence of therapeutic changes;

Table 1: The APES Sequence (Stiles, 1999).

Text in italics is by the current authors, and describes examples from grief experiences.

<p>Stage 0: Warded off/dissociated. Client is unaware of the problem; the problematic voice is silent or dissociated. Affect may be minimal, reflecting successful avoidance. Alternatively, problem may appear as somatic symptoms,</p> <p><i>This corresponds to the numb phase of grief.</i></p>
<p>Stage 1: Unwanted thoughts/active avoidance. Client prefers not to think about the experience. Problematic voices emerge in response to therapist interventions or external circumstances and are suppressed or avoided. Affect is intensely negative but episodic and unfocused; the connection with the content may be unclear.</p> <p><i>Tears and sadness intrude but are pushed away. Attempts are made to deny reality Reminders of the deceased such as photographs and music, are often avoided.</i></p>
<p>Stage 2: Vague awareness/emergence. Client is aware of a problematic experience but cannot formulate the problem clearly. Problematic voice emerges into sustained awareness. Affect includes acute psychological pain or panic associated with the problematic material.</p> <p><i>Tears and sadness can no longer be pushed away. Grief feels very raw and painful.</i></p>
<p>Stage 3: Problem statement/clarification. Content includes a clear statement of a problem: something that can be worked on. Opposing voices are differentiated and can talk about each other. Affect is negative but manageable, not panicky.</p> <p><i>Denial of reality diminishes. Client begins to accept, even embrace tears.</i></p>
<p>Stage 4: Understanding/insight. The problematic experience is formulated and understood in some way. Voices reach an understanding with each other (a meaning bridge). Affect may be mixed, with some unpleasant recognition but also some pleasant surprise.</p> <p><i>Client may now deliberately evoke memories of the deceased. Emotional pain becomes a quieter sadness.</i></p>
<p>Stage 5: Application/working through. The understanding is used to work on a problem. Voices work together to address problems of living. Affective tone is positive, optimistic.</p> <p><i>A stage of adaptation and learning to live without the deceased. Oscillation between grief and restoration is a feature. Sadness becomes an integrated aspect of daily life.</i></p>
<p>Stage 6: Resourcefulness/problem solution. The formerly problematic experience has become a resource, used for solving problems. Voices can be used flexibly. Affect is positive, satisfied.</p> <p><i>New meanings found in a post-loss life without the deceased. Client may also have found meaning in the death; eg. 'He would not have wanted to live with infirmity'</i></p>
<p>Stage 7: Integration/mastery. Client automatically generalizes solutions; voices are fully integrated, serving as resources in new situations. Affect is positive or neutral (ie. this is no longer something to get excited about).</p> <p><i>A symbolic continuing bond with the deceased is established The client may become open to new friendships and relationships .</i></p>

through dissociating from the problem and warding off unwanted experiences, to recognising, accepting and working on the perceived difficulties until mastery is achieved. This has been described as an 8-step sequence: The Assimilation of Problematic Experiences Scale, APES. A client's observed psychological change can be measured against the descriptors in the APES sequence (Stiles, 1999, 2001). Similarly, a client's starting point on the APES scale can be determined from transcription of the assessment session (Varvin & Stiles, 1999). Viewed from a

Piagetian perspective, a client's spoken reflections on her or his thoughts, feelings and behaviour, provide evidence of adapting to change through the assimilation and accommodation of new mental constructs (cf Piaget, 1954, pp 350-354).

In an inter-rater exercise, involving 19 bereavement counsellors, the authors found that even brief extracts of transcription from counselling sessions can be matched to the APES sequence with high reliability: Cronbach's Alpha typically greater than 0.9 (unpublished thesis in progress). Table 1

Table 2: Meaning-making matrix

Descriptors of clients able to manage grief without counselling intervention.

