A Portfolio of Academic, Therapeutic Practice and Research Work

Including an investigation of the impact on family members of having a loved-one go missing and therapists’ agreement with models of bereavement in conceptualising their work with clients who have experienced different types of loss.

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Submitted to the University of Surrey in partial fulfilment of the degree of Practitioner Doctorate (Psych.D) in Psychotherapeutic and Counselling Psychology.

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Introduction to the Portfolio

This portfolio contains work submitted in partial fulfilment of the Psych.D in Psychotherapeutic and Counselling Psychology undertaken at the University of Surrey. It contains academic, therapeutic practice and research dossiers. This introduction intends to contextualise these dossiers through a discussion of my own personal journey into Counselling Psychology and the ways in which my personal history and experience have guided me here.

My passion for the academic pursuit of psychology began in earnest when I opted to take an A’ Level in Psychology at age sixteen. Significantly, it was also at this time in my life (approximately a year prior to electing to do my A’ Levels) when my parents and younger brother moved to live in another country and I, predominantly through my own insistence, remained in England. I recall using the importance of my academic development as my primary ‘defence’. I had learned from a young age that academia was something which earned me praise and attention and I was lucky enough that my learning style suited the expectations of this system. However, my desperation to stay was probably far more about the importance of my social network and its inseparable link with my developing identity as an adult. Consequently, I became acutely aware of the dynamics of relationships, of separations, of loss and of turmoil. The psychology of human experience suddenly became all the more important and personally relevant to me and doubtless my interest in it was in part fuelled by a desire to understand and to soothe my own anxieties and psychological pain.

This interest in Psychology persisted and I took a BSc in Psychology at the University of Bristol and was certain by the end of the three years, that this would be the field in which I would work. This was probably further consolidated by my experiencing of the University and specifically the social context of it, as somewhat isolating and threatening. I struggled with moving from a relatively small academic environment (although my secondary school
was large) where I was acquainted and comfortable with the majority of my peers, to feeling that I did not belong in a similar way at University. The subtleties of social class, status and difference seemed far more prominent here and I felt its isolating effects. This all further motivated me to work with others where such subtleties (or more blatant) differences contributed to psychological angst or isolation. I was particularly drawn by developmental, social and clinical psychology modules. I heard about Counselling Psychology in more depth over these three years and it appealed to me greatly. However, I felt that I needed more experience in the field of psychology more generally before I chose a solid career path.

I began by volunteering as a Samaritan and working in a prison as a psychological assistant. My work as a Samaritan promoted the demonstration of warmth, active listening and empathy, and a respect for the callers' choice. These values and techniques appealed to me, however the work was not guided by theory or evidence base and the relationship with the caller was usually restricted to the length of the call. This is not a criticism of what I believe to be an excellent service, but I was aware of my own desire to develop a professional identity which would enable me to integrate such elements into a 'helping relationship' with others.

My work in the prison involved amongst other things, the facilitation of cognitive-behavioural oriented programmes with groups of male prisoners. The programmes that I co-facilitated promoted the development of good 'working alliances' with the men and made use of theory to inform the work. I became particularly interested in attachment theory and styles (which were explored on the Sex Offender Treatment Programme) which I found inspiring and helpful in the work we were doing. However, I also found the programmes restrictive as they were necessarily guided by the need to reduce offending behaviour, with there being little room to be guided by individual needs. The relationship with the men within the context of the groups seemed fundamental yet is was undermined and curtailed by a system of bars, keys and reports which could influence release and
probationary conditions. Furthermore, whilst I respect the aims and the need for such programmes within the Prison Service, there was nevertheless an undercurrent of ‘doing’ something to the group members in a prescribed way, in order to ‘cure’ in this instance, their offending behaviour, which sat uncomfortably with me. I persisted with this work, becoming a trainee forensic psychologist but knew at this point that a masters in forensic psychology would follow and unless I altered my path, diversion from this would become more difficult.

The time therefore seemed appropriate for pursuing a career in Counselling Psychology and whilst admittedly my desire to achieve academically probably remained on the periphery and influenced my choice to do a doctorate, my interest, enthusiasm and passion for psychology had began to lull these motivations into the shadows. In Counselling Psychology, I felt that I had found a discipline that promoted aspects of my previous experience which I had enjoyed and found helpful, whilst also approaching client work from a philosophy which matched my own. It allowed for the uniqueness of each client to be respected rather than adopting a ‘one size fits all’ approach. Furthermore, it elevated the therapeutic relationship to the centre of practice. This again was hugely appealing as it allowed for the development of a collaborative relationship, making use of humanistic skills, whilst also being aware of the subtleties of interaction which take place between client and therapist. Thus it actively rejected the stance of an ‘expert’ who was ‘doing’ something ‘to’ the ‘patient’ which had sat so uncomfortably with me during my work in the prison.

Given the importance of the interacting process between therapist and client, I was also drawn by Counselling Psychology’s commitment to the development of self-reflection and self-awareness on the part of the therapist. My personal therapy has been a pivotal part of this development and has provided me with a means of support through what has been a demanding and challenging three years. My therapist has also in many ways provided a ‘model’ for my own client work which was particularly helpful when the development of
my own way of ‘being’ with clients was in its infancy. Personal therapy has also allowed me to heighten an awareness of my own personal conflicts (such as a desire to achieve academically, to please and the impact of personal losses) and to consider how these may be manifested in my client work. In such a way, I have benefited from a personal development which extends into all aspects of my life, as well as being better placed to recognise what is ‘mine’ and what is ‘my clients’ and thus reduce the chances of me acting to serve my own needs rather than theirs. It also serves to constantly remind me of what it is like to be a client and how it can be simultaneously insightful and rewarding yet painful and challenging.

Thus in many ways, my journey towards becoming a Counselling Psychologist was one that began many years prior to the commencement of the course. What followed in my journey towards the development of this identity is I feel, best narrated by the remainder of this portfolio. The dossiers highlight skills, abilities and knowledge which I have acquired over the three years as well as a critical and self-reflective stance which addresses evolving conflicts, resolutions and philosophies. I hope this provides the reader with an impression of my own unique ‘way of being’, both with clients and as a Counselling Psychologist more generally.
The academic dossier contains three essays which I feel represent my development over the three years and in particular, my engagement with theory. They move from a discussion of attachment theory to more reflective pieces considering the interaction of theory with dynamics within therapeutic practice and the therapeutic relationship in particular.

The first essay presented is entitled ‘Discuss individual differences in adult attachment styles. To what extent might a consideration of an attachment framework be useful to the work of Counselling Psychologists?’. It considers the development of the study of individual differences in adult attachment styles, methodological limitations of findings and the ways in which learning from such theory and research could be applied to therapeutic work in Counselling Psychology. This piece in many ways reflects the beginning of my journey towards becoming a Counselling Psychologist. Driven by my enthusiasm for attachment theory during my work in the prison, I begin to take a more critical stance both to the findings and the ‘meaningfulness’ of such theory within therapeutic encounter. This includes consideration of how it is both the therapist’s as well as the client’s styles of relating which need to be considered.

The second essay is entitled ‘Resistance in Psychotherapy; Concept, Cause and Confrontation from a Psychodynamic perspective’. It explores sources and forms of ‘resistance’ in the therapeutic encounter from a psychodynamic perspective and the ways in which resistance might be worked with and responded to. It foregrounds the move towards viewing resistance as not only a source of information about the client but also as a form of communication from the client. My increasing rejection of viewing the therapist as an ‘expert’ who is immune from mistakes or being motivated by their own needs leads me to highlight the significance of always questioning and being mindful of this, using supervision and personal therapy to support this process of reflection.
The third essay: 'In cognitive therapy, how would the therapist understand and work with difficulties that arise in the therapeutic relationship? Illustrated with examples from practice', considers the historical development of how cognitive therapy allows for an understanding of difficulties which may arise in the therapeutic relationship and thus how therapists might work with them. It considers the ways in which cognitive therapy has at various points integrated concepts which were perhaps first outlined in other theoretical approaches including the salience of core-conditions and transferential phenomena. The ways in which therapists' own beliefs and schemas (developing from their own past experiences) may contribute to difficulties in the therapeutic relationship are also considered. All such discussion is illustrated with examples of my own clinical practice.

Therapeutic Practice Dossier

The therapeutic practice dossier provides a brief description of each of my three placements and their client populations. The Final Clinical Paper then discusses my journey towards becoming a Counselling Psychologist and provides an overview of how it is that I engage with theory, research and practice.

Research Dossier

This dossier contains my research conducted over the three years of the course. The central strand running through these papers is the experience of having a loved-one go missing and how this relates to Counselling Psychology practice. Each study also contains a section of 'personal reflection and the use of self' within these research pursuits. These statements address my personal motivations for exploring this area which were influenced predominantly by my work with a client in this situation, but also through my own experience of 'being left behind' when my family moved to live in another country. Reflections on the use of self in my third year project in particular, considers my
experiences of conducting the research and some of the more previously 'unconscious' processes which flowed throughout this work.

My first year literature review is entitled: 'Being left behind: The impact on family members of having a loved one go missing'. This paper explores the literature on situations in which going missing occurs and the process and phenomenological experience of family members who are 'left behind'. The implications of these findings for Counselling Psychology practice and in particular for therapists who might come to work with clients in this situation are considered.

Through conducting my literature review, I was inspired to conduct a qualitative piece in my second year entitled: 'A Unique Loss: Four case-study analyses of the impact on family members of having a missing loved-one'. This study allowed me to integrate research and therapeutic skills in the sensitive interviewing of four individuals who had a loved-one who was currently missing. The case-study design allowed me to attempt to inhabit participants' phenomenological worlds, albeit through the lens of my own interpretative framework, to explore their personal experience of loss and the impact this has on their coping strategies and their perceptions of support. The theoretical implications of their unique experience of loss were considered and the therapeutic implications of the analyses discussed.

In interviewing the individuals for my second year study, I had been struck by what I interpreted as attempts by counsellors they had seen to 'fit' their experience into 'traditional' models of loss and bereavement. Some of the interviewees reported experiencing this as unhelpful and consequently I felt motivated to explore therapists' agreement with various aspects of bereavement theory when applied to 'certain' (when a loved-one dies) and 'uncertain' (when a loved one goes missing) loss. I therefore conducted my final piece of research entitled: 'Therapists' agreement with models of bereavement in conceptualising their work with clients who have experienced different
types of loss (certain and uncertain). This study examined differences in therapists’ agreement with certain ‘traditional’ and more recently developed aspects of bereavement theory, dependent on theoretical approach to therapy and whether loss is certain or uncertain. Whilst the analyses yielded some interesting results, I was also particularly interested in the large amounts of feedback I received from those who had completed (or sometimes returned without completing) the questionnaire. Specifically, I felt heartened by the extent to which therapists reported making decisions about therapy and theory dependent on the individual client’s unique needs and wishes, something which mirrored my own philosophies about practice and had motivated me to undertake this research. However, as discussed in my personal reflections, the experience of receiving such feedback and specifically what I interpreted at times as ‘angry’ and ‘frustrated’ emotions behind their words was also an important part of my learning experience throughout the process of this research.

N.B. Any identifying features of clients and research participants referred to throughout this portfolio have been changed and pseudonyms have been adopted in order to protect confidentiality.
ACADEMIC DOSSIER
Introduction to Academic Dossier

The academic dossier contains three essays undertaken for the PsychD course in Psychotherapeutic and Counselling Psychology. The first essay explores theory and research findings on individual differences in adult attachment styles, a critical review of these findings and the ways in which attachment theory may be applied to clinical practice. The second essay addresses the phenomenon of 'resistance' in the therapeutic encounter, exploring it from a psychodynamic perspective. It considers some manifestations of resistance and how it might be interpreted and responded to by the therapist. Finally, the third essay explores difficulties emerging in the therapeutic relationship and specifically, how these difficulties may be understood in cognitive therapy. It uses examples from clinical practice to illustrate the discussion.

As highlighted in the introduction to the portfolio, any identifying information relating to clients within this dossier has been changed to preserve confidentiality.
Discuss individual differences in adult attachment styles. To what extent might a consideration of an attachment framework be useful to the work of Counselling Psychologists?

Attachment theory can be seen to have permeated not only the language of psychology, (e.g. anxious and dependent personality disorders exist in the DSM-IV classification, APA, 1995), but also our laymen lives where terms such as “insecure” or “to avoid intimacy”, are commonplace in our language of relationships. This could be seen as a reflection of the size and broad influence of this topic.

The study of attachment styles was initiated by the pioneering work of Bowlby (1969, 1973, 1979, 1980) and Ainsworth (1979), in their research into early attachment relationships. Since this time, there has been an enormous growth of research in this area, one strand of which is in the study of adult attachment styles. This particular branch of research seems justified considering Bowlby’s early assertions that attachment relationships with parents affect an individual’s “later capacity to make affectional bonds” (1979, p.135), and that “attachment behaviour is held to characterise human beings from the cradle to the grave” (1979, p.129).

Such assertions led researchers to study adult attachment styles, with one branch of this being the study of individual differences that exist between the different styles. In a discussion of these individual differences, it seems necessary to give consideration to such things as what consensus exists about what these styles and what their individual differences might be and whether it is better to consider these differences in terms of prototypes or dimensions. Consideration can also be given to how stable the styles and individual differences are and of course what methodological limitations would need to be taken into account before inferences can be drawn. This can then in turn allow for a discussion of the extent to which this attachment framework may be useful to the work of practitioners including Counselling Psychologists.
The work of Ainsworth, Blehar, Waters and Wall (1978), in the 'Strange Situation', led to the identification of three attachment styles which were postulated to exist between the infant and its caregiver. These styles were identified as 'Secure', 'Anxious/Ambivalent' and 'Avoidant'. In 1987, Hazan and Shaver proposed that adult romantic love could also be viewed as an attachment process and that the inner working models proposed by Bowlby (1973) would in part lead to a continuity of relating to others. It was further hypothesised that depending on the attachment style of the individual, they would "experience romantic love" (Hazan & Shaver, 1987, p.511) in different ways. That is to say that individual differences would exist between attachment styles.

The results of Hazan and Shaver's (1987) study did indeed find differences in individuals' experiences of love relationships between the different attachment styles. It was found that those participants classified as 'secure', described their relationships as "friendly, happy and trusting"; those with anxious/ambivalent styles described their relationships as "marked by jealousy, emotional highs and lows and a desire for reciprocation" (p.518) and those participants classified as 'avoidant', described a "fear of closeness" (p.518).

This study led to a boom in research into individual differences in attachment styles and with this came progressive additions to the differences which could be measured. Indeed the growth was such that today, highly descriptive accounts of individual differences in adult attachment styles can be found (e.g. Bartholomew & Poole, 1996).

This increase of research could be seen as allowing for a more comprehensive understanding of the differences which exist between the styles, a welcome and indeed necessary refinement to reflect our actual experience of relating to others. This could provide Counselling Psychologists with a greater understanding of the ways in which their clients might function within relationships, including of course, the therapeutic relationship. They could be more attuned to those factors which might make a relationship
“successful” as for example evidence exists to suggest that different attachment styles are correlated with relationship satisfaction and length (e.g. Feeney & Noller, 1990; Hazan & Shaver, 1987). Bowlby (1988) also implied that if clients can become aware of those attachment behaviours which are no longer applicable to their current functioning, they can rectify relational difficulties. Practitioners may also suppose that depending on certain individual differences in attachment styles, clients may be “more or less amenable to specific forms of treatment” (Bartholomew & Horowitz, 1991, p.241) and in the extreme, it has been suggested that a recognition of attachment styles may aid an understanding of the risk for psychopathology (Dozier, Stovall & Albus, 1999).

