Hope, counselling and complicated bereavement reactions

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INTRODUCTION

Psychiatric nursing and counselling literature contain a growing number of references to hope. The concept is gaining recognition with respect to its centrality, therapeutic potential and importance in an individual’s life. This is particularly evident in the domain of psychological health and well being. Psychiatric nursing is fundamentally concerned with people and their needs (Peplau 1988), and nursing theory relates to understanding the person’s world and all that effects it (Denzin & Lincoln 1994). Additionally, effective use of counselling skills is seen as an integral component of psychiatric nurse practice (Haber et al. 1982, Rawlins et al. 1993, Cutcliffe 1997b). It is therefore logical to examine, critique and understand the function, impact and influence of hope within the individual who experiences psychiatric nursing care in the form of counselling. Furthermore, there is evidence to
suggest that certain conditions or states of being, which some individuals endure, may be synonymous with a sense of hopelessness. The author postulates that one such state is that of complicated or unresolved bereavement (Parkes 1972, Kubler-Ross 1970, Worden 1988, Lendrum & Syme 1992). However, despite this possible relationship there is a dearth of exploration into how the concepts relate to each other and interact in practice. Therefore this paper examines the relationship between hope and complicated bereavement, and then considers if current bereavement counselling theory addresses this issue.

A BRIEF OVERVIEW OF HOPE

In terms of Christian theology, hope has existed almost as long as man (Cutcliffe 1997a, Lynch 1965). Hope can be viewed as a basic, fundamental, integral part of living (Lynch 1965, Fromm 1968, Mcgee 1984, Hinds 1984, Miller 1989, Herth 1990). Blackham (1986) describes how Marcel saw hope as central and the human soul existing by hope. Hope is concerned with the future. To have hope is to consider the future. It is an expectation, a wish (Lynch 1965, Stotland 1969). Hope is not static, it is dynamic (Herth 1990). Not only do levels of personal hope fluctuate in response to internal and external demands, but the nature of what one hopes for changes throughout life (Farran et al. 1990) and the very process of hoping is dynamic. It begins as an unconscious process and develops into a subconscious process (Snyder 1996, Cutcliffe 1997a). Hope is a holistic or multi-dimensional phenomenon, with each related view of hope involving the multi-dimensional impact and/or influence of hope on the person (From 1968, Vaillot 1970, Stephenson 1991). Hope is viewed as related to help (Lynch 1965) and seeking for and depending upon help (DuFault & Martocchio 1985).

Whilst individuals can maintain their own level of hope to a certain extent, this cannot continue indefinitely. Furthermore, as nursing is inseparable from the action of providing help, nurses play a pivotal role in promoting hope in their clients (Cutcliffe 1996). Hope is interwoven with caring (Vaillot 1970, Benner 1984, Benner & Wrubel 1989, Cutcliffe 1997a). Inspiring hope and caring for clients are subtle, unobtrusive processes. The presence of another human being who demonstrates acceptance, tolerance and understanding is entering into caring practice and simultaneously inspiring hope. Hope has been defined as:

a multi-dimensional, dynamic, empowering state of being, that is central to life, related to external help and caring, oriented towards the future and highly personalised to each individual. (Cutcliffe 1997a)

BEREAVEMENT AND LOSS

Within a person’s life there will be many varied experiences of loss, but individual’s responses to loss and bereavement will be dissimilar to one another. Grief as a result of a bereavement may be strong or weak, prolonged or brief, immediate or delayed (Parkes 1972). However, whilst such a broad spectrum of experience exists there are many commonalities in people’s reactions to bereavement. Various authors have researched the phenomenon of bereavement and several offer theoretical frameworks of the commonalities.