Sense-making and meaning-finding	Directly observed or reported behaviour
Narrative events surrounding the death.	Client is able to talk reflectively, with an ordered (rather than confused and disordered) narrative, about events leading up to and surrounding the death. The account is unhurried and detailed. Client is aware of, understands and accepts the cause of death, even though it may be difficult to do so. They articulate, perhaps with prompts and open questioning, that they can make sense of the circumstances surrounding the death.
Religious/spiritual meaning	Client articulates a religious or spiritual meaning in which the client says they find comfort. Examples include, 'She is at peace now'. 'He died so as to be there in heaven for his grandson'.
Feelings towards the deceased	Client articulates feelings towards the deceased. Examples include, 'I can't be angry with her, she didn't want to die' 'I am angry with him for leaving me' Sometimes the client talks directly to the deceased: eg. 'A fine mess you've left me in!'
Coping strategies	Client has identified coping strategies; for example, restoration activities such as hobbies and social events. These may helpfully (in the client's view) assist the client with temporarily getting respite from grief.
Triggers to negative affect	Client says that they know what things trigger tears, sadness and low mood. Client articulates an awareness of being able to use these triggers to avoid grief or even contact tears when the client feels it appropriate. When put together, 4 & 5 allow the client to oscillate between loss and restoration.
Past experiences	Client draws on learning from past difficulties, losses or traumatic experiences in order to recognise a potential for resilience. They are able to articulate this.
Symbolic bonds	Client has identified a symbolic continuing bond with the deceased through objects which they find comforting. This may include items of clothing, photographs, items of jewellery and personal possessions with imbued meaning.
Meaning in the life of the deceased	Client can find meaning in the life of the deceased, including shared experiences. Client says they are comfortable with memories elicited by photographs. Examples of things the client says include, 'He had a good life'. 'We did so much together'. 'She achieved so much in her life'.
Meaning of the death of the deceased	Although the client did not wish for the death, they have found meaning in the death of the deceased. Examples of things the client says include, 'He would not have wanted to live with disability.' 'It was a mercy that she did not suffer for long'.

shows Stiles' (1999) APES stages, to which we have appended descriptors pertinent to grief, based on our observations of many clients in bereavement counselling. We have observed that bereaved clients do not always move sequentially through the stages. For example, some need to take time out from the

intensity of grief. Although they may not dissociate, they exhibit deliberate periodic avoidance. Resilient individuals appear able to reach some understanding and insight into what they need (APES 4) and are able work through their grief experience (APES 5), sometimes with little or no professional support. Table

2, based on over 100 hours of qualitative client observation, records descriptors of clients who have reached a stage of being able to manage their grief; either because of the support they have received or due to their personal resilience.

Two cases where ongoing support was not needed

Case 1

Ted, a retired police officer aged 72, was referred three months after his son Jimmy's suicide. Three years earlier Ted's daughter had died from cancer. At Jimmy's inquest Ted discovered that following his marital breakdown, Jimmy had expressed suicidal ideation both to professionals and friends. It angered Ted not to have known because he believed he could have kept Jimmy safe. Now Ted was trying to make sense of the story. He said, 'All he wanted was for her to go back and live with him'. Jimmy's estranged wife had gone with him to a friend's wedding, and Ted believed that Jimmy had misinterpreted this as a reconciliation opportunity. The couple had argued shortly before Jimmy hanged himself. Although Ted could see a motive, he explored the possibility that Jimmy had not intended to complete his suicide. However, following discussions with the coroner's officer he had concluded that the suicidal act was deliberate. It troubled him that events could have been different had Jimmy confided his difficulties.

Ted compared the deaths of his daughter and his son. His daughter accepted her diagnosis, but fought bravely. He and his wife had taken care of her and, 'When the end came it was a relief. Jimmy's death was 'out of the blue' and 'hard to take'. Ted believed in an afterlife. 'It will be nice when we meet up again'. Then he would ask Jimmy, 'What were you doing all those years ago leaving us?' In response to the counsellor's question about the effect of Jimmy death on his faith, Ted replied, 'I don't think I can blame God for this.'

In describing his coping style, Ted related being so tearful that he almost passed out. Antidepressants had helped. He had avoided Sunday chapel; 'Hymns or poetry made me cry'. Coping strategies included keeping busy. Although mornings could be difficult, 'I've accepted that and it's decreasing. But sometimes you have a funny feeling that it's not real, it's a dream and he'll walk round the corner in a minute'. He talked about playing golf and talking to friends who understood what he and his wife were going through. He and his wife supported each other. Life had taught him to be resilient, 'I've dealt with things, mishaps, and I'm not one to panic.'