However, it could also be argued that this growth of individual differences reflects a need to call into question the validity of trying to create a comprehensive description of the differences evident between the styles. One might question how useful it is to have such classifications if they cannot easily be defined. It may therefore be of more use to Counselling Psychologists and their clients, to learn about how their client functions on various individual differences and to be mindful of these in their work, rather than making assumptions about the attachment style itself.

Perhaps an inevitable reaction to the increasing number of individual differences being measured was the suggestion that these may be better represented by four as opposed to three attachment styles. This was proposed by Bartholomew and Horowitz (1991) who hypothesised that differences in the inner working models of self and others postulated by Bowlby (1973), would lead to four styles depending on whether these models were ‘positive’ or ‘negative’. They argued that this fourth ‘dismissive’ style was similar to that proposed by Main, Kaplan and Cassidy (1985) in their study of infant attachments.

As with the increase of individual differences measured, this move to four attachment styles could be seen to represent a ‘fine-tuning’ of our understanding and a more accurate reflection of individual experience which could in turn allow for a more accurate
understanding by Counselling Psychologists of their clients’ experiences of relationships.

However, it could also be argued that this creation of a fourth style was a reaction to the increasing number of individual differences being tested and the finding that individuals classified as having the same attachment style were not experiencing certain differences in the same way (Bartholomew & Horowitz, 1991). It could then be proposed that rather than these styles being valid in their own right, they are merely a reaction to the finding that individuals do not ‘fit’ the prototypes. One might then suppose that the more individual differences are tested and the more participants are found not to ‘fit’, the more styles would be created in order to counteract this effect. This view could be seen to be supported by the recent emergence of a fifth proposed category, being ‘cannot classify’ (Hesse, 1996). This in part touches on what might be argued as the false construction of these styles.

However, the acceptance of four different styles can be seen to have developed increasing favour as the evidence base to support it increases (e.g. Brennan, Clark & Shaver, 1998; Feeney, 1995; Fraley, Davis & Shaver, 1995). This could therefore be seen to counteract claims that this was merely a reactional move and indeed it seems desirable that research should inform theory in such a way.

It has also been suggested that viewing attachment styles on dimensions rather than as prototypes would allow for a more accurate reflection of the reality of experience. Bartholomew and Horowitz (1991) commented that they were proposing attachment styles “that different people might approximate to different degrees” (p.227). This move came in part from the recognition that certain measures of attachment styles and their individual differences were somewhat inadequate. For example, in the work of Hazan and Shaver (1987), a number of items were contained within each style e.g. dependency, trust and closeness. Participants were then required to accept all of these when indicating what their attachment style was. Thus because these styles were mutually exclusive, any relevant aspects in more than one style could not be noted (Gkouskos, 2000).
What followed was the measurement of various individual differences on dimensions, thus participants could indicate the extent to which various differences were relevant to themselves (e.g. Collins & Read, 1990; Feeney, Noller & Harnahan, 1994). However, it is apparent that a consensus still does not exist about whether attachment styles should be measured on dimensions rather than prototypes, perhaps because there is still no consensus about which measurement tools should be employed (Gkouskos, 2000).

This debate over prototypes and dimensions could also be cited as evidence of an inappropriate construction of attachment styles and if prototypical attachment styles do not reflect human experience, then discussion of them seems somewhat futile. However, research findings suggest that the extent to which individuals approximate different dimensions is not entirely random. Certain clusters of differences still emerge which means that prototypes can be postulated, but the expectation would be that individuals would reflect this to a greater or lesser degree (Bartholomew & Horowitz, 1991). This again could be seen as desirable given that it is making use of the empirical evidence (and indeed a ‘common-sense’ approach to human experience) in order to inform theory.

This increased representation of human experience would then make the attachment framework far more conducive to being applicable to the work of Counselling Psychologists. If it was just prototypes being postulated, practitioners may have found that this often bore little resemblance to the actual experiences of their clients. Perhaps more worryingly, if a practitioner believed that the prototypes were valid, they may make assumptions about how their clients ‘ought’ to be experiencing various individual differences. However, by viewing the individual differences within attachment styles as operating on dimensions, Counselling Psychologists can remain alert to the factors which might be relevant to their clients, whilst making no specific assumptions about how these might be experienced. Thus the framework can act as a foundation on which the client’s words can build and give a unique form to. This would indeed seem to enable attachment
theory to sit more acceptably within the philosophies of Counselling Psychology as a discipline whereby a respect for the uniqueness and diversity of individuals is placed at the centre of practice (Woolfe, 1996).

As well as giving thought to the extent to which these individual differences might be in evidence, it is also necessary to consider the extent to which attachment styles and their individual differences might remain stable over time. This question does indeed seem key considering Bowlby’s assertions that attachment relationships “characterise human beings from the cradle to the grave” (1979, p.129). Indeed this assumption that attachment styles remain stable can be seen to be hugely inherent in the attachment literature. Of course if this was true, it would have implications for Counselling Psychologists in that there would be little point in interventions aimed at assisting clients with certain problematic patterns of relating to others, if these were fundamentally inflexible (Gkouskos, 2000).

There is a clear need for research employing longitudinal as opposed to cross-sectional designs, in order to provide conclusive data about the stability of attachment. However, of the relatively small number of longitudinal studies which exist in this area, most have found that the majority of attachment styles (approximately 70%) remain stable over time (Bartholomew, 1994). However, some important exceptions have been noted. Perhaps the most significant of these in terms of relevance to the work of Counselling Psychologists, is the conditions under which an attachment style might change. It has been suggested for example, that change can occur as a result of “significant relationship experiences and other major life events” (Feeney, 1999, p.362-3). Evidence of this comes from studies such as that of Hammond and Fletcher (1991) who found that experiences in ‘satisfying’ relationships were associated with increased security. Such findings can then be seen to be of significance to practitioners in that individuals might find such “emotionally significant relationships” with their therapist (Bartholomew & Horowitz, 1991, p.242).

Some consideration has been given to methodological limitations of studies thus far.
However, if practitioners are to be able to make use of attachment research, it is necessary to consider other factors such as the samples employed in studies. This would enable practitioners to be aware of how applicable the findings might be to different client groups. In early research into adult attachment styles, many examples exist of samples consisting of mainly white, undergraduate, heterosexual participants from western societies (e.g. Collins and Read, 1990; Feeney & Noller, 1990; Rogers Kobak & Sceery, 1988). Fortunately, research has expanded to provide evidence of validity of attachment theory across cultures (Van Ijzendoorn & Sagi, 1999) and for lesbian, gay and bisexual individuals (Mohr, 1999). Whilst the study of attachment still remains in its relative infancy, it would be prudent (as always) for practitioners to be mindful of how these and other individual differences may influence each individual client’s own experience.

One particular aspect of the Counselling Psychologist’s work which has not yet been directly discussed, is the therapeutic relationship. In being a relationship, it can be expected to be affected by attachment processes, be this through the client’s expectations or representations of the therapist, or the therapist’s feelings and responses to the client (Slade, 1999). Even if it is the case that attachment styles or dimensions change over time, the current individual differences in attachment styles may influence this relationship. Indeed if attachment patterns can change as a result of significant relationships, this should be precisely why practitioners should give consideration to this framework.

On a more micro-level, attachment styles may impact on the therapeutic relationship in different ways. For example, it has been proposed that those individuals classified as having anxious/ambivalent attachment styles may present as “needy and dependent” (Dozier, 1990, p.57) and may be more likely to “call therapists between sessions, to demand extra appointments and to become extremely dependent on their therapists” (Slade, 1999, p.587). It has also been suggested that this attachment style may also lead to transference manifestations such as the client experiencing the therapist as “insufficiently helpful and available” (Slade, 1999, p.588). This could then in turn lead to
countertransference whereby the therapist feels “devoured and overwhelmed, as well as annoyed and confused” (Slade, 1999, p.588) which, if the therapist were not sufficiently aware of this process, could influence their responses. If this was then combined with the attachment processes relevant for the therapist, it becomes clear that the potential impact of attachment styles and their individual differences on the therapeutic process is potentially immense.

The study of individual differences in adult attachment styles is a large and rapidly growing area of research. This growth is allowing for a ‘fine-tuning’ of theory and an increased understanding of actual experience. A discussion of individual differences in adult attachment styles does in turn allow for a consideration of the extent to which an attachment framework would be useful to the work of practitioners. Indeed it is apparent that consideration of an attachment framework can certainly be of use to the work of Counselling Psychologists in terms of increasing understanding of the possible influence of attachment processes on the experiences of their clients and on the therapeutic relationship itself.

However, ongoing debate within the adult attachment literature in turn impacts on the application of attachment theory to practice. Therefore, further research into adult attachment styles (combined with a refinement of methodology) would not only allow for advances in attachment theory, but would also increase its potential utilisation by practitioners. However, it seems important to conclude by highlighting that attachment theory is of course a ‘theory’ and I agree with the assertion that “theory is necessary so that interpretation is not inspired guesswork. But theory should be the servant to the work of therapy - not its master”. (Casement, 1991, p9). Thus whilst an understanding of attachment theory might have much to offer the discipline of Counselling Psychology, it seems important that it should not become another means of ‘labelling’ or even ‘pathologising’ clients’ experience. Fundamentally, such theory should never eclipse the importance of respecting the uniqueness of each client and our encounters with them.
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Bartholomew, K., & Poole, J. (1996). *Peer attachment prototypes* [document]. Retrieved November 9th 2001 from the world wide web:
http://www.sfu.ca/psychology/groups/faculty/bartholomew/research/attachment/prototypes.htm


The concept of resistance within psychotherapy is a familiar one and whilst it originated in psychoanalytic theory, it can probably be credited with being accepted and recognised within most other approaches to therapeutic work. Indeed it seems likely that all psychotherapists could reflect on their client work and agree that they have encountered resistance in their clients. Resistance is acknowledged as taking many forms "from conscious concealment of facts to unconscious driven acting out, from intellectualisation and cognitive understanding to 'emoting', to missing sessions to obsessionally turning up on time, from only talking about the analytic relationship to avoiding it, from eroticising the relationship to deadening it, and from developing new symptoms to rapidly losing the old and taking a flight into health" (Bateman & Holmes, 1995, p.164).

However, despite this vast range of forms of resistance (which is doubtless not comprehensive) and extensive recognition of the concept and its presence within the therapeutic encounter, an exploration of its forms and causes highlights certain areas of divergence and disagreement. This paper aims to explore the sources and forms of resistance, using Freud’s (1926) framework from which to discuss the ways in which resistance has been predominantly perceived within psychodynamic theory. This will then be followed by a discussion of some of the more influential alterations to this perspective and in particular, the developments which allow for the therapist to be placed less in the role of 'all knowing' expert and the client being viewed more as attempting to communicate to, rather than conceal from the therapist. This discussion then in turn prompts a brief examination of the ways in which resistance may be responded to in therapy.

The clinical concept of resistance emerged in the early work of Freud and was then defined as the myriad of methods which were employed by the client to 'oppose' the therapist’s
attempts to ‘influence’ them (Sandler, Dare & Holder, 1993), or to ‘obstruct’ the therapeutic process (Bateman & Holmes, 1995). It seems important however to distinguish resistance from reluctance, whereby the reluctant client is someone who does not want to be engaged in therapy (but feels obliged or ‘pushed’ into it - perhaps at the request of somebody else) and resistance as what emerges despite the client’s desire to make changes and their belief that therapy may be the best means of achieving this (Jacobs, 1988). It was this observation that clients who were seemingly motivated to be engaged in therapy but nevertheless resisted aspects of it, that has led to the exploration of resistances, their forms and their sources or functions.

Perhaps the most influential classification of sources and forms of resistance within psychodynamic theory to date was proposed by Freud (1926) who distinguished between five major types and sources of resistance. The first of these (and arguably what is most commonly identified as the source of resistance) is repression resistance. This essentially refers to the client’s need not to know (Bateman & Holmes, 1995) and defends against the emergence of hidden feelings, fantasies, impulses and memories into consciousness which would in turn disturb the psychological equilibrium which they have established. Thus the closer these contents come to conscious awareness, the more they are resisted (Sandler et al, 1993).

It is this repression resistance which can perhaps be seen most frequently in definitions of resistance which have emerged out of different schools of psychodynamic theory. For example, object-relations theorists have favoured a view of resistance emerging as a result of a narrowing of the split that separated the presentation of themselves to the external world and that which is maintained in their inner world. It is proposed that this split emerged as a result of early experiences of not having primary needs met and thus the narrowing of the split leads to a glimpse of the original feelings and deficit. This is experienced as painful and so is resisted (Ashwin, 2002). Thus this can be seen to resemble repression resistance, whereby the repressed painful material (or the aspects of self that
have been split from conscious awareness) are resisted as they begin to emerge. Similarly, self-psychology sees resistance as attempts to protect the self from a potentially destabilising condition brought about by “the revival of memories of actual experiences or fantasies of past traumatic experiences” (Rowe, 1996, p.152). However, a common alteration to this particular source of resistance has been to argue that repression resistance was one example of resisting letting go of defences which have developed as an adaptive response to perceived danger or intolerable conflict. Thus it is argued that repression resistance is in fact one form of defence resistance (Daniels, 1974; Sandler et al, 1993).

However, there also lies the possibility that the resistance to painful material has arisen in relation to the analyst which would therefore be classified in the second of Freud’s (1926) proposed types of resistance - transference resistance. More recently this concept has been adapted to distinguish between the resistance to the awareness of transference, and resistance to its resolution (Gill, 1982; Stone, 1973). This may also take many forms including hostility to the discussion of the client / therapist relationship and a denial of connections between past or external relationships and the therapeutic relationship (Bateman & Holmes, 1995).

It would be true to say that all of these sources and types of resistance could take many forms including the third resistance described by Freud (1926); the resistance to the gain from illness (or secondary gain). This would include the client resisting changes to those behaviours or attitudes (symptoms) which are symptomatic of their ‘illness’ (Weiner, 1975) but which have come to be advantageous. Whilst the modern day therapist might recoil at the terminology of a client’s presenting difficulties as forming an ‘illness’, it is likely that they could appreciate the sentiment - that the client may be reluctant to let go of certain patterns of functioning because of the rewards that it brings them - perhaps in the form of the care, attention or sympathy from others (Bateman & Holmes, 1995).

However, not all patterns of functioning may be perceived as desirable or advantageous by
the client, but attempts to challenge or change them might nevertheless be met with resistance. This was described by Freud as *id-resistance* (1926) and has also been known as *repetition compulsion resistance*. Blatt and Erich (1982) emphasised that this was “an expression of the basic wish to maintain well-established modes of adaptation that, although limited and at times even painful, are at least familiar and predictable” (p.74). However others have suggested that the resistance to giving up these adaptive behaviours is more a result of needing to ‘unlearn’ and ‘extinguish’ them (e.g. Sandler et al, 1993) or as a resistance to the threat to a fragile identity and sense of self (e.g. Erikson, 1968).

Others have also described a similar resistance to changing behaviours which might be being encouraged by the therapy as a result of the possibility that these changes might lead to genuine difficulties in the client’s relationships with significant others (e.g. Stone, 1973). It also seems noteworthy that it might at times feel favourable for a therapist to dismiss the maintenance of apparently disruptive patterns of behaviour as due to such id resistances rather than as a ‘failure’ on their part or of the therapy as a whole.