Kubler-Ross (1970) suggests that bereavement can be thought of as a process with distinct stages. The individual needs to progress through these stages in order to come to a state of resolution and re-investment. Kubler-Ross (1970) acknowledges that these stages need not necessarily occur sequentially, indeed this view of grieving in stages may well be simplistic, the danger being that a person’s deviation away from the described stages could then be viewed as maladaptive. Parkes (1972) identifies six key processes of bereavement reactions: alarm, searching, mitigation, anger, guilt and gaining a new identity. Furthermore he describes bereavement as a series of clinical pictures which blend into and replace one another. Importantly Parkes (1972 p.27) goes on to say that each of these clinical pictures has its own characteristics. Even though there are considerable differences from person to person, he states:

Nevertheless, there is a common pattern whose features can be observed... and this justifies our regarding grief as a distinct psychological process.

Lendrum and Syme (1992), Bowlby (1980) and Raphael (1983) support this argument, suggesting that early histories of each person, and subsequent experiences of separation, affect the adult’s response to loss, which produces a wide variety of responses to bereavement. However this wide variety of responses lies on a spectrum with a common fundamental pattern. They too identify stages of bereavement and mourning and again state that a person does not necessarily move through these stages in a linear fashion. The boundaries between each phase are blurred, they overlap. The feelings associated with one phase are sometimes experienced in another phase. Furthermore they state that the way in which these phases are experienced is different for each individual. Yet the fact that they have identified specific stages strongly suggests that there are commonalities within the highly individualized experiences.

There is one commonality that is predominant in the literature on bereavement. That is, in order for the individuals to have completed their grieving, they need to reach a state of ‘peace’, to achieve a resolution, and experience a degree of acceptance. Recent studies further support this argument, but additionally suggest that the final outcome of bereavement is not always a favourable one (Prigerson et al. 1995). Some bereaved individuals do not achieve resolution or reach a state of peace. This raises
questions as to what makes the difference, and is there a defining characteristic that separates those individuals who resolve their bereavement from those individuals who do not? Inextricably bound up in this completed bereavement is the re-emergence of hope (Kubler-Ross 1970, Parkes 1972, Parkes and Weiss 1983, Worden 1988). There is a sense of the individual moving from a position of hopelessness and despair into a position of hopefulness. However this re-emergence of hope is not often explicitly referred to in the literature. It is argued here that it is this relationship between hopelessness/hope and the resolution of a bereavement that requires closer examination.

BEREAVEMENT COUNSELLING

Complicated grief

People’s reaction to their bereavement experience is as individual as the uniqueness of the person themselves. What one culture regards as a maladaptive reaction may be perfectly reasonable to another culture and furthermore there is no single, general, universally accepted theoretical perspective on the phenomena of grief and bereavement (Carter 1989).

However, despite this diversity of experience there appear to be two distinct types of grief reaction. Worden (1988), Lendrum and Syme (1992), Kim and Jacobs (1991) and Glick et al. (1974) all identify a difference between help needed in a normal (uncomplicated) reaction and help needed in an unresolved (complicated) reaction. There are those that resolve or work through their grief experience to a state of peace and then there are those who experience a complicated grief reaction (Marwitt 1991, Kim & Jacobs 1991). Despite this distinction there is, at present, no universally accepted definition or description of what constitutes complicated grief (Prigerson et al. 1995). The difficulty arises from the substantially different cultural and individual reactions and variations that people demonstrate when adjusting to a bereavement experience. Crucially, complicated grief differs from uncomplicated grief in that it is not a self-limiting process (Zisook & DeVaul 1983).

Complicated grief can be viewed as the failure to return to the individual’s pre-bereavement level of emotional well-being, performance or level of hope. Complicated grief means that for some individuals emotional, behavioural and spiritual dysfunction persists. Various authors (Parkes 1965, Parkes & Brown 1972, Bowlby 1980, Raphael 1983) all identify specific symptoms or manifestations that are indicative of complicated grief, such as a disbelief about the death and not accepting the reality of the death, prolonged searching and yearning, preoccupation with thoughts about the deceased, and numbness. Furthermore, recent attempts to differentiate between complicated grief and other affective depressive disorders begin to identify another specific manifestation, i.e. hopelessness (Prigerson et al. 1995).