Ted had, to his own satisfaction, constructed a meaning to explain how events had come together in this sad tragedy and few unanswered questions remained. He compared his grief to that for his daughter. He was aware of his coping style and was choosing emotional avoidance (Bonanno, Keltner, Holen, & Horowitz, 1995) alongside his resilience. Ted concluded that this opportunity to talk had been all that he needed at the present time.

Case 2

Fiona, aged 74 was assessed nine weeks after the death of her husband. Although she was regularly tearful following the diagnosis, having a surgeon in the family helped with understanding the prognosis. She had cried at the cancer diagnosis and her husband said, 'We'll get on with it'. Everything had been 'hunky-dory' until the last six weeks of frequent hospital admissions following a haemorrhage. Fiona vividly recalled his death. Her husband was reading a newspaper when she left and had kissed her goodbye. He died just before she returned a few hours later. The counsellor discussed with Fiona how some people seem to choose the moment of their death. She was comfortable with her husband's choice.

Fiona had planned the funeral with her children; choosing music from her husband's jazz collection. She had 'held it together' up to and including the funeral and in the days that followed. Although she had 'broken down' with her doctor when she had gone to seek help, she generally remained in control; spending time in the company of others, including a friendship group, where people had 'taken me under their wing'. Her husband's clothes had been sent to a charity shop after the funeral, save for emotionally significant items which included a duffel coat, university scarf, a fleece 'which smells of him', a blazer and his gardening shoes. She was deliberately avoiding her husband's photographs and music and was distracting herself with television.

Fiona sought reassurance; asking the counsellor if he saw a lot of 'broken hearted' older people and whether those with 'loneliness of the heart' eventually 'return to sanity?' She asked if 'keeping busy' was a normal way of coping. Although she described herself as a 'well regulated person', she recognised that her adult life had 'always been up and down'; moods she had learnt to live with. She said, 'I'm sensible enough to realise that it could be worse, but it's bad enough'. She feared others reaching a stage of not being there for her. 'I imagine people getting tired of listening'.

Fiona was already beginning to construct meanings around her husband's death, his life and in their life together; 'We lived so much, had a great life'. She described helping with her husband's stroke rehabilitation some years earlier, and how she had become her husband's 'translator' in social situations. Because life without him was hard, suicide had been a fleeting thought, 'but you can't switch off; you have to go on until you are called'. She added that at least 'I don't have to go on being with someone frail'.

The counsellor normalised Fiona's grief but suggested that counselling might help. Fiona was not sure if she needed any more, and had appreciated 'straight and honest talking'. When offered support six weeks later, Fiona said that she was managing well, thanks to the initial session.

Common factors in the first two cases

Both clients were clearly grieving significant losses. As each client told the story of their loss they could be observed constructing meaning and making sense of events, past and present: meaning, both of the life and death of the loved-one and sense-making of their own personal coping strategy. Whilst none of this detracted from the depth and intensity of their grief, it appeared to alleviate any complicating factors that could add to the emotional pain. Both clients employed strategies for a degree of emotional avoidance (Bonanno *et al*, 1995) which we did not see as maladaptive. These strategies included keeping busy, involvement in distracting activities, avoidance of physical reminders of the deceased and spending time with friends and family. While Shear and colleagues (2007) have characterised such avoidance as a feature of complicated grief, others have considered avoidance to be not necessarily maladaptive (Bonanno *et al*, 1995). Another study (van der Houwen *et al*, 2010) found that deliberately avoiding grief did not, as they had expected, mediate risk factors for complicated grief.

Both clients demonstrated a high level of self-awareness, including an understanding of their own psychological processes, a characteristic described as psychological mindedness (McCallum & Piper, 1996; McCallum *et al*, 2003). Both clients demonstrated resilience in their attitude to loss in that they demonstrated 'internal and external resources to help them to survive a challenging life experience' (Relf, Machin & Archer, 2010, p9). They were accepting of the reality, both of the loss and its emotional effects. Each had a sense of what they could and could not control in relation to their grief, and had begun to make sense of their loss (Machin, 2013; Relf, Machin & Archer, 2010).

