Introduction

There is something new to be chronicled every day. Grief is like a long valley, a winding valley where any bend may reveal a totally new landscape. As I've already noted, not every bend does. Sometimes the surprise is the opposite one; you are presented with exactly the same sort of country you thought you had left behind miles ago. That is when you wonder whether the valley isn’t a circular trench. But it isn’t. There are partial recurrences, but the sequence doesn’t repeat. (Lewis, 1961:47) (A Grief Observed by C.S. Lewis copyright © C.S. Lewis Pte. Ltd. 1961)

Lewis (1961) described in this word picture the often frighteningly unpredictable journey of grief. The metaphors he used provide a depth to his account of loss which go beyond the simple use of adjectives to describe his grief. His words – valley, landscape, trench – convey a sense of the vulnerability of the lone traveller making his way through exposed, unknown territory. His account of the valley as a circular trench, conjures up images of the physical conditions endured by soldiers in the First World War and the emotional disorientation of the experience. The terrain was unfamiliar, winding and with bends and the traveller was having to interpret what the aspects of the unfolding journey meant – revisiting the same place, feeling lost but recognising progress etc. Metaphor is often used by grieving people (Spall, Read and Chantry, 2001) as a way of ‘understanding and experiencing one kind of thing in terms of another’ (Lakoff and Johnson, 1980: 5). It generates a richness of conceptual language which captures multiple layers of meaning. This book will use the metaphor of journey to describe and explore the experience of grief. It elaborates on the metaphor by conceptualising theory as a ‘compass’ and a new practice model as a ‘map’. These are the tools needed by practitioners, as they become fellow travellers on the grief journey with their clients/patients.

Individual accounts of grief are heard in everyday life, in counselling/therapy and are also found in much autobiographical literature, both that which focuses upon loss and that which weaves within a larger life story an experience of loss or bereavement. Personal stories provide a rich source of knowledge about grief, which is distinct from
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the research-based theoretical literature on loss and bereavement. The two contribute to
different ways of understanding the nature of grief as an integral part of life experience.
One provides an account of the highly individual nature of grief and the other explores
and conceptualises the universality of grief (Rosenblatt, 1993). Stroebe, Stroebe and
Hansson (1993) believe that it is necessary to develop a coherent theory to bring
together these different ways of understanding and defining grief, in order for the uni-
versal and the individual to find a complementary place.

This book provides a new model and practice tool, which together propose a way of
integrating broad perspectives on loss and individual variations within it. The notion
of travelling with loss and mapping grief are introduced in this chapter through the
following themes:

• The social context of loss and grief.
• The broad spectrum of life losses – the landscape of loss.
• The theoretical background to grief and therapy – establishing theoretical bearings.
• A new practice model for understanding grief and a tool for its implementation – a
  compass and a map.
• Therapeutic ways of working with the Range of Response to Loss model and the Adult
  Attitude to Grief scale – the territory of loss and the journey through grief.
• Practitioner perspectives – travelling with grief.

The social context of loss and grief

It is important to give brief consideration to the social context in which loss and grief
occur within contemporary Western society. The experience of loss is influenced by the
ways in which society perceives of life and death issues and how it regulates grief. The
expression of grief has changed considerably over the last century. The First World War
transformed the overt mourning of the Victorian era to one in which expressions of
loss were suppressed. The pain of loss was subsumed within the greater national imper-
ative to express pride in the heroism of its young men and the need to sustain national
morale and patriotism. Individual grief was often suspended because of the absence of
a body. The stiff upper lip was a national response to the slaughter of a generation of
men. Private grief was replace by controlled public remembrance (Walter, 1999).

The need to ‘leave the dead behind’ was largely confirmed by the rising movements
in psychology, particularly the psychodynamic school (Freud, 1957) which saw
extended mourning as pathological (Walter, 1999). However, it has been in the evolving
sphere of psychotherapy that attention to the ‘continuing bond’ with the dead (Klass,
Silverman and Nickman, 1996) has been reasserted as desirable for the healthy adjust-
ment to bereavement. With the proliferation of counselling and psychotherapy, loss is
seen as a personal experience needing personal remedy, and emotion is seen as a com-
ponent of grief as acceptably present in men as women. The redefining of grief is
described by Walter (1999), as the ‘clinical lore of bereavement experts’. This clinical lore
has influenced a shift in perceptions about grief, and is powerfully exemplified in the
change – from soldiers at the beginning of the century being shot for cowardice, to
intense medical treatment and social compassion being afforded to modern-day soldiers traumatised by war. An understanding of the impact of traumatic loss has become widely integrated into the theory and practice of health and social care practitioners.