Hopelessness, or despair, mirrors a complicated grief reaction in the absence of any self-limiting process. If hopelessness goes unchecked, this will only lead to the perpetuation of the hopelessness state. Similarly, complicated grief reactions do not usually resolve themselves without intervention from an outside source of help (Worden 1988). Hopelessness begets hopelessness, just as an unresolved grief reaction is self-perpetuating. Individuals will experience the world according to their current emotional well-being: bleak, pointless, empty and in particular hopeless. A complicated grief reaction then will contain an element of hopelessness, and it is therefore worth examining if the current theory supporting bereavement therapy and describing individual’s experience of complicated grief reactions include the presence and influence of hope/hopelessness.

Theories of bereavement counselling

Worden (1988) describes a theory of bereavement counselling where individuals need to accomplish tasks. Just as the experience of bereavement can be seen as a process, so too can bereavement counselling, with the process being the accomplishment of each of these tasks. Worden’s (1985) four tasks are described as follows:

Task one

Bereft individuals need to come face to face with the fact that their loved one will not be coming back. Denial and bargaining are common dynamics of bereavement (Kubler-Ross 1970). There is often a sense of disbelief. Bowlby (1980) writes of individuals searching, seeking desperately to achieve consolation. The reality of the loss is too painful to face. Hence the first task is to encourage acceptance of their loss at not only an intellectual, but also at an emotional and spiritual level. Bereaved people may move in and out of the dimensions of acceptance, appearing to fully accept the loss at one moment, and yet the next behaving irrationally.

Task two

To achieve this task the clients need to acknowledge their pain and work through it. It can be described as experiencing the grief. A cathartic process, or discharge of pain needs to occur otherwise it will eventually manifest itself in some symptom or aberrant behaviour. Worden argues that it is impossible to lose someone you have been deeply attached to without experiencing some level of pain. Unless the pain is released, then no resolution of the grief experience will happen.

Task three

This task involves coming to terms with such factors as living alone, caring for one’s family alone, dealing with
everyday activities of life by oneself. At the same time the clients may have to take on new roles, roles once occupied by the deceased. Paradoxically, one strategy is to redefine the loss in such a way that the survivors can view it as benefiting them, by providing them with new skills or responsibilities and Worden suggests that this process is often indicative of a successful completion of task three. Similarly, the clients will have to adjust to a new sense of self. Their identity changes considerably with their loss, necessitating a re-appraisal of their self-image as they begin to take on new ways of dealing with and being in the world. Furthermore, the loss may force the clients into an adjustment of how they view the world. Death of loved one may challenge beliefs and philosophies and this change also needs to be adjusted to.

**Task four**
In this task the clients need to find an appropriate place for the deceased in their emotional lives. Not to forget or discard but to make room for others, placing the deceased in a place that will enable the clients to go on living effectively in the world. It is more a case of relocation than of emotional withdrawal. Worden suggests that task four is often the most difficult to accomplish. Yet the bereavement can be considered to be complete when the clients can think of the deceased without pain (Worden 1988). The sense of sadness may never disappear completely, but lack the intensity and debilitating effect that it once had. Worden (1988 p. 18) makes further remarks suggesting that ‘mourning is finished when a person can reinvest his or her emotions back into life and in the living’.


**Emancipation of the bereaved from bondage to the deceased**
This element is concerned with the bereft individual processing any unresolved issues related to the deceased. The person needs to experience a sense of freedom from the deceased. It is concerned with establishing an identity as a single person. There may well be a need to learn new skills, especially skills pertaining to those activities that the deceased was responsible for.

**Readjustment to an altered environment**
This element is concerned with the bereft individual participating in activities that were once shared and enjoyed, and also discovering new activities. There may be a need to engage in very specific activities that have been avoided (for example cooking the favourite meal of the deceased). There is also the requirement for the bereft person to fill the time which would have been spent with the deceased with constructive activity.