Two cases where ongoing support was requested

Case 3

A year after husband Derek's death, Kate, aged 67 presented for assessment. Derek had been diagnosed with cancer three years earlier but the end was sudden and unexpected, such that when Paramedics failed to revive him, the house became a possible crime scene. A public holiday delayed the autopsy, and Kate felt 'left in limbo', adding, 'He wasn't mine for four days'. Cancer was the cause of death. Kate told the counsellor, 'I knew he was going to die, but not like this.' After surgery to remove a tumour, Derek had been told there was no need for chemotherapy. Only when cancer returned a year later was chemotherapy started. Kate believed that this was the wrong decision; 'I felt a year was wasted'. Kate regretted Derek's choice of chemotherapy right up to his death because it made him so ill. Although he may have died sooner without it, 'He could have been himself.'

Kate found it hard that Derek would talk neither about his illness nor his mortality, and would not ask how long he had left.

Even when things got very bad, Kate said 'He still wouldn't ask the question.'

Kate discussed her coping strategy. She had written the funeral eulogy and after a long delay had arranged a memorial plaque, which she said 'feels final'. Kate said that although she felt 'left stranded', she had many things to keep her busy for a time. Her son, 'took over and got rid' of the clothes', which was the right decision, and she had kept only one garment of sentimental value. Having a pet helped Kate. 'I talk to the dog about him. If I cry the dog licks my face, which gets me out of it.' Kate's daughter-in-law had been helpful in encouraging her to get on with life. Kate said that she did not cry in front of family members, that she bottled up her grief by keeping busy, and that her family perceived her as being strong. She had reluctantly agreed to this counselling assessment because she dreaded another winter without support.

A continuing bond (Klass, Silverman, & Nickman, 1996) with her husband had both positive and negative aspects. Kate smiled when she said that whenever she forgot a shopping item, she could hear her husband saying to her 'You should have made a list!' Against this, when each night she locked up the house, something her husband had always done, she felt alone.

There were aspects of unfinished business in Kate's continuing grief for Derek. She said that there were things she would have done very differently if she had known how her husband would die. His treatment had made Derek too ill for short holidays they had planned. Kate regretted not calling the doctor the day before Derek died, if only that this might have pre-empted the shock of the sudden death. She felt traumatised by trying to administer CPR, by watching the paramedics working on Derek, and by police officers asking her to leave the scene.

Kate viewed Derek's death in the context of an already difficult life. Her 16 year marriage to Derek followed a 25 year 'awful marriage'. In Derek she had found happiness. 'We had everything and it just got taken away and I feel so cross.'

Kate jumped from one subject to another, rather than in the ordered narrative presented here. In the assessment notes, the counsellor concluded that the client was self-aware but tended to bottle up her feelings. He suggested that counselling would mean that Kate did not have to remain alone in her confused and disordered state and she agreed to ongoing support

Two weeks later Kate met with a highly experienced bereavement supporter. She reported coping better since the assessment. She recognised her continuing anger, particularly with her husband's treatment in the last months of his life, but concluded that she needed no further professional help. A telephone call from her supporter two weeks later confirmed that she was indeed coping and needed no further support.

Clients like Kate may find themselves in a dilemma. Deliberate emotional avoidance may be a helpful strategy. However such avoidance strategies can be confounded by the confusion of disordered thoughts. Counselling can alleviate the confusion and help the client to find meaning, but it risks opening a Pandora's Box of helpfully avoided emotions.

We suggest that Kate chose a middle course. She used a counselling model of support sufficiently to make sense of events, while continuing on her chosen path of emotional avoidance. The door was left open for her to resume support should she need to but she did not do so in the year following her single support session.

Case 4

Mary, aged 38 was assessed five months after her mother's death from Alzheimer's disease. She and her three sisters had shared home care, but when residential care became the only option, Mary and her family relocated to be closer. Mary asserted, 'We are super strong, mum made us.' Mary coped well until the funeral after which her physician diagnosed anxiety, panic attacks and depression.