It is apparent that this somewhat cynical accusation could also be levelled at the last of Freud’s types of resistance - *Superego resistance*. This refers to an apparently masochistic tendency to revert to problematic symptoms after progress seemed to have been made. It is proposed that this particular resistance is brought about by powerful feelings of guilt or the need for punishment (Sandler et al, 1993). The most extreme form of this resistance is suggested to be the ‘negative therapeutic reaction’ (Freud, 1923) whereby accurate interpretations seem paradoxically to lead to their condition ‘worsening’.

However, such apparent resistance to ‘accurate’ interpretations or a move towards positive change has been proposed by other theorists to result from different and perhaps more tangible or ‘credible’ sources. One suggestion is that the resistance in this instance results from the client’s fear that to ‘get better’ would mean that they would have to ‘give up’ the therapy and so the therapist to whom they may feel significantly attached or
dependent (Bateman & Holmes. 1995; Sandler et al, 1993). This can be demonstrated in what seems to be clients ‘getting worse’ when the end of therapy is nearing. However, conversely, there is also the suggestion that such behaviour could result from a resistance whereby the client feels a need to assert their self-sufficiency and independence from the therapist (e.g. Messer, 2002). It has also been suggested that resistance to an apparently accurate interpretation from the therapist could be as a result of envy, resenting the therapist’s skill and knowledge and so wishing to destroy it (e.g. Kernberg, 1975; Rosenfeld, 1975; Spillius, 1993).

The debate surrounding this last proposed source of resistance does perhaps therefore indicate that not only can resistance take an almost infinite number of forms, but the cause and sources of this resistance are also something that is a matter of debate and disagreement. Indeed whilst these sources proposed by Freud remain central to many current categorisations, they have not surprisingly been altered and amended as new strands of psychodynamic theory have emerged. Whilst some have been mentioned in the above discussion, there is not the space (nor the need) to outline every minute addition and alteration here. However others seem worthy of note in terms of their ability to provide practitioners with different ways of conceptualising and perceiving resistances in their clients and so in turn providing creative and different ways of responding to them.

Arguably the most important addition to classifications of sources of resistance is resistance resulting from therapist error. Reassuringly this has been acknowledged by a number of theorists (e.g. Bateman & Holmes, 1995; Casement, 1985; Freud, 1968; Messer, 2002; Sandler et al, 1993). Such therapist error could of course take many forms including inaccurate interpretations, inadequate listening or empathy. Indeed the salience of empathy in understanding resistance is favoured by self psychologists who view the therapist’s lack of attunement to their client’s needs as the cause of resistance (Hedges, 1983). However, whatever form this therapist error may take, the need to acknowledge and address this within the therapeutic setting seems crucial as failure to do this could...
result in a termination of treatment or a continuation of it with a damaged therapeutic alliance (Glover, 1955; Greenson, 1967). Furthermore, a reluctance to acknowledge therapist error may also make it all too easy to name clients' 'resistance' as the culprit in therapy whenever an impasse or 'difficulty' emerges which would locate the therapist very much in the role of 'expert' who essentially 'knows best'.

In such a way, it can be seen that resistance becomes viewed as less of something that is concerned with concealment but rather something that is concerned with communication to the therapist. Indeed resistance (or behaviours classically interpreted as resistance) as a means of communication (conscious or unconscious) to the therapist is another important addition to the psychodynamic view of resistance. This view allows for the possibility that what may have been considered to be a therapist failing to get through to the client thus triggering resistance, may in fact be more about the client feeling that they have failed to get through to the therapist and so communicating this to them (Casement, 1990). Lack of recognition by the therapist that the client's behaviour may be more about desperation about a breakdown in communication than resistance may make it much harder for the client to offer corrective cues (Casement, 1985; Langs, 1978).

It could of course be argued that this view of resistance as a form of communication has stepped away from what was classically considered to be resistance. However, it must surely be embraced as an important addition to our understanding as it allows resistance to be seen as not only something which provides a unique insight into the individual client's inner world, but also as something which provides crucial information about the interaction between the client and therapist. Indeed if we were to adhere rigidly to the early definitions of resistance as behaviours which 'opposed' and 'obstructed' the therapeutic process, it would be easy to miss some important forms of resistance such as 'compliance' (Jacobs, 1988), which the therapist may be tempted to interpret as a sign of 'success' rather than as a signpost to resistance.
The oversight in recognising compliance as a form of resistance is one example of the way in which the counter-transference impacts on the way a therapist may respond to resistance. It can be seen that in this instance the therapist is drawn into a non-challenging collusiveness (Ashwin, 2002) perhaps as a result of their own needs to feel skilled and successful as a therapist. However, counter-transference to forms of resistance may also promote quite the opposite response from the therapist; one of anger, irritability and hostility whereby the therapist then wants to attack the client’s attempts to ignore painful experiences (Ashwin, 2002). Both of these examples of a therapist’s potential response to a client’s resistance would be instances of a failing to recognise the resistance in the first place (although that is not to say that a therapist may recognise resistance yet choose to ignore it, hoping that it may evaporate, Weiner, 1975). It can for example be seen that whilst a therapist may still feel anger or irritation towards their client in the counter-transference, in attending to the meaning of this, they can begin to identify the resistance and so assist the client in ‘working through’ this (Messer, 2002).

It has been suggested that this ‘working through’ or ‘confronting’ resistance would begin with the therapist sensitively drawing attention to it at an appropriate time, namely if the therapist feels confident that they can demonstrate its presence (Weiner, 1975). It would for example be inappropriate to suggest a client is being resistant if they arrive five minutes late for a session when they are usually prompt. However, if this is a repeated pattern, then the therapist could reasonably assume that it was an indication of resistance and so draw attention to it. This would then involve suggesting an explanation for the behaviour which recognises the client’s anxiety and identifies the feeling or thought that is being resisted (Jacobs, 1988). As with all kinds of interpretation, it should invite the client to confirm or reject this interpretation (Jacobs, 1988). However, it is of course possible that the therapist may not fully understand the anxiety behind the resistance or what may be being defended. It is therefore proposed that in this instance, the therapist can sensitively invite the client to consider its meaning (Jacobs, 1988).
However, this emphasis on explicitly addressing and encouraging the emergence of resistance is not shared by the aforementioned self-psychologists. Kohut (1984) for example asserted that “all these so-called resistances serve the basic ends of the self; they never have to be ‘overcome’” (p. 148). This approach therefore highlights the important function of resistances and so suggests that the emphasis should not be on removing them but understanding them and in such a way enabling the client to perhaps surrender them voluntarily (Rowe, 1996). Thus whilst more traditional approaches might emphasise the therapist’s task as to assist and facilitate the ‘emergence’ of material which is leading to resistance, self-psychology promotes a more passive approach by first acknowledging the importance of maintaining their developmental position and thus allowing the client to feel understood and so move forwards in their treatment (Rowe, 1996).

However, it seems likely that even therapists who do not necessarily adopt a self-psychology approach to their work are likely to acknowledge an important feature of this - namely that resistance should be respected as serving an important function to the client who employs it. Whilst this may serve a number of different ‘functions’ (as indicated by the many different sources of resistance that have been discussed), they should always (ideally) be dealt with sensitively and respectfully.

Thus it can be seen that whilst resistance itself may take an infinite number of forms, the proposed sources or causes of resistance may be more limited. Whilst Freud’s (1926) categorisation of types and sources of resistance are helpful to their discussion (and so ultimately to psychodynamic practitioners), they are by no means comprehensive and so have invited alterations and additions which are often dependent on the theoretical orientation of the particular author. This serves as a reminder that these are indeed ‘theories’ or ‘hypotheses’ about the causes of resistance and so highlights the need for the individual therapist to consider the specific resistance presented by each individual client and the ways in which they can strive to understand and work with these. The move to viewing resistance as not only a source of information about the client but also as a form
of communication from the client can only be welcomed. Similarly an acknowledgement that resistance may result from therapist error and a therapist’s individual needs is also useful and suggests the importance of therapists being constantly mindful of this and making use of supervision and at times personal therapy to work through these challenges.
References


In cognitive therapy, how would the therapist understand and work with difficulties that arise in the therapeutic relationship? Illustrated with examples from practice.

Introduction

The importance of the quality of the therapeutic relationship to psychotherapy outcome has long been established and it has been acknowledged that a positive relationship is as predictive of positive outcome as any particular theoretically oriented technique (e.g. Blatt, Sanislow, Zuroff & Pilkonis, 1996; Castonguay, Goldfried, Wiser, Raue & Hayes, 1996; Karasu, 1990; Luborsky, McLellan, Woody, O'Brien & Auerbach, 1985). Despite this, cognitive therapy has historically paid scant attention to the significance of this factor, particularly when compared to psychodynamic and client-centred approaches, which place the relationship at the forefront of the work. However, more recently the therapeutic relationship has been elevated in its perceived significance by cognitive therapists, beyond its needing to ‘be in place’ in order to carry out effective technique. This is welcome, not only for its consistency with findings of the importance of a good relationship to outcome, but also as it opens up the possibility of addressing ‘difficulties’ in the relationship, beyond viewing them as ‘non-compliance’ which must be resolved before ‘getting on with the therapy’ (Sanders & Wills, 1999). In fact, the therapeutic relationship is now viewed by many cognitive therapists as a ‘vehicle of change’ in itself (Jacobson, 1989; Safran & Segal, 1990; Young, 1990).

A traditional view: difficulties arising in the relationship as a failure of collaborative empiricism and core conditions.

Whilst the cognitive-behavioural tradition may not have esteemed the therapeutic relationship to the degree of other theoretical approaches, it has long since heralded a good therapeutic relationship as a successful component for treatment (e.g. Beck, Rush,
Shaw & Emery, 1979). In particular, it corroborated the principles of the client-centred approach (Rogers, 1951), by emphasising the importance of the core-conditions of therapy, namely empathy, congruence and unconditional positive regard (Rogers, 1957). In adopting these principles, cognitive therapy can understand difficulties which arise in the relationship as resulting from inadequate demonstration of these qualities by the therapist. This in turn may lead to poor adherence to the demands of therapy or premature termination (Burns & Nolen-Hoeksema, 1992; Overholser & Silverman, 1998).

Cognitive therapy also emphasises the importance of ‘collaborative empiricism’ which it views as “going beyond the core-conditions” (Sanders & Wills, 1999, p.58). This “implies a team approach to the solution of a patient’s problem... The emphasis is on working on problems rather than on correcting defects or changing personality” (Beck & Emery, 1985, p.175).

It is therefore important, when applying techniques in cognitive therapy, to simultaneously maintain the core-conditions and establish a stance of collaborative empiricism. This may be usefully illustrated with an example from my practice, with a client named Mr. A, a twenty-four year old man who presented with anxiety in social situations and in particular, fear of being criticised and negatively evaluated by others (indicative of social phobia). After approximately four sessions, Mr. A and I had begun to illicit his thoughts related to social interactions and to find alternatives which might help to reduce anxiety in collaboration with ‘exposure’ work. However, in the following session it transpired that Mr. A had not done the at-home assignments and seemed much more withdrawn. After some discussion, it emerged that these difficulties could be understood as both a failure of core-conditions and collaborative empiricism. In my eagerness to begin to find alternative thoughts, Mr. A had not felt adequately understood or respected and the work had felt more like ‘correcting defects’ than working together on his difficulties. In such a way, I had fallen into the trap of trying to be an ‘effective technician’ whilst sidelining the importance of being a good therapist.
So the question remains of how then to address such difficulties. In this instance, it was first of all important to attend to Mr. A’s ambivalence and be cautious not to imply that he simply needed to comply with work I set. We spent some time discussing how he was feeling about the work we had done and how I had implemented it. This allowed him to express dissatisfaction with what he saw as my simply trying to ‘alter’ his thoughts, without adequate acknowledgement of the powerful emotional charge behind them. His feedback helped me to adjust the way in which we worked together, ensuring that I demonstrated more empathy for his difficulties. I also ensured that any alternative thoughts we generated were ‘meaningful’ for him, arrived at in collaboration and that I obtained regular feedback from him about the process of the work.

However, my example is more one of dealing with difficulties in the relationship retrospectively, whereas it would of course be preferable to minimise the extent to which these arise in the first place - clients are not always as forgiving of our mistakes. Nevertheless, it can be seen that this still seems to imply that such difficulties are obstacles which need to be overcome before ‘getting on with the business of therapy’. However, even in the example presented with Mr. A, his being able to express dissatisfaction with how we were working could be viewed as progress in itself, given his fear of negative evaluation by others. Indeed viewing ‘difficulties’ which arise within the therapeutic relationship as opportunities for change, is something which is welcomed and theoretically explained by more recent contributions to cognitive therapy. This is particularly useful given that for some clients and particularly those who experience significant difficulties in relationships (perhaps meeting criteria for personality disorder), developing a collaborative relationship would present significant difficulties (McGinn, Young & Sanderson, 1995, cited in Corrie, 2002).
Difficulties in the relationship as ‘windows into the patient’s private world’ (Beck & Freeman & Associates, 1990, p. 65)- Contributions from schema theory.

This quote illustrates how cognitive theorists have come to view difficulties which arise in the therapeutic relationship as a rich sources of information (Safran, 1998; Young, Klosko & Weishaar, 2003). This is based on the understanding that the pattern of relating in the therapeutic relationship, will be a reflection of the client’s relationships outside of the therapeutic setting (McGinn et al, 1995; Safran, 1998; Safran, 1993; Safran, 1990a; Safran and Segal, 1990).

This repetition of patterns of relating have come to be understood in cognitive theory in terms of schema. Schema are generally viewed as the “deepest level of cognition” (Young, 1990, p. 8), which develop from an individual’s early experience, forming the core of their self-evaluation and evaluation of their environment (Beck, 1967; Young, 1990). Young (1990) highlighted the significance of Early Maladaptive Schema (EMS), which develop as a result of ‘dysfunctional’ early experiences with significant others. These EMS’s are then developed as a means of ‘making sense’ of such experiences (Young et al, 2003).

However, this view of schema has been further refined by Safran and colleagues by drawing on the interpersonal theory of Sullivan (1953; 1954; 1956). Safran stresses the role of interpersonal schema (Safran 1990a; Safran, 1998; Safran & Segal, 1990) which develop from early interpersonal experience and a primal need to maintain relatedness to others. Significantly, these interpersonal schema are seen as interactional and a representation of self-other interactions and not just evaluations of self and environment. Thus somebody who views themselves as unlovable is more likely to view others as rejecting (Safran & Segal, 1990).

This schema approach also acknowledges that schema about self and others are likely to be self-perpetuating, whereby they invite an ‘action tendency’ (Kiesler, 1982; 1988) in others.
which ‘hooks’ or ‘pulls’ them into responding in schema-confirming ways. This has been described as ‘cognitive-interpersonal cycle’ (Safran, 1990a; Safran 1998) and ‘schema-maintenance’ (Young, 1990; Young et al, 2003), both essentially referring to reactions from others which continue to confirm their beliefs about self and others.

Thus it is primarily in this triggering of inter-personal cycles or EMS and their associated ‘action tendencies’, that schema theory helps us to understand difficulties arising in the therapeutic relationship. However, it is notable that from this perspective, the word ‘difficulty’ seems misplaced, as it implies something to be overcome, rather than viewing the dynamics which arise not only as providing information about such schema, but also as opportunities for learning and change. This becomes even more apparent when we consider how such ‘difficulties’ may be worked with.