**Development of a new or renewed relationship**
This element is concerned with the bereft individual developing of renewing meaningful relationships. It is not suggesting that the bereft individual needs to find another partner. It is a more concerned with the individual being able to enter fully into relationships and being able to trust others again. There may well also be a renewal of any specific religious beliefs that the loss of their loved one has challenged. Furthermore, the loss of their loved one is integrated into the religious belief system and given meaning. For example, the bereft individual who holds Christian beliefs, believes that the deceased has gone to a better place, to heaven. In support of this model, Snyder (1996) suggests tentatively that as this new relationship becomes the object of the bereft person’s attention, there is a renewal of hope.

**Learning to live with memories of hurt, happiness, suffering, and joys associated with the deceased, without experiencing discomfort**
This element is concerned with the bereft individual saying goodbye to the deceased. It is not about forgetting, it is more concerned with treasuring but not living in memories. It allows the bereaved to remember pleasures while not forgetting disappointments.

Lendrum and Syme (1992) describe a theory of bereavement counselling that is less concerned with specific tasks of bereavement, but more with certain processes and dynamics.

**Process one**
Lendrum and Syme (1992) argue that a bereavement counsellor has to have certain attitudes, including care, empathy, genuineness and non-judgemental acceptance. The counsellor who has these attitudes enables the client to talk, to stop fearing and condemning feelings, and to accept the loss and experience the grief. These attitudes clearly have their origins in the core qualities of humanistic psychotherapy (Rogers 1952) and are applicable to any counselling situation (Carkhuff & Traux 1965). However, Lendrum and Syme (1992) suggest that having these attitudes or core qualities is particularly important within bereavement counselling due to the highly individualized nature of loss.

**Process two**
The second process Lendrum & Syme (1992) describe is the conveying of these attitudes by means of responding skills. It is not enough for the attitudes to be present, they have to be conveyed by responses. Connor (1994) supports this argument, illustrating that the presence of the quality of empathy in the counsellor is insufficient, the quality must be communicated. Egan (1994) also describes the communication component of healing attitudes, suggest-
ing expressing primary level empathy is concerned with communicating initial basic understanding. The duality of empathy is further supported by Gladstein (1983) who states that empathy has two components, affective (or feeling) and cognitive (role taking). With the affective component being akin to the quality of empathy and the cognitive component being akin to the skills/communication of empathy.

Process three
In this process the counsellor attempts to identify the specific patterns of defence that the client uses in order to avoid the pain of the loss. These defence mechanisms being protection against intimacy, protection against feelings, and suicidal thoughts as a fantasy of relief from pain. Once the counsellor has identified these defences, the counsellor makes attempts to confront them. With a supportive underpinning, the counsellor points out these blind spots (Heron 1990) in an attempt to raise them into the consciousness of the client. This creates a new awareness and enables the blind spots to be addressed.

HOPE INSPIRATION WITHIN BEREAVEMENT COUNSELLING

Worden’s (1988) ‘task one’ involves creating an environment where the client can begin to vent painful emotions. This appears very similar to the cathartic atmosphere generated by the counsellor conveying the Rogerian core qualities in any person-centred counselling (Rogers 1952). Furthermore, Lendrum and Syme (1992) highlight the importance of creating such an environment during the first process of bereavement counselling. Given the importance of creating such an environment, it is worth considering if the process of attachment and the Rogerian core qualities would not be too dissimilar from having one’s individual worth affirmed by a genuinely caring individual. Indeed is this not the very point of conveying the Rogerian core qualities?

In order that identification and challenge of the many varied defence mechanisms that prevent cathartic release can occur, the counsellor again needs to create an environment where such discharging of painful emotions can take place. Bowlby (1980 p. 158) supports this need for catharsis, suggesting ‘sooner or later, some of those who avoid conscious grieving, break down’.

If a client is going to take risks and access their pain, then that will only occur if the therapeutic climate is caring, supportive and safe.