The change in how death and loss is seen has been accompanied by the rise in secularism and cultural diversity which has contributed to wide variations in expressions of public and private grief. Ritual may vary from traditional public rites to personally constructed ceremony to mark death or other life-changing loss. In the spirit of the postmodern era what is individually meaningful has become more important than what can collectively be demonstrated. However, finding individual meaning may generate a personal sense of ambiguity or ambivalence, as old certainties are swept into a tide of social change (Machin, 1998).

The interface between scientific/medical advances and life and death perspectives impact upon political judgements and private attitudes. Fast-changing ethical concerns shape the context in which contemporary life and death takes place:

- The possibilities for creating life – IVF, selecting embryos for their value, for example, one life to save another, cloning, etc.
- The possibilities for extending life – experimental life-saving surgery and medicine, transplant surgery (including stem cell transplants), hi-tech life-support machines, etc.
- The possibilities for ending life – abortion, switching off life-support machines, euthanasia, etc.

Dilemmas are produced when the state of knowledge outstrips the capacity to manage the social and legislative consequences of new life and death possibilities. For many people medical longevity is not met with adequate care provision and continued social inclusion but results in ‘social death’ (Mulkay, 1993).

Perceptions and understanding about life and death issues reflect the social climate in which they take place. Often the influence of contemporary psychological, social and ethical perspectives may be unconsciously or unreflectively absorbed into our thinking. If we are to understand the nature of loss experience(s) for those who seek support we need to recognise the centrality of these contextual factors.

The landscape of loss

Chapter 2 sets out the diverse situations in which loss might be experienced. Equating grief with death and bereavement often obscures the reality that multiple losses are experienced across the life cycle. Those most readily overlooked are the losses which come with developmental change – starting school, leaving school, moving house, retirement, etc., which may be so absorbed into the fabric of day-to-day life that the impact may hardly be noticed (Sugarman, 2001). However, some of these ‘little’ losses are rehearsals for more profound encounters with loss and provide a strengthening of the emotional and cognitive capacities for dealing with grief. The coping demands will be more forcefully tested when relationships or health are damaged or disintegrate, and where deeply held aspirations are thwarted, or unexpected or traumatic death occurs. Where the internal resources and external sources of support are inadequate for the
meeting of loss, vulnerability will result (Folkman, 2001; Lazarus and Folkman, 1984). Recognising loss and the vulnerability it may produce is central to the agendas encountered in health and social care.

Within the broad range of loss experiences, the sensitive and expert involvement of practitioners is required at various stages in the grief journey (see Figure 1.1):

A – Practitioner engagement in anticipation of a loss, for example, supporting people making choices about placing a child for adoption, preparing for an abortion, pre-bereavement support, etc.

B – Breaking bad news or discussing emerging life-changing events/circumstances, such as imparting a medical diagnosis where there will be a poor outcome, emergency services informing people of serious accidents and deaths, etc.

C – Giving support during the process of loss, for example, support for people with a chronic disability who are physically/mentally deteriorating, providing palliative care for the dying, etc.

D – Retrospective support, for example, as the result of abuse, following the break up of a relationship, following a bereavement, etc.

A knowledge and skill base are essential for the challenges faced by practitioners in this demanding work.

The theoretical background to grief and therapy – establishing theoretical bearings

Theory provides a conceptual background for understanding loss as part of psychosocial development, for recognising the characteristics of grief, and for defining practice approaches for engagement with loss. The acquisition of psychosocial competence for dealing with life’s losses is undertaken from birth. Erikson’s account of life span development (1980), described in Chapter 2, explores the interface between the individual and his/her social world. He saw maturation as a sequential process in which there were biological and social challenges to be met, in order to move from the dependence of infancy to a fully functioning, autonomous adult. Erikson’s theory has remained influential along with
others such as Havinghurst (1972), Levinson et al. (1978), Reese and Smyer (1983), who have used a life-course perspective to understand human developmental social psychology.