It is proposed that it is first of all crucial for the therapist to identify when difficulties are representative of schema and to ‘unhook’ themselves from the pull to respond in a schema consistent way (Safran, 1990b; Safran, 1998; Safran & Segal, 1990). The therapist’s role is then to help the client to explore the ways in which their non-verbal behaviours and paralinguistic communications impact on others and their reactions to them (Safran, 1990b; Young, 1990; Young et al. 2003). Clients are then further encouraged to test out their expectations in the context of the therapeutic relationship (Safran & Segal, 1990), thus allowing them to experience new ways of relating to others and hopefully beginning to loosen their grip on dysfunctional schema, in favour of new, less restrictive schema. Young (1990) and Young et al (2003) describe this as ‘limited re-parenting’ whereby the therapeutic relationship “provides a ‘corrective emotional experience’ specifically designed to counteract the patient’s Early Maladaptive Schemas” (Young et al, 2003, p.182). Thus this again emphasises the importance of collaborative empiricism whereby clients ‘actively seek’ to test hypotheses, but within the context of the therapeutic relationship (Safran, 1990b). Clients are then encouraged to generalise any findings by testing them outside of the therapeutic setting (Jacobson, 1989; Safran, 1990b).
The power of schema in influencing the therapeutic relationship even in the very first encounter, can be illustrated by a presentation of my work with Miss. H, a thirty-nine year old woman. She presented with anxiety primarily related to relationships, particularly with men. As her narrative filled our first session, I felt bombarded, overwhelmed and almost entirely unable to exert any presence in the room. My automatic thoughts whilst listening to her included; ‘I don’t think we can work together’; ‘I’ll have to refer her on’. It transpired as she spoke that she had a deep fear of commitment and a tendency to keep people ‘at arms length’ (as she seemed to be doing with me), something which (I began to formulate), seemed to serve as a protective measure against being hurt by letting others too close or ultimately being rejected by them. My formulations implied that she may well have EMS in the domain of ‘disconnection and rejection’, fearing both rejection by others (abandonment / instability schema) as well as the expectation that others will abuse, manipulate or take advantage of her (mistrust / abuse schema) (Young, 1990).

As I reflected upon this after our meeting, I realised how my thoughts and thus behaviour (my action tendency) of being unusually absent in the session, were probably consistent with her early maladaptive schema (abandonment / instability), perhaps confirming her belief that others would not want to get too close to her or would reject her. Thus had I not considered the role of these schemas, I might well have acted upon my automatic thoughts that I needed to ‘refer her on’, thus confirming her schema that others reject her and it is safer not to let them near.

Miss. H later spoke of how at aged twelve, she had been sexually assaulted by a man. We considered how this seemed to be highly salient (and understandable) in the development of the belief that ‘others can hurt her’ (mistrust / abuse schema) and thus it is safer to keep them at a distance. Understanding these ‘difficulties’ in our relationship in terms of her early experiences and associated schema, helped me to remain mindful of the potential for our relationship to represent a different way of relating to somebody, where she hopefully felt held and accepted, despite allowing somebody closer to ‘knowing her’ than she usually
felt able to do.

For some readers, it may strike them that my above example of dynamics in the session with Miss. H appears to describe the phenomena of transference and countertransference. Indeed Young et al (2003), highlight how the triggering of EMS in the therapeutic relationship is similar to Freud's concept of transference, whereby the client "is responding to the therapist as though the therapist were a significant figure from their past" (p. 179). In such a way it can be seen how the cognitive-interpersonal approach acknowledges the importance and usefulness of these mechanisms and thus enables therapists to consider schema which may be triggering their countertransference. Consequently, they can be more cautious of responding in counter-therapeutic, schema confirming ways (Scaturo, 2002). This seems highly desirable given that practitioners who do not acknowledge or are not able to theoretically understand such phenomena, are not "any more immune to counter-therapeutic reactions and feelings than their psychoanalytic counterparts" (Safran and Segal, 1990, p41). Instead, therapists can usefully address such phenomena which are after all, common to all (therapeutic) encounters (Safran, 1998; Scaturo & McPeak, 1998).

The role of the therapist's beliefs in difficulties in the therapeutic relationship.

Given that the discussion thus far has emphasised the importance of the interactional process of difficulties arising in the therapeutic relationship, the lack of consideration of the impact of the therapist's beliefs or schemas is apparent. This caveat is in part filled by the work of Rudd and Joiner (1997) and their Therapeutic Belief System (TBS). This provides a framework for identifying the client's and the therapist's beliefs about the client, the therapist and the therapeutic process. As with the aforementioned schema theory, this can then serve as information regarding the client's schema and provide opportunity for change (cited in Corrie, 2002).

Rudd and Joiner (1997), further elaborate this theory describing how a client's beliefs
about the therapist can lead to viewing them on a continuum from victimiser to collaborator to saviour. The client will also view themselves on a continuum from victim, to collaborator to caretaker. Therapists can then see clients as victims or aggressors, responding accordingly as aggressor, saviour or victim (cited in Corrie, 2002).

The TBS can again help to understand difficulties arising in the therapeutic relationship, as can be illustrated by my work with Mrs. G, a fifty-four year old woman who presented with depressed mood and generalised anxiety. From very early in our work together, Mrs. G wanted repeated reassurance that she was worthy of coming to therapy and resisted decisions such as establishing goals, setting agendas in sessions or homework tasks. She instead wanted for me to make all decisions and to ‘tell her what to do’. She seemed to position me as a ‘saviour’ and herself as a ‘victim’. My immediate action tendency was to become overprotective, controlling and directive - essentially seeing her as a ‘victim’ and myself as ‘saviour’. However, not only was I aware that this would be unhelpful for any client; but I also knew that she had had a particularly controlling and dominant father and thus to behave instinctively would have been to confirm her beliefs about herself (as incapable victim) and others (as controlling). Instead, we discussed the dynamics that seemed to have arisen in our sessions and focused on encouraging autonomy, finding that this was complimented by the cognitive-behavioural approach; developing skills and techniques which she could take away, rather than feeling reliant on therapy or a therapist to make a difference.

However, the TBS still seems to emphasise the therapist’s beliefs ‘in response’ to the client. But what of the therapist’s own beliefs and schemas? In my previous example of my work with Mr. A, I identified inadequacies in attending to core-conditions and collaborative empiricism as contributory to the difficulties we experienced. However, it was also revealing that I noticed my desire to be an ‘effective technician’, thus neglecting these fundamental aspects of therapy. This had come at a time when I had recently begun working in the cognitive-behavioural framework and was keen to ‘quickly grasp the
techniques'. Acknowledgement of this allowed me to further reflect on some of my own beliefs and schemas and in particular those related to perfectionism. I was able to consider (with the help of personal therapy and supervision) how such beliefs may in themselves have played a contributory role in the difficulties which emerged and thus consider ways of minimising them both during this and future work.

This reveals how important it is for therapists to enhance their awareness of these potential processes both through personal therapy and clinical supervision. Whilst this will not eliminate the chances of us acting on counter-therapeutic action tendencies or to maintain our own schema, it is certainly an important step towards minimising this.

Conclusion

So it can be seen that at several levels, cognitive therapy allows for an understanding of difficulties which may arise in the therapeutic relationship and thus how therapists might work with them. The traditional view primarily saw difficulties arising as a failure of the fundamental principles of the core-conditions and collaborative empiricism. More recently, schema theory has allowed therapists to view difficulties in the therapeutic relationship both as providing important information regarding the client’s interpersonal relationships, as well as providing opportunity for change. The Therapeutic Belief System further compliments these theories by providing a framework for acknowledging the role of the therapist’s as well as the client’s beliefs in impacting on the relationship. However, we should also not sideline the possibility that the therapist’s own beliefs and schemas (developing from their own past experiences) may contribute to difficulties in the therapeutic relationship.

It is also apparent from this discussion that cognitive theory has at various points integrated concepts which were perhaps first outlined in other theoretical approaches. Cognitive theorists have for example long since recognised the value of the core-
conditions, first promoted in the client-centred approach. More recently (in schema theory), it has acknowledged the significance of transference and counter transference reactions in describing the phenomenon as the triggering of EMS or schema confirming response. This appears to be an example of continued attempts to adapt theories and their application in practice, in order that we can best understand and meet the needs of the client rather than being restricted by any one theoretical approach.
References


THERAPEUTIC PRACTICE DOSSIER
Introduction to Therapeutic Practice Dossier

The therapeutic practice dossier aims to provide the reader with a sense of my development as a practitioner. It contains brief descriptions of my the three placements and their client populations where my clinical experience was gained. It also contains a Final Clinical Paper which describes my personal journey towards the development of a Counselling Psychology identity and how it is that I engage with theory, research and practice.

As highlighted in the introduction to the portfolio, any identifying information relating to clients within this dossier has been changed to preserve confidentiality.
Clinical Placements

Year 1: NHS Secondary Care Psychology Service

My first year placement was in a secondary care Psychology Service situated in the south-east of England. The service received referrals from General Practitioners at local medical practices, Community Psychiatric Nurses and Consultant Psychiatrists based at local hospitals. The service was staffed by a multidisciplinary team of a Counselling Psychologist and trainee Counselling Psychologist, Clinical Psychologists and trainees, Counsellors and a Behavioural Nurse Therapist. There was a waiting list of between twelve and eighteen months.

The service provided psychological therapy for adults aged between sixteen and sixty-five and the client group varied in terms of age, ethnicity and socio-economic status. Clients presented with a range of difficulties including depression, anxiety, obsessive-compulsive disorder, eating disorders, post-traumatic stress disorder and difficulties arising from various life events such as loss and bereavement. The clients would usually have been experiencing their primary presenting problem for at least six months and may have had some psychological intervention in primary care prior to their referral. Once clients had been assessed, the number of sessions offered to them and the approach taken to the intervention was flexible according to the individual client’s needs.

My primary responsibilities were to conduct individual therapy with selected clients from the waiting list which took a primarily humanistic or cognitive-behavioural approach to therapy. I also liaised with client’s G.P.’s or other professionals involved in their care, received weekly supervisory sessions and attended several departmental allocation meetings and a Care Programme Approach review meeting.
Year 2: NHS Psychotherapy Service

My second year placement was undertaken in an adult Psychotherapy Service of an NHS trust located in the South-East of England. The service was staffed by a Consultant Psychotherapist, four Psychotherapists and several honorary therapists. Referrals to the service were usually made by General Practitioners and Consultant Psychiatrists. The service had a waiting list of approximately four months.

The service provided individual or group interventions (including group psychotherapy and art therapy) to clients who varied in terms of age, sex, ethnic background and socio-economic status. Clients presented with a range of relatively enduring presenting difficulties including eating disorders, depression, anxiety, inter-personal difficulties and issues arising from life events such as loss and bereavement. The service offered predominantly long-term, psychodynamic oriented therapy.

My primary responsibility was to conduct long-term psychodynamic therapy (ranging from between twelve to forty-five sessions) with selected clients from the waiting list and to make onward referrals to group interventions where appropriate. I also liaised with other professionals involved in the clients' care as necessary. As all assessments were carried out by core members of the department, I had the opportunity to observe a number of assessments conducted by the Consultant Psychotherapist and attended weekly supervisory sessions.
Year 3: NHS Community Mental Health Team

My third year placement was undertaken in a Community Mental Health Team (CMHT) located in the South-East of England. A ‘Psychology Service’ was run within the CMHT and was staffed by a Consultant Clinical Psychologist and two trainee Counselling Psychologists. The CMHT as a whole was staffed by a large multidisciplinary team of Community Psychiatric Nurses (CPN’s), Occupational Therapists, Social Workers, Mental Health Practitioners, two Consultant Psychiatrists and a Consultant Clinical Psychologist. Referrals to the CMHT were usually made by General Practitioners or Consultant Psychiatrists and referrals to the Psychology Service within the CMHT were made either directly from these sources or from other members of the team.

The client population was varied in terms of age, sex, ethnicity and socio-economic status and clients presented with a range of severe and / or enduring difficulties including depression, anxiety, obsessive-compulsive disorder, post-traumatic stress disorder, phobias, psychoses and histories of trauma and abuse. The Psychology Service offered individual and group therapy which took a primarily cognitive-behavioural approach. Clients receiving individual therapy were usually offered short or mid-length interventions (between eight and sixteen sessions) although some clients were seen for longer periods where appropriate.

My primary responsibilities included working with clients in cognitive-behavioural or integrative individual therapy as well as co-facilitating groups for ‘Managing Depression’ and Post-Traumatic Stress Disorder (PTSD). I conducted assessments and administered diagnostic tools (such as those used for PTSD) under supervision. I liaised with other members of the team who were involved in the care of clients and with their G.P.’s and Consultant Psychiatrists where appropriate. I also had the opportunity to attend a number of allocation and Psychology departmental meetings and accompanied and observed a CPN in an assessment and on a home visit. I attended weekly supervisory sessions.
Introduction

This paper aims to give an overview of my development as a Counselling Psychologist and in so doing, discuss how it is that I engage with theory, research and practice. This includes reflection upon my journey into Counselling Psychology and the values inherent to it, the role of empirical enquiry and its integration with practice and my personal engagement with psychological theory. Whilst this in many ways requires a description of an underlying structure or outlook from which I practise, I hope also to paint colour and detail onto this structure through a discussion of my work in placements and my learning both from supervisors and from clients.

Personal journey into Counselling Psychology and the values therein

Prior to the commencement of my training, I had worked as a Samaritan which promoted the demonstration of warmth, active listening and empathy as well as respect for the callers' phenomenological experience and choice. These values and techniques appealed to me. However, the work was for the most part, not guided by theory or evidence-base and there was rarely opportunity for the development of a relationship beyond the length of the call. This is not a criticism of what I believe to be an excellent service, but rather an acknowledgement of my own desire to develop a professional identity which would enable me to integrate such elements into a 'helping relationship' with others.

I also worked in a prison where I facilitated cognitive-behavioural oriented programmes with groups of male prisoners. The skills I used as a Samaritan were valuable here in the development of good 'working alliances' with the men and one of the programmes which I co-facilitated, also took attachment theory (e.g. Bowlby, 1979; Bartholomew and
Horowitz, 1991) into consideration, which I found hugely inspiring and indeed helpful in
the work we were doing. However, whilst I welcomed the opportunity to work in a way
which drew on psychological theory and was supported by research evidence, I also found
the programmes restrictive as they were (necessarily) guided by the need to reduce
offending behaviour, with there being consequently little room to be guided by what the
individual wanted or would find helpful. Furthermore, whilst I respect the aims and the
need for such programmes within the Prison Service, there was nevertheless an
undercurrent of ‘doing’ something to the group members in a prescribed way, in order to
‘cure’, in this instance, their offending behaviour, which sat uncomfortably with me.

However Counselling Psychology seemed to promote aspects of my previous experience
which I had enjoyed and found helpful, whilst also approaching client work from a
philosophy of placing a respect for the uniqueness and diversity of individuals at the centre
of practice (Woolfe, 1996). In addition, it stresses the primacy of the therapeutic
relationship characterised by the person-centred conditions of empathy, congruence and
unconditional positive regard, first promoted by Rogers (1951), whereby the helper is
viewed as working in collaboration with the client to facilitate the client’s growth (Woolfe,
1996). It is evident that this therefore takes a very different stance to that of the traditional
‘medical-model’, whereby practitioners are seen as ‘doing’ something to the ‘patient’ to
‘cure’ some kind of illness (Woolfe, 1996).