Martocchio (1985) suggests the goals of grieving are to remember the loved one without major emotional pain and to re-invest emotional energy in life so that the person may love again. In order to achieve these goals, she argues that the counsellor needs to consider two general factors. First to encourage the individual to face the pain by recognizing that what is happening is a normal part of life, and second, to participate in the full range of feelings and their emotional expression.

From this it becomes evident that the temporal focus of the bereft individual needs to change from the past to the future. They need to cease to think about what was, what could have been, and begin to think about what is, and more importantly, what could yet be. They need to consider all the possibilities that the future can bring. This mirrors the movement from a hopeless outlook to a more hopeful one. However, none of the theories makes specific reference to encouraging the re-emergence of hope. It appears to be an implicit process and perhaps a process that is not yet clearly identified or fully understood.
HOPELESSNESS AND BEREAVEMENT: JUSTIFICATION FOR CASE STUDIES

In order to examine the relationship between a completed bereavement process and the presence and influence of hope it is logical to illustrate this link using vignettes or case studies. Vignettes allow the writer to focus on the naturalistic, holistic, cultural and phenomenological paradigms of a given situation (Janessick 1994). They enable readers to juxtapose their own practice and experiences with those described, creating parallels between the case and the readers’ actual experiences. Vignettes serve an epistemological function allowing readers to consider what can be learned from this case (Stake 1994). Additionally, they provide detailed insight into ‘real world’ situations.

Therefore vignettes of bereavement offer insights into some of the dynamics and processes involved in the person’s world and enable readers to ask, ‘how is hope affecting the person’s world, and what can be learnt about the role of hope from this case?’ Although the insights and findings these vignettes provide are not generalizable to all bereavement situations, and any subsequent counselling interventions (Barnes 1996), they do reveal interesting patterns and commonalities, particularly how hopelessness manifests itself in various forms in the life of a person experiencing a complicated bereavement reaction.

Vignette 1

Martha shuffled in looking grey, drooping and without any sparkle or life. Her boyfriend had committed suicide over 6 months ago and she had shown no signs of grieving, but was stuck in a deep sense of hopelessness. She states: ‘I don’t feel like bothering to go for anything else ... what’s the point ... Its all hopeless’ (Lendrum & Syme 1992).

Vignette 2

Evelyn was a single parent and lost her only daughter in an automobile accident in 1981. She describes the intensity of her emotions. Sadness, anger, hate and despair. She speaks of the hopelessness manifest in the absence of action. There is no desire to cook, to clean, to stock the refrigerator: ‘Food sustains life and life is now a burden’ (Gillis 1992 p. 275).

Vignette 3

Ellen was a 32-year-old woman whose 9-month-old daughter died. Ellen’s bereavement experience was measured 2 months after her daughter’s death. At that time she scored very high on the despair scale. A repeated measurement 1 month later still showed a very high despair score, coupled with expressed feelings of shock, confusion and grief. In no way did Ellen feel that she had completed her bereavement (Jacob & Schandrett-Hibdon 1994).

Vignette 4

Vilna was very close to a friend called Stephen and she had no other support networks. Stephen’s new wife was envious of this relationship between Stephen and Vilna and encouraged him to move away. Vilna’s response, ‘If Stephen goes I can see no hope for me. I will think only of the past and there will be no one to look after me. Why should I go on living’ (Lendrum & Syme 1992).

Each of the vignettes illustrates an incomplete bereavement reaction and similarly each of them conveys a sense of hopelessness in the individual. Lendrum and Syme (1992) highlight specific dynamics of bereavement which serve as defence mechanisms or patterns that prevent the individual from experiencing further pain. These dynamics are described as: protection against intimacy, protection against feelings, and having suicidal thoughts as a fantasy of relief from pain. If there is a link between a complicated, unresolved bereavement and the presence of hopelessness, it is reasonable to suggest that the hopelessness would be evident in the defence mechanisms. It is therefore logical to consider these defences in more detail and support the arguments with evidence from the vignettes.