Mary recalled a sudden deterioration necessitating mother's hastily arranged 'unsatisfactory' residential care. After moving her to excellent facilities, Mary had neither regrets nor guilt, 'We did everything she would have wanted.' Unfortunately Mary's mother was attacked by another resident with dementia. Mary was upset by her mother's hospital treatment. On being denied access to her mother during a procedure, she had listened to her screams. Since the loss Mary had experienced panic attacks at the sound of an ambulance.

Another issue which continued to affect Mary was her mother's marriage to a psychologically abusive father and husband. In hindsight she recognised her father's mental illness. Mary believed that her mother had stayed in the marriage in order to keep the family together, never complaining and only leaving once her three daughters reached adulthood. Mother's self-sacrifice was rewarded with a demented and traumatic end. 'Finally mum was away from him and it could have been so much different [pause] so unfair'.

Mary explored other factors that were contributing to her grief, including an early miscarriage. Although she trusted nature and believed it was not meant to be, it was a planned pregnancy and she admitted that it 'adds to the mix'. She acknowledged the stress of home-based self-employment with a young family. 'When I'm working I'm really good, good at what I do and in control. Domestically, with the kids, that feels less in control and I'm scared. Why do I feel like this all the time? When will it stop and how do I make it stop?' Mary found it hard particularly when her husband was away from home, 'Being on your own is scary. Sometimes I feel overwhelmed. Am I going mad?'

Mary described herself as 'like a machine' when with her three young children. 'I can keep going but it's probably to my detriment.' On the positive side, she had, with her family's agreement, temporarily reduced the number of after-school club runs, taken up running for stress reduction, and the family were taking regular short breaks and holidays. Mary recognised her resilience. 'I know that I will be okay. I can't imagine that I will lose it'. She knew what she wanted from counselling, 'I just want to stop crying, stop reliving and thinking about things. Let

the past be the past and be fine.' She was already developing a new, symbolic relationship with her mother, 'I do talk to her, feel a sense of closeness. Better than in the state she was. Not suffering now, in a better place I can visualise'.

Mary appeared to display greater tension between emotional engagement and avoidance than the other case examples presented here. This tension has been described by Machin in her observations of grief as a need to control overwhelming emotions (Machin, 2013; Machin & Spall, 2004). Aspects of unfinished business Mary might explore in counselling included wondering if the stress of living with her father for so many years had triggered her mother's dementia. She was also curious, and perhaps anxious about what genes her father may have passed on. She believed she had closed the chapter on her father's behaviour by sitting outside the church during his funeral immersed in her emotional response. A few years earlier she had written the story of 'Dads craziness' to make sense of it.

In the assessment feedback the counsellor told Mary that he thought it very likely that ongoing support would be of benefit, and that it might help if Mary relaxed into her grief rather than struggling to control it.

A waiting list delayed Mary's counselling for three months. She presented very tearfully, saying that she was crying a lot and that she felt out of control. The second session followed a three-week holiday with her family, where she reported feeling fragile while she was away from home. The following week she told her counsellor that she was pregnant again. Although her husband was working away from home a lot of the time, she acknowledged the helpfulness of her support network. In the fourth session two weeks later, Mary announced to her counsellor that the family had employed a nanny to help with the children and as a result she was generally feeling better. Due to work commitments, Mary postponed session 5 for one month. In the fifth and final session her supporter reported that Mary looked really well. There was mutual agreement that counselling support could be successfully ended.

Case similarities and differences

Like the two clients who chose not to receive support Kate and Mary, both of whom opted for ongoing support, constructed meaning in order to make sense of their loss and their attitude to grief. Unlike the other clients, her assessment recording and transcript revealed Kate's disjointed narrative. Two weeks later she referred to the assessment when reporting her improved mood. We suggest that the opportunity to tell her story may have helped her meaning-making process.

Kate, Ted and Fiona could each successfully distract themselves from loss and grief, but this was not so easy for Mary. She demonstrated a tension between experiencing her grief and staying in control of her emotions, her motherhood role and her high-powered occupation. Initially this overwhelmed her and undermined her resilience. With bereavement support Mary was able to make sense of her situation and quickly establish a balanced coping style (Relf *et al*, 2010).