Chapter 3 looks at how early experience of positive nurturing provides the psychological and social basis for the development of well-being and competence in coping with life changes and losses. Foremost among the theories which have made the link between psychosocial development and loss response, is Bowlby’s Attachment Theory (1980). This theory has been foundational in the study of relationships, in defining the quality of human attachment, and in accounting for the consequent reactions to separation and loss. The work begun by Bowlby, was taken up by his colleagues, who refined his concepts with further empirical evidence about the nature of styles of attachment (Ainsworth et al., 1978).

Contemporary theorists have moved the focus to adult attachment (Hazan and Shaver, 1987) and are particularly interested in how far early attachment styles are enduring traits, and how far they are properties of individuals or of relationships. Bartholomew (1990) and Bartholomew and Horowitz (1991) have developed a framework for categorising four adult attachment styles. These attachment styles are based on the Bowlbian concept of the ‘internal working model’, a model carried internally as a representation of what has been learned about the interaction between self and others. The four elements consist of secure, preoccupied, dismissing and fearful attachment, and are characterised by the varied combination of positive and negative self-view and other-view. The quality of adult attachments has significance for understanding the nature of lost and severed adult relationships.

Theories of psychosocial development and attachment form the background against which concepts of grief have developed. The characteristics of grief, particularly as they relate to bereavement, have emerged from Bowlby’s work, along with other field-leading colleagues like Parkes (1996), who have contributed hugely to the literature on loss. Students of grief and bereavement are familiar with the defining symptoms associated with grief – denial, despair, guilt, anger, hopelessness, etc., which have been embedded within a structure for understanding the processes of grief. The stage and phase models of grief (Bowlby, 1980; Kubler-Ross, 1970; Parkes, 1996) have been very influential in shaping practice. However, the intention of these theorists was never to make grief formulaic or prescriptive (Parkes, 2001), but the reality is that many practitioners have applied their work with disregard for the individuality of grief and its fluctuating timetable. The importance of this extensively researched elucidation of the nature of grief should not be overshadowed by its misapplication.

Classical grief theory based on Freudian concepts had been predicated on the belief that grief was a process of disengagement, from the deceased, and that severing bonds was indicative of readiness to form new attachments. A gradual recognition that this perspective was an inaccurate reflection of the true nature of grief and unhelpful to practice eventually found recognition with the publication of the book, Continuing Bonds (Klass, Silverman and Nickman, 1996). The sense of continuity both through memory and through a revised inner representation of the deceased (or person or thing which has been lost) becomes a process of reconciling the past with the present for the future. Many non-Western cultures demonstrate the significance of this continuity through their religious beliefs and rituals (Irish, Lundquist and Nelsen, 1993; Klass, 1999).
The notion that a satisfactory outcome in loss or bereavement depends fundamentally upon the emotional expression of grief was implied within the psychodynamic tradition and was a perspective carried into practice. This concept of ‘grief work’ was challenged by Wortman and Silver (1989) and by Stroebe (1992–93). A significant new theoretical perspective, the Dual Process Model of grief, emerged from the research, which sought to test the validity of the grief work hypotheses (Stroebe and Schut, 1999). Stroebe et al. proposed that adaptation to grief consists of a two dimensional process: loss orientation and restoration orientation. The former attends to the distress of grief and the latter focuses upon diversion from it and attention to ongoing life demands. Successful movement, oscillation, between these two grief modes is necessary for successful adaptation to loss. Giving theoretical recognition to the restoration aspect of grief alongside a focus on traditional grief work, not only addresses the multidimensional nature of grief but also makes visible the variable ways in which individuals may respond to it.

Taking a multidimensional view of grief also means that responses to loss which were previously regarded as pathological or abnormal, now fall within a spectrum of normality. Using culture as a lens for viewing grief also gives recognition to the ways in which symptoms and intensity of grief will be variably understood in different cultures and communities (Rosenblatt, 2001). The shift in perspective, which previously made clear distinctions between normal and pathological grief, should be fully understood and recognised as a way of embracing diversity. Nevertheless, persistent grief remains a clinically identifiable condition which may result from unresolved loss issues and/or an ongoing life grief, such as a long-term disability. Roos (2002) describes this as chronic sorrow. The new ways of defining and understanding ‘problematic’ grief have significant implications for practice in health and social care settings.