Protection against intimacy

When an individual shares intimacy with another person there will be a sense of mutual trust. After the loss of such intimacy this trust is broken, with accompanying pain. Consequently individuals protect themselves against experiencing further pain of this nature by avoiding intimacy. The individual has a sense of hopelessness with thoughts centred around ‘Why bother, I will only end up hurt again. What’s the point? There’s nothing to be gained by trusting anyone, look what happened last time’. Such expressions of hopelessness and the defence these bring are evident in the first and the third vignettes. In vignette one Martha did not feel like engaging in anything new, certainly not a new relationship, where she would run the risk of more pain. Similarly in vignette three the continued sense of despair prevented Ellen from engaging in relationships where further possible pain could be experienced.

Protection against feelings

To protect oneself from feelings, to avoid the overwhelming guilt, anger and searching, clearly reduces the pain associated with such intense feelings of loss (Bowlby
Having suicidal thoughts as a fantasy of relief from pain

The link between suicide and hopelessness is highlighted by Wiesharr and Beck (1992). Building on the many studies that predict suicidal intent, the 1992 study suggests that the variable most likely to indicate suicidal intent is the presence of continued hopelessness. If a bereaved person is contemplating suicide it is likely they will be feeling hopeless. As Lendrum and Syme (1992) suggest, clients may mention the word suicide or may be thinking about ending their life as their only way of ending their despair. This dynamic is evident in the vignettes two and four. In case study two Evelyn states that life is a burden, death would bring relief. Similarly, Vilma speaks of the relief that death would bring.

The case studies and exploration of hopelessness as a self-protection mechanism each identify hopelessness as being present and influencing the person’s process of bereavement. Furthermore, theories and accounts of completed bereavements indicate the re-emergence of hope within the individual. Jacob (1996, p. 284) studied the grief experiences of older women and found that ‘As the grief process unfolded reality increased and the widow accepted that she was experiencing a new lifestyle and that no amount of trying to recapture the presence of her husband was going to bring her husband back to this life’. The widow’s temporal focus moved from what was, to what could be. New interests, new friendships, more physical activity, more motivation, were reported in the widows as their own bereavement process continued, each of which indicated a higher hope level present in the widows and consequently a more hopeful sense of being. What becomes clear is that there is an unequivocal link between a complicated bereavement reaction and the presence of hopelessness within the individual. Similarly, those people who experience an uncomplicated bereavement experience the re-emergence of hope. Current theory on bereavement counselling appears to relate to the re-emergence of hope to a very limited extent, and the literature review revealed no evidence of a theory related to how the counsellor specifically facilitates this re-emergence. What is needed is further qualitative research to explore how this hope inspiration in bereavement counselling occurs, triangulated with a quantitative study that illustrates that a change in hope level of the bereft individuals has actually happened. Such research is currently being undertaken by the author for his PhD thesis.

CONCLUSIONS

Hope continues to gain recognition with respect to its centrality, therapeutic potential and importance in an individual’s life. This is particularly evident in the domain of psychological health and well-being in relation to bereavement. Bereaved persons need to reach a stage of acceptance, to achieve a resolution in order to complete their bereavement. Yet all individuals do not achieve this resolution naturally. Some individuals appear to become retarded in this process, and this can be described as experiencing a complicated grief reaction. Unequivocally bound up with bereavement is hope/hopelessness, with a completed bereavement process being bound up with the re-emergence of hope and a complicated bereavement process being bound up with continued hopelessness. There are many theories of bereavement counselling, with commonalities between these theories. Whilst the theories indicate implicitly the re-emergence of hope in the bereft individual as a result of the counselling, they do not make specific reference to how this inspiration occurs. Since the re-emergence of hope appears to be clearly linked to a person’s movement towards a completed bereavement reaction, and this movement is facilitated by means of bereavement counselling, there is a clear need to examine how this hope inspiration occurs.

References