In foregrounding the interactional process between client and therapist, Counselling
Psychology also promotes substantial self-reflection and commitment to developing self-
awareness on the part of the therapist. My personal therapy has been a crucial part of this
development and something I was keen to engage in on a regular basis after having had
some sporadic therapy provided by the Prison Service.

In particular, personal therapy has provided me with a means of support through what has
been a demanding and challenging three years and also my therapist has provided in many

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ways, a ‘model’ for my own client work – something which was most helpful in the early stages of training, when the development of my own way of ‘being’ with clients was in its infancy. Furthermore, it has allowed me to heighten an awareness about my own personal conflicts and to consider how these have at times been triggered by or manifested in my client work. In such a way, I have benefited from a personal development which extends into all aspects of my life, as well as being better placed to tease apart what is ‘mine’ and what is ‘my clients’ and thus reduce the chances of me acting to serve my own needs rather than theirs. In addition, it serves to constantly remind me of what it is like to be a client and how it can be simultaneously insightful and rewarding yet painful and challenging.

Thus many of the underlying values and training requirements of Counselling Psychology were instinctively appealing to me, as was the integration of these values with theoretical understanding and empirical enquiry.

**Evidence-based practice in Counselling Psychology**

Whilst the therapeutic relationship might be both intuitively and theoretically foregrounded by Counselling Psychologists (and other practitioners), this does not occur without consideration of objective measures of ‘what works’ in therapeutic practice. The importance of the quality of the therapeutic relationship to psychotherapy outcome has long been established and it has been acknowledged that a positive relationship is as predictive of positive outcome as any particular theoretically oriented technique (e.g. Blatt, Sanislow, Zuroff & Pilkonis, 1996; Castonguay, Goldfried, Wiser, Raue & Hayes, 1996; Karasu, 1990; Luborsky, McLellan, Woody, O’Brien & Auerbach, 1985). It is believed therefore, that it must be such ‘common factors’ between all therapies which have led to the failure to find significant differences in outcome of psychotherapy between different theoretical approaches (e.g. Lambert & Bergin, 1994; Smith & Glass, 1977; Stiles, Shapiro & Elliot, 1986).
However, whilst I have therefore placed the development of a good therapeutic relationship at the centre of my work, there are instances where the evidence-base does favour certain approaches to therapy for certain presenting difficulties. This has guided my work for example with clients with phobias (e.g. vomit phobia and claustrophobia) where we have focused primarily on a graded exposure to their feared stimuli given that this is suggested in the research evidence to have significant efficacy (Roth & Fonagy, 1996). In such a way, the gap between research and practice is bridged by taking the stance of 'scientist practitioner', whereby instinct and faith in ways of working are not seen as sufficient, but rather are evaluated by more scientific testing (O'Brien & Houston, 2000).

As well as considering how existing research integrates with theory and practice, I have also carried out my own research, the focus of which was inspired by my work with a client who had a missing loved-one as well as by my own experiences of loss. It became apparent to me that my client’s phenomenological experience, whilst having parallels with other types of loss, was in many other ways distinct (beyond the uniqueness which is of course inherent in each individual). I was therefore motivated to use empirical inquiry to research the phenomenological experience of individuals with missing loved-ones (Gibbard, 2003). In this instance, it was evident that an exploration required the use of a research method which could do justice to the richness of their accounts and thus I analysed the data using Interpretative Phenomenological Analysis (IPA) (Smith, Jarman & Osborn, 1999; Smith 1996; Smith, Flowers & Osborn, 1997). This is used for the analysis of qualitative data and attempts to inhabit the participants’ phenomenological worlds through engaging with the data and thus the participants’ perspective. It is assumed that through this process meaningful interpretations can be made about the participants’ experience and thinking (Smith et al, 1997).

Whilst I certainly value such qualitative approaches, not least for their ability to reflect richness and diversity of subjective experience which is central to the discipline of
Counselling Psychology, I see myself as embracing a ‘methodological pluralism’ (Barkham, 1990), whereby research methods are selected on the basis of how they might best answer the research questions being posed. Indeed, this methodological pluralism can be said to parallel the theoretical pluralism or diversity which is also embraced by Counselling Psychology (Woolfe, 1996), which I shall consider next.

Theory in Practice

Theory is necessary so that interpretation is not inspired guesswork. But theory should be the servant to the work of therapy - not its master. (Casement, 1991, p9).

This quotation helps to reflect my approach to theory and how I make use of it within my practice. It is my responsibility to find a way of working with a client which will best meet their needs and thus make use of theory accordingly. This is of course an age-old principle in psychotherapy. In 1928, Jung advised beginners to “learn your theories as well as you can but put them aside when you touch the miracle of the living soul” (p362, cited in Clarkson, 1996). I therefore welcome the message in both quotations as they imply that theory is something to be used, to guide us, a map perhaps which we can follow. However, a map it is, thus there may be many different routes to arrive at a destination.

I also believe that no one theory can ‘have the answers’ about how to work with all clients, but more than that, theories can be used together to compliment and enhance one another (Clarkson, 1996). However, using theory as a map or ‘servant to the work of therapy’ is I feel made rather more complex when there are at least these three ‘servants’ or maps to choose from (as is required by the BPS Diploma in Counselling Psychology, BPS, April 2001- March 2002) and in particular, when attempts are made to combine these theories or aspects of them. How I make this work in practice, requires further explanation.
Readers may already have noted that my belief in the usefulness of combining aspects of different theories together, to suit the evolving needs of the client, suggests that I take an approach of ‘technical eclecticism’ to my work. This enables the practitioner to choose “the best or most appropriate ideas and techniques from a range of theories or models, in order to meet the needs of the client” (McLoed, 1993, p. 99). I would therefore not profess to practise ‘integration proper’ or ‘theoretical integration’, whereby a new internally consistent theoretical framework is developed from the combining of at least two theories (Ryle, 1995). The need for internal consistency in theoretical integration seems particularly complex and it can be difficult to always identify when aspects of different theories (or techniques therein) are at some deeper level, contradictory. Indeed, it has been suggested by some that such ‘incommensurability of paradigms’ (Kuhn, 1970) makes true theoretical integration ‘impossible’ (e.g. Lazurus, 1995). However, I also agree with O’Brien and Houston who assert that “theoretical compatibility of ideas is not always a necessity for good clinical work” (2000, p7).

It is also noteworthy that I have used a form of ‘common factors’ integration in my use of schema theory (e.g. Young, 1990; Young, Klosko & Weishaar, 2003; Safran & Segal, 1990) on my third year placement. Common-factors has been said to represent the third category of approaches to integration (the other two being technical eclecticism and theoretical integration) (Castonguay & Goldfried, 1994) and involves identifying common themes across different approaches to therapy and combining them into a new approach (Goldfried, 1982). Thus my approach to the integration of theories, is essentially pluralistic (Samuels, 1989) as the integration occurs more at the level of clinical practice than at deeper levels of analysis (Horton, 2000).

This journey towards integration has certainly been an evolving, uncomfortable, frustrating yet at times rewarding and satisfying process. I have had to question such things as whether I am trying to combine theories which at some point down the line are incompatible, complimentary, or whether the differences that exist are more differences in
language than concept. However, perhaps most importantly, my combining of aspects of theories has been done so with consideration, in particular, of how it would impact on and be experienced by the client.

Casement wrote that "competence is not about being certain, it is about preserving a state of not-knowing" (1991, p.8). I feel that this is a useful idea to bear in mind, not only in my client work, but also in the integration of theories and how in turn they are applied in situ. This is not a defence against ignorance, but rather a source of energy and inspiration. I recognise the anxiety created in me now by 'not-knowing' and hope that I learn to tolerate this more as I become more experienced as a therapist, thus allowing me to continue to embrace new theories despite the tension which may be created.

The account I have given thus far has in many ways been a description of a framework of my integration of research and theory to clinical practice, upon which the detail and colour of individual sessions with clients is painted. I hope now to provide more of that detail by turning to consider my development on placements and give more specific examples of the ways in which I have used humanistic, psychodynamic and cognitive-behavioural theory in practice.

**First Year Placement**

During my first year I worked in a Psychology Service of an NHS Trust. This gave me the opportunity to work in a multidisciplinary team, allowing me to observe how the team members worked together and how the service integrated with others within the trust. It also provided me with the opportunity to work with clients with a range of psychological difficulties including ambiguous loss, bereavement, social anxiety, depression and self-harm.

My client work took a primarily humanistic approach (Rogers, 1951, 1957, 1961) on this
placement. This suggests that people have an inherent need for and drive towards growth and self-fulfilment and, given the opportunity and appropriate conditions, the healthy though hidden self (organismic self) will emerge (O'Brien & Houston, 2000, p87). It is argued that the therapist can provide such conditions by creating a safe and supportive environment and demonstrating the ‘core-conditions’ of empathy, congruence and unconditional positive regard. This process primarily focuses on the ‘here and now’, allowing clients to express and explore their current feelings and experience.

However, even at this early stage in my training, I was at times drawn towards other theories or aspects of them. My past experience in the prison of considering the impact of attachment styles and the cognitive-behavioural approach to the programmes, at times influenced my work with clients. Furthermore, my supervisor, a Counselling Psychologist, made regular use of cognitive-behavioural theory and techniques, which in turn had an influence on my ways of thinking about and working with clients. The holding in mind of these different theories may be best exemplified in my work with Mr. W.

Mr. W, a thirty-six year old man was referred for depressed mood following the deaths of his mother and a close friend. During the assessment it seemed that his low mood was maintained by a number of prominent thoughts such as being a “bad person” and “letting people down” and he voluntarily spoke of the thoughts which would be “running through his mind”. In discussion with my supervisor (and no doubt influenced by my past experience), the decision was therefore made to take a cognitive approach to the therapy, with the hope of allowing Mr. W to re-evaluate some of these cognitions in favour of those which could boost his sense of self-worth. However, I soon became aware of a sense of a ‘power struggle’ between us and considered that in my efforts to encourage Mr. W to re-evaluate his thoughts, I had probably failed to allow him to feel truly ‘heard’ or ‘held’ and to express the painful emotions he felt surrounding the losses he had suffered. In discussion with my supervisor, the decision was therefore made to abandon such attempts to focus on cognitions and instead to take a more specifically humanistic approach to the
work.

Through this work we considered that the depression triggered by the loss of his mother and the guilt that he felt at being involved in the decision to have her life support machine switched off, led to the loss of a more ‘ideal’ sense of himself which was ‘happy’ and ‘fulfilled’. However, as the sessions progressed, Mr. W began to consider that he could “get that [his name] back” and that his current difficulties may have been a temporary albeit painful barrier against continued growth and self-actualisation.

Throughout these sessions Mr. W also made frequent reference to the ending of a relationship with a female friend and we would often discuss his fears of being “abandoned” and “rejected” by others and by women in particular. He also frequently made links between the relationship he had had with his mother and the relationship he had had with his friend. I found it helpful at this point to consider attachment theory and how he may have developed styles of relating early on, which were characterised by such fears (anxious / avoidant attachment, Bartholomew and Horowitz, 1991) and continued to influence his relationships in the present. In discussion with my supervisor, it was agreed that tentative interpretations around this hypothesis could be made and thus in this regard, my work with Mr. W resembled a technical eclecticism whereby I was introducing more psychodynamic ideas and techniques into our work. I also found such theory useful in terms of thinking about how these hypothesised ‘styles’ of attachment might manifest themselves in my relationship with Mr. W, alerting me to the need to be mindful of creating an ‘ending’ to our work which would reduce the chances of him feeling similarly ‘abandoned’ or ‘rejected’.

Second Year Placement

During my second year of training I worked in an adult Psychotherapy Service where I took a primarily psychodynamic approach to my client work. The ‘calm’ which seemed
inherent in this small department was welcome as I felt ‘de-skilled’ when I first began working in the psychodynamic model, not only because of my lack of knowledge of it at this point, but also because I struggled to visualise what working in this way might ‘look like’ as the following extract from my diary highlights;

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I’m struggling to find a balance whereby I am not bringing too much of myself into the room so that it detracts from the emergence of transference, but where I am not simultaneously appearing ‘cold’ and ‘distant’ and thus damaging the therapeutic relationship.

I was of course falsely assuming that working psychodynamically would somehow exclude the fostering of a good therapeutic relationship. The dilemma I had created, therefore led to feelings of anxiety and it was a challenging time for me. Supervision and informal conversations with my fellow trainees were extremely helpful at this point. Some colleagues echoed my anxieties and together we teased apart this dilemma – reminding ourselves that working psychodynamically was not done to the detriment of the therapeutic relationship and that this, as always, was central to the work. There was also guidance and solace in theory. In particular, I found it reassuring to read about the necessary conditions for therapy in self psychology (Kohut, 1971, 1977) and the reparative powers of the relationship advocated by object-relations theorists, such as representing the ‘good enough mother’ (Winnicott, 1965) or providing a ‘reparative relationship’ (Clarkson, 1995).

Supervision provided a safe place to ‘play’ with ideas and theory, whilst simultaneously placing the well-being and safety of the clients as paramount. I feel particularly that I developed an awareness of macro and micro-processes in client work and how to be more attuned to the less ‘literal’ communications of clients. For example, Mrs. G, who had been referred for depression following the miscarriage of her baby at a late stage in pregnancy,
spoke in an early session about having gone to a dentist. She reported how she felt very anxious that he might find something “wrong with her jaw” that she feared might require extensive and painful work. I hypothesised that she might be feeling a similar way about coming to therapy and feared that I might tell her that there was something ‘wrong’ with her which would require psychologically painful and costly work. An interpretation around this enabled us to discuss her fears regarding therapy and indeed about me. We were also able to consider together that the work might well be ‘painful’ but that hopefully it could be paced and contained in a way which would feel ultimately helpful.

This placement also increased my attunement to the inter-relationship between clients’ internal and external worlds and how these were also at times affected by various social issues. This may be exemplified in my work with Mr. B, a thirty-six year old man who had been suffering from long-standing difficulties surrounding his feelings of social isolation and his ability to develop intimate relationships with others. Mr. B had begun to suspect he was gay during puberty at which time he was also subjected to prolonged anti-gay bullying by his peers. However, he had increasingly identified himself as bi-sexual over the past ten years.

Mr. B’s minority status added a complexity to the work, in particular of acknowledging the reality of difficulties this presented him with (e.g. feeling people could not accept his bi-sexuality and wanted to pigeon-hole him as gay or straight), whilst also considering the inter-relationship between internal and external factors. He spoke at length for example of his fear of contracting AIDS, which led to an avoidance of sexual contact with men in particular. I noticed that he would always refer to contracting AIDS rather than HIV and wondered whether this in part reflected a kind of so-called ‘internalised homophobia’ (Hershberger & D’Augelli, 1996), developing as a result of the traumatic anti-gay bullying he had suffered as a teenager, that was ignorant about HIV and AIDS and conceptualised them as a ‘gay disease’ (Taylor, 2002). However, I also considered that naming AIDS rather than HIV reflected a dilemma in his internal world, where he both wanted a
relationship and sexual contact, but also attacked it, in this case making it something that was both dangerous and possibly lethal. In such a way, it seemed to serve as a mechanism for keeping people ‘at arms length’, perhaps for fear of being ostracised by society, but possibly also developing from an unconscious fear of being abandoned or rejected.