Having explored the background theories of grief, Chapter 3 examines those concepts which look at the process of adjustment to loss. Worden (2003) has influenced practitioners working with grief since his book on *Grief Counselling and Grief Therapy* was first published in 1983. It has been revised in the light of new theoretical perspectives and in Chapter 3 the tasks of mourning are integrated within the conceptual frame of the Dual Process Model of grief and Continuing Bonds theory.

Theories of intervention (counselling/therapy) are explored in Chapter 4. Fundamental to all counselling/therapy is the creation of a safe base within which the client/patient can disclose his/her concerns and feel free to explore new ways of understanding their troubled situation. Attachment Theory identifies the conditions which promote security (Holmes, 1993) and a person-centred approach to counselling/therapy (Rogers 1961; 1980), provides the principles for the acceptance and valuing of people, which is crucial to engagement with individual grief.

Stories are the means of communicating the nature of distress felt by clients/patients. Angus, Levitt and Hardke (1994) suggest that the narrative heard in therapy consists of three elements – the external narrative, the internal narrative and the reflexive narrative. It is a structure which, when working with grief, identifies what has been lost and how (external narrative), its impact upon the teller (internal narrative) and the emerging therapeutic process of making sense of experience (reflexive narrative). The role of the practitioner is to facilitate the telling of the story of loss (construction), to assist in the
exploration of the story (deconstruction), and to work towards the 'reconstruction' of the story which has a sustaining meaning for the client/patient (McLeod, 1997). This narrative approach will be used as the basis for exploring the case studies used in Chapters 7, 8 and 9.

A number of therapeutic approaches are pertinent to the process of reconstruction, that is, moving to an acceptance of reality and finding more satisfying ways of understanding the experience of loss. Recognising differences in grieving style (Martin and Doka, 2000; Nolen-Hoeksema and Larson, 1999) is an essential starting point when considering the most appropriate therapeutic focus. Schut et al. (1997) found that countering the usual (gender biased) grief response in therapy was beneficial, that is, men gained from emotion-orientated interventions, while women gained from problem-focused interventions. Consistent with this perspective, Martin and Doka (2000) propose a therapeutic objective in which intuitive grievers are helped to a cognitive and active approach to their loss while instrumental grievers are confronted by their feelings. They conclude that ‘those with the widest range of adaptive strategies are best able to surmount crises’ (Martin and Doka, 2000: 144).

Achieving a wide range of adaptive strategies, is likely to begin with the exploration of significant relationships; relationships which may have been lost or damaged and relationships which are necessary, and may or may not be available, for the support of a client/patient. Attachment Theory can be helpful in suggesting the relationship factors which have produced individual security or insecurity. In looking more closely at the nature of communication within relationships, Transactional Analysis can provide a framework for identifying effective or destructive interactions (Berne, 1961; 1964; 1975). Care of grieving people needs to address the way in which clients/patients are thinking about the losses in their lives. This aspect is sometimes forgotten within the dominant grief-work perspective, which has traditionally attended more to feelings than thinking. Cognitive and cognitive/behavioural approaches to grief focus on mastering new situations and re-appraising changed life situations (Beck, 1976; Ellis, 1962, 1989). The approach to meaning-making developed by Frankl (1959) is concerned with the transformation of perspectives, from tragedy to triumph, and is explored as part of the reflexive narrative which seeks to reconstruct a story which can be 'lived by and lived with' (McLeod, 1997: 86).

While Chapter 4 predominantly focuses upon counselling theory and therapeutic engagement with grief, the principles of person-centred sensitivity and careful attention to the story of loss, can also be applied by those people whose role is not primarily therapeutic.

A new practice model for understanding grief and a tool for its implementation – a compass and a map

Chapters 2, 3 and 4 form a background to the introduction of a new model for understanding and working with grief, described in Chapter 5. The model and the approach...
to practice which flow from it are described in Chapter 6 and constitute the central themes of the book.

Listening to accounts of loss, heard in counselling practice and in research, lead me to a greater understanding of the highly individual nature of grief but it also drew my attention to three broadly different loss reactions (Machin, 1980; 2001). This observable pattern was contained within three kinds of discourse:

1. A deeply distressed discourse where grief is experienced as overwhelming.
2. A balanced account of grief, where emotions are accepted and faced, and the practical consequences of loss approached with realism and a sense of agency - a balanced/resilient reaction.
3. A discourse dominated by the need to suppress emotions and remain focused on ongoing life demands - a controlled reaction.