Discussion

Both resilient clients and those on a 'recovery' grief trajectory (Bonanno, 2004, p102) can experience complicating factors. For Kate these included concurrent grief for her mother, the juxtaposition of a previously difficult marriage with the happiness she had found in remarrying, her husband's denial of the inevitable outcome, the trauma surrounding the circumstances of the loss and her belief that time she and her husband could have shared was wasted on futile treatment. Yet for all these complications, Kate was able to use the assessment and one session of bereavement support soon afterwards, to gain sufficient resilience not to need further skilled intervention. Mary was also subjected to additional complicating factors. She had experienced a concurrent loss through miscarriage, she sometimes felt isolated when caring for her children during her husband's absences, and she struggled to make sense of the unfairness of her mother's dementia on top of a difficult life and marriage. In spite of these complications, five sessions of support with a skilled and experienced supporter were sufficient for Mary's needs. Kate and Mary are examples of clients inherently resilient yet who valued emotional and practical support in order to bolster this resilience. Kate used the assessment and support to find meaning and to validate her understandable anger. Mary used the opportunity to reflect on her loss and make practical changes to her domestic situation. We suggest that the in-depth assessment was of benefit in both cases.

... as we have become more attuned to the client's assimilation process, our interventions have become more focused towards facilitating the construction of new meaning.

Our means of assessment offers the opportunity for client and counsellor to explore the value or otherwise, of emotional avoidance. The natural tendency for grieving people to oscillate between loss and restoration (Stroebe & Schut, 1999; Stroebe & Schut, 2010) enables those grieving normally to find a balance between emotional confrontation and avoidance (Shear *et al*, 2007). Machin and her colleagues (Machin, 2013; Relf *et al*, 2010), suggests that resilience is fostered if the individual can balance the overwhelming reality of the loss with a measure of control. Part of the assessor's role is to determine when a client's emotional avoidance is a form of adaptive resilience. As client-centred practitioners we would suggest to a large measure trusting the client to find her or his own balance, whilst pointing out the risks of remaining static at either extreme of the acceptance/ avoidance oscillation.

To what extent can a client's choice to receive no further support be attributed to the single assessment session? As we have become more attuned to the clients assimilation process, our interventions have become more focused towards facilitating the construction of new meaning. An increasing number of clients are giving positive feedback on the value of the assessment session. In one recent assessment, a widow who was distressed by events that had occurred in her husband's final hours was able to reframe the experience and relinquish feelings of misplaced guilt. She concluded that as a direct result of this opportunity, ongoing support was not needed.

Limitations to the present study

Clients who give informed consent for research are more likely to be interested in the grief process, and hence are likely to be self-selecting in making effective use of counselling. Whilst not affecting the present case comparisons, it makes it difficult to make comparisons with clients who are less psychologically minded (McCallum & Piper, 1996) and hence may have less successful outcomes. Another limitation concerns the lack of follow-up of each client. In obtaining initial consent, no such arrangements were made, and to do so retrospectively was considered to be unethical. Future research will address this omission. However each client received a letter advising them that they could at any point contact the bereavement service again should they need to, and none of them have done so in the two years since being assessed.

Implications

Although our conclusions based on the four case studies described here must remain tentative, they are based on service appraisals over many years in which in-depth assessments are offered by the service. An assessment which includes a therapeutic element, and which helps the client to make sense of the loss can address the dilemma presented when clients on a normal grief trajectory seek specialist support. Working in this way offers a client-centred humane response and meets a perceived community need. It may also be an opportunity for clients to acquire resilience which will prevent future complications. It could be that in the long run, working in this way equips clients to cope without ongoing support; thus reducing waiting lists. More research into bereavement needs assessment is to be encouraged. It would be informative to compare both the bereavement support uptake and the individual grief trajectories following this way of assessing, with an approach that offers a more structured, symptomological focus to screening for risk. ■

Acknowledgements

The authors would like to thank the clients who generously allowed their assessments to be recorded and transcribed. Thanks also to the colleagues who have made suggestions in the development of the meaning-making matrix.

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