Through the interpretation of some of these hypotheses, Mr. B and I were able to explore the function and origins of some of these unconscious fears and in particular, considered how his experience as a child of feeling “unwanted” by his father and his sense of isolation from peers may have contributed to their development. Furthermore, he spoke of his mother as being both his ‘ally’ and ‘companion’ and as critical and withholding of affection (both in the past and the present). However, noticeably, he appeared to hold these representations separate from one another. This again was usefully explored in our sessions, considering how it both reflected his internalised representations of relationships with others (as potentially rewarding, yet damaging), but also as it appeared in the transference - at times flattering me and holding me up as distinct from other therapists he had seen, whilst at other times finding me similarly judgmental and critical.

**Third Year Placement**

During my third year, I worked in a Community Mental Health Team (CMHT). This was a particularly large department and provided invaluable experience of working within a multidisciplinary team where my clients might simultaneously have been under the care of Community Psychiatric Nurse, a Psychiatrist and myself. My work took a primarily cognitive-behavioural approach and I had the opportunity to apply this model to my work with clients with a range of presenting difficulties including depression, claustrophobia, vomit phobia, anxiety and Obsessive Compulsive Disorder. I also facilitated groups for managing depression for Post Traumatic Stress Disorder.

My supervisor, an experienced Consultant Clinical Psychologist, helped me to develop an
understanding of cognitive-behavioural theory and technique and how to work together with the client to identify and challenge thoughts which may be maintaining their difficulties (Beck, 1967; Beck, Rush, Shaw & Emery, 1979). Such cognitive restructuring was combined, where appropriate, with other more behavioural techniques, such as graded exposure for clients with phobias. However, I was also fortunate to have the opportunity of occasional supervision with a Counselling Psychologist. This was particularly useful in considering how to integrate aspects of my previous learning into my current practice and proved invaluable in my work, for example, with Mrs. D, who disclosed having been sexually abused as a child part way through our work on her claustrophobia. In this instance supervision helped me to sensitively manage a shift to a more humanistic way of working which allowed Mrs. D to express and explore the powerful and painful emotions surrounding her abuse and to work with the transference feelings which were evoked.

Whilst my work with Mrs. D reflected more of a shift in theoretical approach combined with a technical eclecticism, with other clients the use of the ‘common-factors’ approach of schema theory was particularly helpful. This allowed for the attendance to cognitive aspects of the client’s experience whilst simultaneously recognising the role of past experience in current difficulties and the importance of work being done within the therapeutic relationship. I had found the latter to be particularly lacking in more traditional cognitive-behavioural theory (beyond the promotion of collaborative empiricism), particularly after my experience of working in humanistic and psychodynamic models.

Drawing on the interpersonal theory of Sullivan (1953; 1954;1956), schema theorists highlight the importance of early interpersonal experience and a primal need to maintain relatedness to others, as being central to the development of interpersonal schema (Safran 1990; Safran, 1998; Safran & Segal, 1990) with Early Maladaptive Schema (EMS) developing as a result of ‘dysfunctional’ early experiences with significant others (Young, 1990). It is also suggested that schema are likely to be self-perpetuating, inviting an ‘action tendency’ (Kiesler, 1982; 1988) in others which ‘hooks’ or ‘pulls’ them into responding in
schema-confirming ways, known as the ‘cognitive-interpersonal cycle’ (Safran, 1990; Safran 1998). In such a way, the therapeutic relationship is fore-grounded as it is suggested that the pattern of relating in this relationship will be a reflection both of the client’s interpersonal schema and relationships outside of the therapeutic setting (McGinn et al, 1995; Safran, 1998; Safran, 1993; Safran, 1990; Safran and Segal, 1990).

Furthermore, the theory lends itself to working in the therapeutic relationship as it is proposed that it can provide the opportunity for ‘limited re-parenting’ whereby the therapeutic relationship “provides a ‘corrective emotional experience’ specifically designed to counteract the patient’s Early Maladaptive Schemas” (Young et al, 2003, p.182).

The power of schema in influencing the therapeutic relationship, even in the very first encounter, can be illustrated by a presentation of my work with Miss. H, a thirty-nine year old woman. She presented with anxiety primarily related to relationships, particularly with men. As her narrative filled our first session, I felt bombarded, overwhelmed and almost entirely unable to exert any presence in the room. My automatic thoughts whilst listening to her included; ‘I don’t think we can work together’; ‘I’ll have to refer her on’. It transpired as she spoke that she had a deep fear of commitment and a tendency to keep people ‘at arms length’ (as she seemed to be doing with me), something which seemed to serve as a protective measure against being hurt by letting others too close or ultimately being rejected by them. My formulations implied that she may well have EMS in the domain of ‘disconnection and rejection’, fearing both rejection by others (abandonment / instability schema) as well as the expectation that others will abuse, manipulate or take advantage of her (mistrust / abuse schema) (Young, 1990).

As I reflected upon this after our meeting, I realised how my thoughts and thus behaviour (my action tendency) of being unusually absent in the session, were probably consistent with her early maladaptive schema, perhaps confirming her belief that others would not want to get too close to her or would reject her. Had I acted upon my automatic thoughts that I needed to ‘refer her on’, I would probably have confirmed her schema that others
reject her and it is safer not to let them near.

Miss. H later spoke of how at aged twelve, she had been sexually assaulted by a man. We considered how this seemed to be highly salient in the development of the belief that ‘others can hurt her’ and thus it is safer to keep them at a distance. Furthermore, she spoke of how as a child, she had experienced her mother as being ‘unavailable’ and unable to provide protection or support when she needed it most. Thus it seemed that such experiences may also have contributed to the development of schema related to ‘abandonment and instability’, whereby others are perceived as unreliable in the provision of protection and support (Young, 1990; Young et al, 2003). Understanding the early dynamics in our relationship in terms of her early experiences and associated schema, helped me to remain mindful of the potential for our relationship to represent a different way of relating to somebody, where she could feel held and accepted, despite allowing somebody closer to ‘knowing her’ than she usually felt able to.

Thus it can be seen that schema theory integrates concepts from a number of approaches. As well as its cognitive focus, it explicitly draws on interpersonal theory and there is striking overlap of the concepts of ‘cognitive-interpersonal cycle’ with ‘repetition compulsion’ (Freud, 1913; 1920), of a ‘hook’ similar to that described in transactional analysis (Berne, 1964) and of ‘limited re-parenting’ with the ‘reparative relationship’ proposed by Clarkson (1995). Young et al (2003), also acknowledge how the triggering of EMS in the therapeutic relationship is similar to Freud’s concept of transference, whereby the client “is responding to the therapist as though the therapist were a significant figure from their past” (p. 179). In such a way, I found that this cognitive-interpersonal approach acknowledged the importance of, and provided a theoretical explanation for these mechanisms and phenomena, thus enabling me to integrate aspects of my past learning into a cognitive framework.
Conclusion

I hope that this paper has given the reader an understanding of my development as a Counselling Psychologist over the past three years and how it is that I integrate theory, research and practice, whilst remaining faithful to the underlying philosophies of the discipline. However, it seems important to conclude by highlighting that this discussion is not intended to suggest that this process of development is complete or that the underlying structure from which I practise is fixed. I am aware that where I am now in regards to this task is very different to where I was one and two years ago and this will, I am sure, continue to evolve, re-form, melt and solidify as the years go on and I meet new clients, encounter new theories, new work contexts, supervisors and colleagues.
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Press.


Introduction to Research Dossier

The research dossier contains a literature review, and two empirical pieces of research; one qualitative and one quantitative. The common strand running through these studies is the situation of having a loved-one go missing. The literature review identifies situations in which 'going missing' occurs and reviews the literature relating to the process and phenomenological experience of family members who are 'left behind'. The implications of these findings for Counselling Psychology practice are considered. The second study is a qualitative piece exploring the phenomenological experience of four individuals who had a loved-one go missing. The third paper explores therapists' levels of agreement with various aspects of bereavement theory and their implications for practice. It highlights differences in agreement dependent on whether loss is 'certain' or 'uncertain' and different theoretical approaches to therapy. Reflections on the use of self in these research studies are included at the end of each paper.

As highlighted in the introduction to the portfolio, any identifying information relating to participants within this dossier has been changed to preserve confidentiality.
Being left behind: The impact on family members of having a loved one go missing.

Abstract

An estimated 210,000 people are reported missing in Britain every year (National Missing Persons Helpline, 2002) and there are many families who are consequently left behind. Given the increasing potential for practitioners to be required to support individuals and families in this situation, the present paper explores the impact of this loss through a review of the literature in this field. The situations in which going missing occurs are highlighted before the process and experience of family members who have a loved one go missing are reviewed along with the implications of these findings for practitioners. Finally, especially in regard to a lack of specific theory related to this experience, implications for future research are considered.
Introduction

A missing person can be defined as somebody who is absent from social expectations and responsibilities (Payne, 1995) and fundamentally might constitute those whose whereabouts are unknown by significant others. According to Home Office estimates, approximately 210,000 people are reported missing in Britain every year and whilst the majority return home within seventy-two hours, thousands do not (National Missing Persons Helpline, 2002).

When people go missing, there are usually those who are consequently ‘left behind’ – families and friends for whom the whereabouts of their loved ones are unknown. Whilst in some cases of missing children, the distress of the families is transmitted nation-wide into our homes via television and newspapers, the experience of many more goes unreported and indeed even the academic literature in this field is relatively sparse. The scale of the problem of ‘missing persons’ and the increasing awareness of this within society would suggest that a review of the literature on the impact on families would be timely and appropriate. Such a review could be of use in order to generate hypotheses for further research, as well as to inform practitioners including Counselling Psychologists who might come to work with clients in this situation.

To the author’s knowledge, such a review has not been conducted. This paper therefore aims to review the literature on the experience of family members of having a loved one go missing. It will first briefly outline the situations in which ‘going missing’ occurs before extensively reviewing the process and experience of those who are left behind. The primary focus of this will be on the feelings generated by such a loss, as these appear to be fundamental to the experience of such individuals. Other aspects which may impact on this process will also be considered, such as the situation in which going missing occurs, the relationship between the family member and the missing loved one and the family system as a whole. A discussion of the above in turn allows for a consideration of the implications that the findings have for practitioners and in particular, the ways in which an enhanced understanding of this experience might enable them to work insightfully and effectively
with individuals in this situation. This seems particularly important considering the relatively unique nature of this loss, as whilst it might have parallels with other forms of loss, it brings with it its own unique dynamics and difficulties. Whilst this review will draw on existing theory where appropriate, it would seem that ‘losing’ family members in such a way contributes a significant and relatively unique dynamic to their experience. The paper will therefore call for the development of a more localised theory that can better account for the specific nature of this loss and is more sensitive to the phenomenology of those in this situation.

**Situations in which people go missing and the reasons why**

The situations or reasons for going missing can be seen to be influenced by various personal, interpersonal, social and at times political variables. Biehal, Mitchell and Wade (2002) reviewed ‘going missing’ in the UK, drawing on records of 2000 people reported to the National Missing Persons Helpline and questionnaires completed by 114 formerly missing people. The authors summarised the meanings of going missing on a spectrum of disappearances ranging from ‘intentional’ to ‘unintentional’ and found that 64% ‘decided’ to leave, 19% ‘drifted’ out of touch, 16% went missing ‘unintentionally’ and 1% were ‘forced’ to go missing (Biehal et al, 2002).

The majority of adults and children who decided to leave, did so as a result of conflict and breakdown in relationships. Others left to escape problems such as domestic violence, abuse, financial difficulties or problems at school and some left following deterioration in their mental health, or in order to commit suicide. Of those who ‘drifted’ out of touch, the majority did so as a result of moving away or their ‘transient’ lifestyles influenced by mental health, drug or alcohol problems. The majority of those who went missing ‘unintentionally’ were over 60 years of age and suffering from dementia. Other unintentional disappearances were connected to depression, psychotic illnesses, or having missed medication. Finally, the authors found that the majority of those who were ‘forced’ to go missing were children and their disappearance had occurred as a result of parental
abduction or being ‘thrown out’ of their family home by a parent (Biehal et al, 2002).

Such classification of the reasons for going missing can be found elsewhere. For example Payne (1992) identified five categories; ‘runaways’, resulting from an immediate social pressure, ‘throwaways’, constituting those who are asked to leave, ‘pushaways’, referring to those who are forced to leave to escape a situation such as abuse, ‘fallaways’, including those who have drifted out of touch and ‘takeaways’, where individuals are kidnapped for criminal intent or abducted by parents (Payne, 1992; Payne, 1995).

It is estimated that up to 1000 children are abducted away from the UK every year by a parent (Reunite, undated) and it might be supposed that the numbers still residing within the UK are significantly greater (Payne, 1995). Estimates in the USA of parental abductions of children are as high as 163,000 per year (Hatcher, Barton & Brooks, 2000) with 35,000 lasting a month or longer (Finkelhor, Hotaling & Sedlak, 1992).

However, whilst intrapersonal and interpersonal difficulties may therefore be the most common causes of going missing, particularly in western culture and at this particular point in history, it is also apparent that national and political events can lead to multiple missing persons. Perhaps the most obvious of these events is War and indeed much of the information available about the impact of having a loved one go missing is derived from the aftermath of the Vietnam War, which ended in 1973 with 2,453 men listed as ‘Missing in Action’ (MIA) (Campbell & Demi, 2000; Doyle, 1992). Even more striking is the case of the so-called ‘dirty war’ in Argentina which raged from 1976 to 1983 and resulted in an estimated 11,000 disappearances at the hands of the Argentine military. (Robben, 2000). Such widespread disappearances prompted research into the impact on those left behind.

Thus the situations in which people go missing are varied and as such there are many ways in which people can be ‘left-behind’. Indeed going missing is a two-way social situation, that is to say that people go missing and are experienced by others as missing (Payne, 1995).
Family members' process and experience

It is apparent that within the literature on the experience of family members of having a loved one go missing, the situations outlined above are not equally represented. There is for example, little reference to more 'intentional' forms of going missing. Instead the focus seems to fall on missing children, children abducted by a parent and other more widespread disappearances such as those occurring during War. Much of the literature is also descriptive and apparently derived from numerous in-depth interviews, although the method of gathering data or the sources used are often not made explicit. However, those studies which are more transparent in their approach to gathering data can often be seen to confirm and parallel the more descriptive literature available.

The organisation of these experiences within this review (and in particular a focus on feelings) has been intended to reflect the predominant themes within the literature as well as to remain true to what appears to be the phenomenology of these families. For this reason it seemed appropriate to attribute significance to those elements of the experience which appeared to be most salient to the families of missing loved ones. However, these experiences are of course communicated through the researchers' and authors' interpretative frameworks and even if authors strive to reduce the impact of this (as is the case in this review; see personal reflections), it can never be entirely eliminated.

Uncertainty

Throughout the literature on the impact on family members of having a loved one go missing, perhaps the most frequently observed difficulty relates to the ambiguity and uncertainty of the situation. This has been noted when children go missing (Fravel & Boss 1992; Lloyd & Zogg, 1986) or are abducted by a parent (Hatcher et al, 2000) as well as in situations where families at least know that their loved ones have gone missing in the course of War. However, this uncertainty relates not only to not knowing the whereabouts of their loved ones, but also to whether they are dead or alive. Furthermore, the uncertainty of the situation appears to be so central to these families' process, that it would seem to permeate all aspects of their experience (Fravel & Boss, 1992; Payne, 1995). The
families are in fact often referred to as being “in limbo” (Boss, 2002; Campbell & Demi, 2000; Hunter, 1986b; 1988; Nichols & Pace-Nichols, 2000; Payne, 1995).