The categories of difference were conceptualised in the language heard in practice - ‘I feel overwhelmed’, ‘I need to be back in control’, ‘I can (want to) feel able to balance all that’s going on (as a result of the loss)’. These grief reactions were incorporated into a framework – the Range of Response to Loss model – which identified the socially constructed perspectives likely to produce the proposed categorical variations in loss responses. The model also suggested how these influential social constructs might lead to identifiably different personal perceptions about loss as experienced by self and by others.

Exploring the validity of the notions proposed in the RRL model was undertaken in two ways. First, by looking for conceptual consistency with other theoretical propositions. The ideas did clearly resonate with other key theories, significantly with Attachment Theory (Ainsworth et al., 1978; Bowlby, 1980) and the contemporary Dual Process Model of grief (Stroebe and Schut, 1999). The categories in the RRL model equated well with descriptions of attachment style: overwhelmed with anxious/ambivalent attachment, controlled with avoidant attachment, and balanced/resilient with secure attachment. Similarly with the Dual Process Model of grief there were echoes between overwhelmed responses and loss orientation, controlled responses and restoration orientation, and balanced/resilient responses, represented by the capacity to oscillate between these two grieving modes.

Comparison with other theories provided some justification for the concepts in the RRL model but research was undertaken as a second form of validation. An attitude scale was devised to explore the grief perspectives of a sample of bereaved people seeking counselling support (Machin, 2001). The scale, the Adult Attitude to Grief scale, consists of nine self-report statements, which reflect three perspectives for each of the three categories in the model (see Appendix 1). Along with questions about past experiences of loss, the current bereavement, and a number of psychometric tests (Beck Depression Inventory, Beck et al., 1961; Impact of Events scale, Horowitz, Wilner and Alvarez 1979; and Leiden Detachment Scale, Cleiren 1991), the AAG scale was statistically analysed. Factor analyses indicated that the AAG scale provided a good measure of the three categories proposed in the RRL model. However, the 2001 study demonstrated that the differences could most appropriately be applied to understanding the diverse reactions, that is, the blend of overwhelmed, controlled, balanced...
responses taking place within individuals, rather than as a simple account of categorical
difference between people. This suggested that the AAG scale might be used within
practice as a measure to access and gain understanding about the complexity of individual loss experiences and perspectives.

Further study to test this proposition supported the use of the AAG scale in practice settings (Machin, 2007a; Machin and Spall, 2004). The AAG scale was used effectively as a measure of assessment, as a tool for the exploration of the grief dynamic, as a cue for therapeutic dialogue and as a measure of change. Both clients and practitioners affirmed its face validity as a tool pertinent to the therapeutic focus on grief and as a measure readily integrated into the wider practice repertoire.

Chapter 6 explores in more detail the components of grief described in the RRL model. Overwhelmed and controlled reactions are seen as core elements of grief. They represent the emotional and cognitive tension prompted by an experience of loss. The capacity to manage this tension is reflected in the responses to the balanced/resilient items on the AAG scale. Agreement with the balanced/resilient items, reflects the resourcefulness necessary to manage grief, and disagreement implies vulnerability. Vulnerability, therefore, represents a position at the opposite end of the coping spectrum to resilience. The intersection between the core grief states (overwhelmed and controlled) and the mediating factors (resilience and vulnerability) is viewed as a theoretical compass for understanding the grief dynamic (see Figure 1.2).