The ways in which this uncertainty interacts with the other factors will be highlighted in the following sections. However, fundamentally the evidence of the predominating role of uncertainty in the experience of these families would suggest that practitioners should be mindful of the salience of this. Boss (2002) suggests that ambiguity should be acknowledged and articulated as a stressor in these families. However, in addition, family members may have to prepare for the possibility that they may never know the fate of their loved one. As such, practitioners may need to support their client in finding a means of existing indefinitely with this stressor. Greif (1999) proposes that it may be of use for certain clients to consider how they have coped with ambiguity in the past. It might also be supposed that a therapist should be particularly attentive to creating clear boundaries within the work and reducing the potential for additional uncertainty to exist within the therapeutic relationship.

**Grief**

Having a family member go missing appears to trigger a significant grief reaction in many individuals. This has been noted for the parents of missing children (Fravel & Boss, 1992; Lloyd & Zogg, 1986), the parents of children abducted by the other parent (Hatcher et al, 2000), for families of servicemen MIA (Campbell & Demi, 2000) and for the mothers of the disappeared in the Argentine ‘dirty war’ (Fisher, 1989; Robben, 2000). Grief has been proposed to be the “process of experiencing the psychological, behavioural, social and physical reactions to the perception of loss” (Rando, 1993 p.22). Loss can be defined as something which “produces persistent inaccessibility of an emotionally important figure” (Weiss, 1993, p.272). Arguably, in all cases of missing persons highlighted here, the families’ experience constitutes such a loss.

The ways in which specific grief responses such as anger, guilt and searching may be manifest in individuals who have a loved one go missing will be explored in the following
sections. However, a great deal of literature also exists on the proposed phases of grief and mourning. Whilst it is not within the scope of this study to review the literature on such phases or the contention surrounding them, it is significant to note the prevalence within these models of a stage of acceptance or acknowledgement of the loss (e.g. Bowlby, 1980; Kubler-Ross, 1969; Rando, 1993). Worden (1982) pointed out that mourning cannot continue unless the primary task of acceptance is met. As such, it is apparent that in the case of families who have a loved one go missing, this process is significantly interrupted by the uncertainty of the situation and the lack of confirmation that their loved one is permanently gone (Hunter, 1986b).

This was demonstrated in the qualitative study conducted by Fravel and Boss (1992) which utilised an in-depth semi-structured interview with parents whose three young sons went missing simultaneously forty years prior to the study. Whilst due to the nature of the study, the findings cannot be generalised to other parents in a similar situation, they nevertheless offer an extremely poignant insight into experience of these parents. As the father spoke in reference to the parents of another missing child, he highlighted the essential ambiguity of whether their loss can be accepted as permanent; “As long as they have never found the body...nobody can say he is dead” (Fravel & Boss, 1992, p.135).

Lloyd and Zogg (1986) in a descriptive review of the impact of having a child go missing, also compared the experience of family members to the bereavement process. They highlighted that whilst family members who suffer a loss through death should eventually accept its finality, for families of missing children to accept that the child will never be found, would be “to deny the very existence of the child” (Lloyd & Zogg, 1986, p.271). Thus it is not only the lack of physical evidence to confirm the loss that is significant, but also the meaning attached to this resignation.

Another significant aspect of the grief reaction for families who have a loved one go missing, is the lack of ritual and recognised social response to the loss. Whilst following a death, cultures have a prescribed way of marking the situation through ceremony, such as
a funeral, when a person goes missing, the uncertainty of this loss means that such ritual does not take place (Boss & Greenberg, 1984; Doka, 1989; Rando, 1986). A spokesperson from a missing persons organisation commented that “Like with death, (the families) go through denial, anger, grief - but there is no funeral, no funeral director to take care of their needs” (Gelman, Agrest, McCormick, Abramson, Finke Greenberg, Zabarsky, Morris, & Namueth, 1984, p. 85). The absence of this is said to further exasperate the grief response through a lack of ‘closure’ to the loss (Boss, 1991). The ritual of a funeral is also proposed in psychoanalytic theory to allow the corpse to represent the transitional object (Robben, 2000). Anna Freud (1969) suggested that feelings of anger, abandonment and hurt are displaced onto the physical remains and thus allow for the transition from the phases of denial and detachment. Thus the lack of this element of ‘mourning’ the loss may be significant as it is suggested that mourning as well as grief must occur if successful accommodation of the loss is to be achieved (Rando, 1993).

The importance of such ritual following loss was evident in some wives whose husbands went MIA in the Vietnam War. Memorial services held after the end of the war when their husbands had not returned with the other Prisoners of War (POWs) were found to be helpful in aiding them to complete the grief cycle and to reach the final stage of acceptance (Hunter, 1981). However, most parents of these men fought against this ‘presumption of death’ as for them it constituted a giving up of hope (Hunter, 1986b).

For practitioners working with families who have had a loved one go missing, the findings of a ‘grief response’ are significant. For example, it may be helpful for certain clients to have their loss validated and to be reassured that this reaction is a ‘normal’ response to such a loss. This may enable exploration of the loss, reactions to it and the meaning of the lost relationship (Middleton, Raphael, Martinek & Misso, 1993). The significance of absence of ritual would also imply that certain clients might benefit from some means of commemorating their loss. This was the case for a daughter of a serviceman who went
MIA, who commented that; “the most important thing I learned was the need to somehow honour and remember a parent who has died” (Campbell & Demi, 2000, p. 13). However, fundamentally, the uncertainty of the permanence of the loss suggests that the experience of grief is qualitatively different for these families. This would imply that existing models of grief and mourning are inadequate in their ability to account for the experience of these family members. Thus in the absence of more localised theory, practitioners would need to respect the meaning of the loss to the individual client as indeed they would for any client faced with the loss of a loved one.

Hope and Acceptance

Hope of finding their loved ones alive is a commonly highlighted theme for families who have a loved one go missing whereby the uncertainty of the situation prohibits a resolution of grief, whilst simultaneously maintaining a sense of hope (Lloyd & Zogg, 1986). This hope can be seen in the extreme in the case of the parents who maintained the hope of finding their three children alive forty years after their disappearance (Fravel & Boss, 1992) or the wives and parents of servicemen MIA who maintained hope of their husbands and sons returning 28 years after the men disappeared into the jungles of Southeast Asia (Hunter, 1986b; 1988). The level of hope fostered by children of fathers MIA seemed to be particularly linked to their mother’s degree of hope and acceptance (Hunter, 1988). One teenaged child in a documentary film spoke of the impact of seeing the North Vietnamese propaganda films featuring American POW; “I was positive that little face in the lower left hand corner was my father. You don’t even see that face immediately, but when I saw it, I gasped, because I knew...It was all I needed...I knew my father was alive...but my family was one of 25 families that each claimed that tiny little face to be their missing man!” (Smith, 1978).

Parents of children abducted by the other parent also maintained hope of being reunited with their children. This was highlighted in an in-depth review of one mother’s experience (Hatcher et al, 2000) and a quantitative study of the experience of 371 parents (Greif,
1999; Greif & Hegar, 1991). In this latter study, parents' experiences were only identified if they were part of the pre-selected reactions identified by the researchers and thus there was a lack of 'richness' to the data. However, these quantitative and qualitative studies appear to complement one another in their findings.

In a review of the information gathered from a series of in-depth interviews with parents of servicemen MIA, Hunter (1986b) noted their hope was maintained by the 805 reported sightings of American POWs in Indochina as of 1985 and the continued release POWs for sixteen years after the end of the war (Hunter, 1986b). In contrast, some of the wives of these missing men were able to accept that their husbands were probably not going to come home. They felt they had to 'close-out' their husbands in order to continue with their lives (Hunter, 1988). This desire would seem to have developed from another form of hope - a hope of closure, even if this means knowing that their loved ones are dead (Fravel & Boss, 1992).

Throughout the literature on the impact on family members of having a loved one go missing, numerous authors have asked the question 'to what extent is hope dysfunctional' or can the lack of acceptance of the loss truly be labelled as 'pathological grief' (Fravel & Boss, 1992; Robben, 2000). The conclusion has often been that in the face of such uncertainty (and occasionally genuine cause for hope such as sightings) such labels are not justified. However, it has also been proposed that a balance needs to be achieved between hope and acceptance by developing a realistic appraisal of the chances of finding their loved ones alive (Boss, 1991; 1999; 2002; Fravel & Boss, 1992).

Practitioners working with individuals who have had a loved one go missing may therefore have to support their client in establishing this balance, whilst avoiding imposing what they consider to be a 'realistic' appraisal of the situation. It would also seem that the practitioner should fundamentally respect the client's need for hope and avoid labelling the maintenance of this as 'dysfunctional' or 'pathological', particularly when acceptance of the loss as permanent could simultaneously heighten feelings of guilt.
Guilt

Guilt is also a common reaction in grief, although there are certain situations of loss which may give rise to more complex and intense feelings of guilt than others (Rando, 1993). Perhaps unsurprisingly, guilt has often been identified in those who have had a loved one go missing.

In a review of the impact on parents of having a child go missing, Lloyd and Zogg, (1986) proposed that the guilt experienced is triggered by feelings of helplessness as well as wondering if they were in some way responsible for their child's disappearance. This may in some cases lead to the parents insisting on accepting full responsibility for the loss of their child and seems to be particularly prevalent when the child was abducted by the other parent (Lloyd & Zogg, 1986).

Descriptive evidence of numerous in-depth interviews suggests that the parents of the 'disappeared' in Argentina also felt guilty for having failed to protect their adolescent and adult children (Fisher, 1989; Robben, 2000). This was felt even more profoundly when their children were taken from the family home which was the preferred tactic of the Argentine military (Robben, 2000). Parents of servicemen MIA also had significant feelings of guilt, ruminating that "perhaps I didn't raise him strong enough to survive" (Hunter, 1986b, p.283) and appeared to find it harder to let go of their guilt than did the wives of the missing men (Hunter, 1983).

Increased acceptance and diminished hope have also been found to increase guilt. One mother of a serviceman MIA commented that; "There have been many, many times when I think I'll just have to give up on this; we are not getting anywhere. Then almost immediately I realise I can't give up. My son might be alive and if I don't do all that is humanly possible, how could I deal with that?" (Hunter, 1986b, p.279). This interplay between guilt and acceptance is also echoed in the words of a father whose son disappeared in Argentina; "I never ever thought that my son was dead, if not it would have
given me the feeling that it was me who had killed him” (Robben, 2000, p.89). For another mother it took less than an acceptance of her loss to trigger feelings of guilt; “I have often felt guilty for not having thought about my son every moment” (Hunter, 1986b, p.286).

An element of ‘survivor’ guilt also seems to be present in family members who have a loved one go missing. This normally refers to the feeling of guilt for surviving when someone else has died (Rando, 1993). However, in this instance it appears to be related to guilt at surviving when the other person has disappeared. This was identified in some siblings of children abducted by a parent, who experienced guilt for their sibling having been abducted rather than themselves (Greif & Hegar, 1991). Some mothers of the disappeared in Argentina also felt that they should have disappeared instead of their children (Bettelheim, 1979).

Such findings would suggest that practitioners working with individuals who have had a loved one go missing, would need to be aware of the possible existence of such feelings of guilt in their clients and to validate them as a ‘normal’ response to such a traumatic loss. Clients may benefit from an opportunity to express these feelings and perhaps to reappraise them. However, these feelings may also serve a protective function and to attempt to ‘strip’ them away, could prove more damaging than productive (Rando, 1993). This seems particularly important considering the apparent interrelationship between feelings of guilt and continued hope.

**Searching**

Bowlby (1980) and Parkes (1970; 1972) have suggested that the desire to search for the deceased is an innate part of mourning and that “pining is the subjective and emotional component of the urge to search for a lost object” (Parkes, 1972, p.40). However, for the families of missing people, this desire to search is also part of the hope of recovering the relationship, which is maintained by the ambiguity of the loss.
Lloyd and Zogg (1986) highlighted the importance of the search to parents who have a child go missing. They described this as a period of “action oriented momentum” (p.272) where members of the community are frantically contacted in an effort to locate the child. When this fails, it gives way to a more widespread search involving law enforcement and the media. However, if the child is not found, this search is fundamentally endless (Lloyd & Zogg, 1986).

Incessant search has also been noted in parents whose children were abducted by the other parent (Hatcher et al, 2000) and in the parents of three missing boys who forty years on post adverts in the paper for their children (Fravel & Boss, 1992). Mothers of the disappeared in Argentina also extensively searched for their children which was highlighted as one of their means of coping (Robben, 2000). Gaining information was also the most frequently observed need in families of servicemen MIA as noted by volunteers working with them (Teichman, Spiegel & Teichman, 1978). Despite the subjective nature of this study, focusing on the volunteers’ observations, rather than directly on the families, such a desire to search and seek information seems to be supported by the accounts of families who have a loved one go missing.

Indeed such search is probably not surprising when the observations of Klass (1989) are considered. He proposed that parents come to accept the reality of a child’s death by learning the full details; “Autopsy reports, medical examiner’s reports, and, where they exist, police reports are read over and over” (Klass, 1989, p.159). Thus considering the ambiguity of the situation and the lack of information that tends to characterise missing persons cases, such search is understandable and seems to represent an attempt both to find the missing loved one and to reduce the extended uncertainty of the situation.

Practitioners may need to be supportive of this need to search and seek information as well as to respecting its possible role as a functional means of coping. As with maintained hope the practitioner may need to support the individual in achieving a balance between hope, searching and continuing with their life. The search might also require that families have
extensive involvement with law enforcement agencies and often the media. Whilst some individuals may find this activity a helpful means of coping, for others it may be much more anxiety provoking and they may require additional support through this period (Hunter, 1986a; Payne, 1995). It would also be helpful for practitioners to be aware of other avenues of support for their clients, such as the Missing Persons Helpline who offer advice and practical help with such things as publicising their case.

**Anger**

Anger is proposed to be a “normal reaction to loss” (Rando, 1993, p.463) and has been suggested to result from an attempt to find the lost loved one and to ensure that no other separations occur (Bowlby, 1969; 1973). However, for families of missing persons, this anger seems to be particularly influenced by the specific nature of their loss. Parents of servicemen MIA for example, were found to shift anger from the self, to the missing loved one, to the military and government (Hunter, 1986b). Such anger directed towards the military was also evident for those families of the ‘disappeared’ in Argentina (Robben, 2000).

In the case of a mother whose child was abducted by the father, her anger was found to be directed towards the father, the courts and police for not protecting her and her child and herself for trusting her ex-husband (Hatcher et al, 2000). Anger or more specifically ‘rage’, was also identified by Greif and Hegar (1991) in a study of 371 parents whose children had been abducted by the other parent. Anger has often been found to be displaced towards the police when children go missing for failure to locate their missing loved ones, or prevent the disappearance in the first instance (Fravel & Boss, 1992; Lloyd & Zogg, 1986). In cases where the ‘going missing’ is considered by families to be more ‘intentional’, such as ‘running away’, anger is often directed at the missing person (Payne, 1995). When these missing people are parents, children may blame the missing parent or remaining parent for their loss (Payne, 1995). This anger often translates into a loss of trust in others, law enforcement agencies (Fravel & Boss, 1992; Lloyd & Zogg, 1986) and the government
(Campbell & Demi, 2000) particularly when they are perceived by families to have been instrumental in the person’s disappearance or inadequate in their attempts to recover them.