In listening to the story of loss, the practitioner can begin to identify the detailed characteristics of their client’s/patient’s grief (O/C) and gauge the level of resilience or vulnerability (R/V) (see Figure 1.3). Distress alone is not a measure of vulnerability. It is important to distinguish between temporary overwhelming feelings (O/R) and distress which persists and is symptomatic of an inability to accept the loss and its consequences (O/V). Similarly, control may be used effectively to counter the powerlessness of grief (C/R) or it may be an anxious and ineffective struggle to master overwhelming distress (C/V). For the practitioner the RRL model provides a structure for appraising the client’s/patient’s grief reaction, and gives a focus to the helping process by indicating the desired direction of change from vulnerability to resilience.
A second innovative area of practice is where the AAG scale is used as a specific clinical 'mapping' tool (Machin 2005/6/7). The quantitative aspects of the scale and the qualitative themes, which arise from it, form the first four steps of a six-step practice protocol. Client/patient responses to the nine items on the scale reveal the complex individual variability in grief and its change over time. The wider social context of a client's/patient's grief is explored in the fifth step, as a way of understanding the influences which shape grief perspectives and in order to appreciate the level of available support, or lack of it. Step six uses the individual grief ‘map’ to consider which therapeutic route should be taken to restore a sense of balance/resilience. This includes a cognitive approach to restoring a sense of agency, that is, encouraging the client to think and make decisions about ways in which they can be empowered to think and act outside the emotional distress generated by grief. Alternatively, for those people whose controlling instinct is proving ineffective in regulating their grief, a person-centred approach provides the possibility for the safe exploration of damaging early experience (a psychodynamic perspective) and cultivates opportunity for the development of trust and self-worth. Identifying painful emotions and thinking about new life perspectives (cognitive perspective) can be undertaken in a climate of acceptance.

Therapeutic ways of working with the RRL model and AAG scale – the territory of loss and the journey through grief

Chapters 7, 8 and 9 each provide detailed case examples (names and identifying features have been changed) to demonstrate the application of the RRL model and the AAG scale. Chapter 7 focuses on the essential characteristics of the grief story brought to counselling/therapy by looking at the external narrative – what happened, and the internal narrative – the impact on the narrator. In listening to the initial account of loss, the primary therapeutic approach is person centred, in which the client/patient is heard, accepted and understood (Howe, 1993). This provides the climate in which the loss
story can be developed (‘construction’) and sensitive exploration (‘deconstruction’) can take place. In Chapter 8, the focus is on the nurturing and promotion of resilience which occurs as client and counsellor explore the loss narrative through the reflexive process. Increasing the capacity to function with resilience is seen as the goal of therapy (Machin, 2007b). Chapter 9 examines more complex grief reactions and the vulnerability this produces. The limitations which this puts upon the practitioner needs to be recognised and more restricted therapeutic goals may have to be set. Table 1.1 shows how the dimensions of grief described in the RRL model are applied to the narrative structure, and suggests the range of therapeutic approaches which might be used to facilitate the process for achieving a more satisfying narrative outcome for the client/patient (McLeod, 1997).

**Practitioner perspectives – travelling with grief**

This book in focusing on loss, and providing a theoretical concept and a tool which can be taken into practice, attempts to make that process of engagement with grief one that can readily be undertaken by a wide range of practitioners. The roles in health and social care are variable but the demands of working with another’s grief is potentially challenging at all practice levels. Openness to a client’s/patient’s emotional pain can be a reminder of personally experienced losses, or generate anxiety about what life might hold in the future. Achieving a balance between being the objective ‘professional’ and a subjective human being is central to providing useful and sensitive care to grieving people. This is only possible where the value put on those who seek care is matched by recognition of the need for practitioner support, and by putting in place strategies to sustain resourcefulness. Good collaborative team work embedded in supportive supervision is essential to the maintenance of good practice. A restoring balance of relationships and activities outside work, are vital for practitioners to function with resilience.
Conclusion

Loss is not always recognised as central to the fabric of human experience. Theories of grief, therefore, have majored in their focus on indisputable life losses – death, dying and bereavement. While the application of these theories to all other losses might not be appropriate (Sapey, 2002), they are broadly pertinent to an understanding of loss and change. Chapter 3 explores how theoretical perspectives on grief have evolved during the twentieth century. However, the growth in research-based knowledge has not been matched by methods for putting theory into practice. This book seeks to make a clear connection between theory and practice by providing a new practice-generated theory (Machin, 2005), conceptualised as the Range of Response to Loss model and a tool, the Adult Attitude to Grief scale, to operationalise the notions contained within the model.

The book provides practitioners with a way of looking at the nature of loss across the life cycle and identifying ways in which support might be given to those who are grieving. The valley of grief, spoken of by Lewis, is a route which can be undertaken with courage and optimism, when the innate ability for healing is recognised and the nurturing care of others is available. The role of practitioners in health and social care plays a crucial part in supporting travellers on this journey.