Practitioners may also need to be aware of this loss of trust being extended to them and may therefore need to pay particular attention to the development of trust within the therapeutic relationship. The therapist should also be mindful of the potential for anger stimulated by the situation and the ways in which it might present itself in the transferential relationship. As with guilt, the client may benefit from the opportunity to name, explore and perhaps reappraise these feelings in order that they might function effectively. This may be particularly difficult and bewildering for clients whose anger is directed at the missing person (Bright, 1996).

**Stigma and Social Support**

Throughout the literature on the experience of family members of having a loved one go missing, there is frequent reference to a sense of ‘stigma’ surrounding their loss. It is suggested that the discussion of death is already taboo in our society (Provost, 1989) and it would seem that this is increased by the ‘loss’ of a loved one in such an unconventional way as them going missing. Diana Lamplugh whose daughter went missing in 1986, related this stigma to a sense of fear in others; “they feared and therefore they reasoned there must be something wrong with the family, the mother, something wrong with the daughter” (Lamplugh, 1992, p.3). The extent of this stigma was also referred to by another mother whose child went missing; “I received so much criticism that I began denying I had a child to avoid the pain” (Lloyd & Zogg, 1986, p.271).

However, rather than avoiding the family of the missing child, it is suggested that members of the community simply become self-absorbed by the fear that their child might also disappear (Greaves, Currie & Carter 1982; Lloyd & Zogg, 1986; Teichman, 1975). Nevertheless, support from others, or more specifically the perceived availability of social support (Reif, Patton & Gold, 1995; Sarason, Sarason, Shearin & Pierce, 1987) is proposed to be crucial to successful grieving (Bowlby, 1973). Thus, such perceived stigma
could serve to hinder the grief process and exasperate feelings of isolation that families of missing children report feeling (Lloyd & Zogg, 1986).

In other situations in which people go missing, the stigma surrounding the situation may be at a much broader social level as was the case in the Vietnam War (Hunter, 1998). Families of servicemen MIA were cautioned not to discuss their missing loved ones with anyone in case it brought harm to themselves or the missing person (Hunter, 1986a; 1986b). The stigma and unpopularity of the War also impacted some children of fathers MIA. They often hid their fathers’ MIA status from their peers and were confused by their feelings of shame that they struggled to verbalise (Hunter, 1986a).

One parent of a serviceman MIA spoke of the prolonged effect of this stigma; “After the peace treaty and our men came home, no one wanted to talk or hear about the Vietnam war...Besides the tragedy of losing a son, the indifference of the government, other people, and even friends, is difficult to deal with.” (Hunter, 1986b, p.278). In contrast, a qualitative study of five family members of American servicemen MIA found the building of the national monument significant in its symbolism of a changed and more positive national attitude towards those who served in the Vietnam War (Provost, 1989). However, these families had had confirmation of the death of their loved one and thus may have been freed from many of the other complications surrounding an ambiguous loss.

Despite these findings of stigmatisation and a lack of socially prescribed response to the situation, the level of social support received by many families who have a loved one go missing does not appear to be similarly impaired. The parents of three missing sons reported receiving a tremendous amount of support from others and highlighted this as one of the factors that enabled them to survive the trauma (Fravel & Boss, 1992). The mother of a son abducted by the other parent also referred to people going out of their way to help and support her (Hatcher et al, 2000). However, it was suggested that this level of support was unusual. In addition, a parent whose child is abducted by the other parent may find
family and friends supporting the abductor or being unable to understand their distress since the child is not with a stranger (Hatcher et al, 2000).

The potential for feelings of stigmatisation in family members suggests that practitioners should be aware of these macro-level influences in order that they might have a greater understanding of the difficulties faced by their clients (Tubbs & Boss, 2000). This seems particularly important considering that stigmatisation can impact on the ability to grieve (Bright, 1996) and thus could hinder the therapeutic work. The findings that support needs to be perceived as meaningful suggests that practitioners should also strive to offer support which may be helpful and meaningful to the individual client (Boss, 1999).

**Coping and perceived benefits**

In the literature on families who have a loved one go missing, certain authors frame many of the aforementioned difficulties in terms of coping strategies which are functional means of dealing with such a traumatic situation (e.g. Boss, 2002; Campbell & Demi; Fravel & Boss, 1992; Hatcher et al, 2000; McCubbin, Dahl, Lester, Benson, & Robertson, 1976). It has also been suggested that certain variables predispose individuals to cope more effectively with this crisis. This research is particularly related to servicemen going missing during War and highlights the variables of long-standing marriages with open communication, high-achievement, religious faith, families with children and flexibility of role structure within the family, as being linked to more effective coping (Hunter, 1977; McCubbin, 1979; Nice, McDonald & McMillan, 1981). In cases where children go missing, it has been found that whether the parents’ relationship survives is determined to a great degree by the strength of the relationship prior to the trauma (Lloyd & Zogg, 1986). Indeed the parents of three boys who went missing highlighted gaining strength from one another and religious faith as crucial to their ability to cope (Fravel & Boss, 1992).

Children’s ability to cope and adapt to having a father go MIA was also found to be determined to a large extent by the mother’s ability to cope. A seven-year longitudinal study of families of men MIA or held POW during the Vietnam found that the mothers
played a major role in determining the adjustment of children (Hunter, 1986a). In particular it was suggested that the impact on the children was determined by the mother’s attitude towards the separation, the mother’s satisfaction with the marriage prior to separation and the mother’s ability to cope with the separation (Hunter, 1977; 1978; 1982; 1983; 1984; 1986a; McCubbin & Dahl, 1976; McCubbin, Hunter & Dahl 1975).

It has also been suggested that those families who were able to prepare to an extent for the possibility of separation through discussing it, were better able to cope with the situation if it arose (Hunter, 1983). However, it is significant to note that whilst this may be possible for families of servicemen who know their loved one is going to war, families whose loved ones go missing in much more unexpected situations would have had no such reason to prepare.

Some parents and wives of servicemen MIA also identified positive effects of their experience, highlighting personal growth, increased self-confidence and a maturation in their ability to stand up for their beliefs (McCubbin & Metres, 1974). Positive effects were also identified for some children of MIA fathers, including financial aid to obtain higher education, closer family relationships, increased maturity and a greater valuing of life in general (Hunter-King, 1993; 1998). However, the benefits for parents and wives were drawn from a population attending religious retreats; thus their religious faith may have been increasing their ability to cope and may be unrepresentative of families of the MIA in general.

Nevertheless, the emphasis on coping and benefits in these studies has important implications for practice as it enhances an understanding of those factors which have helped families to cope and move on despite their ambiguous loss. This in turn could assist others who find themselves in this situation. Clients can also be reassured that their responses are ‘normal’ reactions to the helpless situation that they have found themselves in (Hunter, 1986a) and as such are not ‘dysfunctional’. Indeed the therapist may need to be cautious of pathologising their client and be open to and encouraging of their client’s
perceived benefits from the trauma.

**Relationship to the missing person and their role in the family**

Whilst thus far, the review has focused mainly on the impact on family members in general of having a loved one go missing, it might well be expected that the experience would differ depending on the particular relationship between the family member and the missing person. Indeed, whilst most of the research into MIA families has focused on wives and children, Hunter (1986b) suggested that the suffering of parents, whilst going through the same phases, was in fact deeper and longer lasting than for wives and children. This might well be expected considering that the loss of a child been suggested to be the most difficult loss to deal with and that recovery is slower following the loss of a grown rather than a young child (Gorer, 1965; Rubin, 1993).

The research into MIA families has also found that wives were more likely than parents to make a conscious decision to close out the roles of their missing husbands (Boss, Hunter & Lester, 1977; Hunter, 1984). Wives reported that they made this decision in order to cope with the practicalities of everyday life, whereas parents (without the responsibility for young children at home) had no such need to close out their sons (Hunter, 1986b). The way in which the experience may differ for the wife and the mother of a missing person was highlighted by one mother of a serviceman MIA; “You wives can still have another life; he was my only son. I shall never have another. I shall always hope that some day he will come walking through that door.” (Hunter, 1983, p.177).

The impact of having a son go MIA was also proposed to differ for mothers and fathers (McCubbin & Metres, 1974). It was found for example that mothers showed a need to talk and express their feelings, whereas fathers tended not to openly discuss the personal meaning of their sons’ MIA status. Similar responses were found in the parents of the disappeared in Argentina, where the mothers externalised their pain at times at an international level as was seen in the mothers of the Plaza de Mayo, whereas the fathers tended to be more resigned to the power of the military and pined in isolation (Navarro,
This distinction between the reaction of mothers and fathers might again be somewhat expected considering that mothers have been found to have more difficulty coping with the loss of a child than fathers (Gorer, 1965; Rubin, 1993). However, it might also be considered that an individual's established styles of communicating and coping might to an extent determine their reactions to such a loss.

A small pilot study of 82 MIA children, using written comments from a mailed survey, indicated some longer-term effects on the children of losing their fathers. These included fear of abandonment in relationships, especially for daughters of MIA fathers and a lack of a male role model as a husband or father, particularly for sons of MIA fathers (Hunter-King, 1993; 1998). Older children and in particular first born sons were in some instances declared by their mothers to be 'head of the household' and were expected to 'take care of mother' (Hunter, 1983).

Siblings may also be impacted by the loss of a brother or sister and in particular, be susceptible to emotional deprivation if the focus remains on the missing child. They may then develop symptoms such as developmental regression and phobias (Greaves et al, 1982; Lloyd & Zogg, 1986), which may in turn lead to 'acting-out' behaviours such as truancy, drug and alcohol abuse (Lloyd & Zogg, 1986). Greif and Hegar (1991) also noted feelings of neglect in siblings of children abducted by the other parent, both by the remaining parent and the parent who 'chose' to abduct their sibling. The extent of these feelings are perhaps best indicated by the words of a child whose brother had gone MIA; "My parents always talk about my dead older brother, but I'm alive! I guess I'll have to commit suicide to get them to care about what I do" (Hunter, 1983, p.175).

Thus for practitioners working with individuals who have had a loved one go missing, it would be important for them to be attentive to the specific relationship between the client and their lost loved one, but more than that, to explore the 'meaning' of the loss for them.
Change in Family Dynamic

In addition to highlighting how individual relationships in the family may become affected by having a loved one go missing, certain research focuses on how the family system as a whole might suffer. Lloyd and Zogg (1986) suggested that the family system becomes totally disorganised and exists in a sense of dismemberment, where communication may be profoundly affected. Lloyd and Zogg (1986) also suggest that in families of missing children, the child may become a taboo subject, may supersede any other conversation or may become a scapegoat for emerging difficulties. However, it might be supposed that the extent to which these develop are determined by prior patterns of communication within the family.

Boss (1977; 1980a; 1980b; 1987; 1988; 1991; 1999; 2002) and Boss and Greenberg (1984) highlight such disorganisation in the family system as resulting from family 'boundary ambiguity', whereby it is unclear who is in and who is out of the family system. Whilst this concept was first applied by Boss to the impact on families of servicemen MIA, it was later extended to situations when “a family member is kidnapped, taken hostage, or gone and no one has any knowledge of the individual’s condition or whereabouts” (Boss, 2002, p.107). Boss (2002) suggested that such “long-term boundary ambiguity is virtually intolerable for even the strongest families” (p.170). The boundary ambiguity is proposed to be a manifestation of the family’s perception of the event. Thus developing an ‘agreed-on perception’ is critical to the reduction of stress. However, in order to reduce this ambiguity, the family may need to ‘take a gamble’ and make a joint decision to ‘close-out’ the missing family member. In such a way, they may free themselves to grieve what they have lost (Boss, 2002).

This theory of family stress management has significant implications for practitioners working with families who have had a loved one go missing. The approach to therapy may first be determined by the ‘gamble’ taken by the family. If the family focuses on the hope that the family member may be found alive, they could be encouraged to keep the missing
person present by continued inclusion in rituals and celebrations (Boss, 1991). If and when the family comes to an agreement that the person is in likelihood not coming back, this could be marked by ritual decided on by the family, in order that they can symbolically gain some closure to their loss. This should also include the wider community where possible, in order that there is social validation of the loss (Boss, 1991). This would at face value seem appropriate considering the aforementioned difficulties resulting from stigma and the lack of a socially prescribed means of dealing with such an ambiguous loss.

Conclusions, implications and future directions
The above review of the literature highlights a number of factors which appear to be significant to the experience of family members who have a loved one go missing. Reactions such as anger, guilt and searching are particularly prominent and seem to be representative of a 'grief response'. The experience would also seem to differ (as might be expected) depending on the relationship that the individual had with the missing person and their role in the family. However, it is apparent that the experience is fundamentally impacted by the uncertainty of whether the missing loved one is permanently lost and thus hope often supersedes acceptance. The situation also brings with it dynamics such as stigmatisation which in turn impact at times on the social support received. All such findings can be of use to practitioners who come to work with clients in this situation, enhancing their understanding of the dilemmas the client might face and the difficulties that might be presented. However, the practitioner would need to be aware (as with any client) of the specific meaning of the loss for the individual involved or indeed for the family system.

This caution of generalising findings to all those who have had a loved one go missing should also exist because of the research from which these findings are derived. Much of the information comes from families of servicemen MIA in the Vietnam War, parents of missing children or children abducted by a parent. Thus when the findings of Biehal et al (2002) are considered, these represent only a very small proportion of those who go
missing in Britain today. As such, this suggests future directions for research such as attention to the impact of other situations in which people might go missing, including those more ‘intentional’ reasons.

Future directions for research are also suggested by the observations that whilst established theories and models of loss, grief and mourning are useful in a discussion of the experience of these families, they nevertheless seem inadequate. This is particularly apparent considering that the label of ‘pathological grief’ could often be applied, particularly in regards to the prolonged nature of the ‘grief reaction’ and the lack of acceptance of the loss (Middleton et al, 1993). However, given the situation (assuming the person remains missing) this seems fundamentally inappropriate. The theory of boundary ambiguity is more helpful, but is very much a systemic approach to explain the level of stress in the family in general, rather than attending to the specific process and experience of the individuals within it. These conclusions would suggest that the field would benefit from utilisation of qualitative methods such as ‘grounded theory’ (Glaser & Strauss, 1967) in order that the phenomenological experience of families be used to directly inform the development of theory which is more specific to the nature of their loss. This would complement some of the extremely rich and informative data that already exists and might in turn assist practitioners in their formulation and interventions with clients faced with such trauma.
Personal reflections of the author: The use of self

My interest in researching the impact on families of having a loved one go missing was stimulated in the first instance by working with a client in this position. This was combined with the growing media interest into the case of a missing girl. When the family’s pain and distress was transmitted to the nation in harrowing press conferences and newspaper articles, despite their visible pain, the focus still remained on the missing girl and the attempts to recover her. This led me to wonder who was there for them, but more than that, how did having a loved one go missing in such an ambiguous and inexplicable way impact on them. As the media interest dwindled to only sporadic updates on the case, how did they continue to suffer or cope and how many other families were in a similar situation, yet their experience remained unreported? I had come to work with a client in this position and thus so might other practitioners. I wanted to discover what research already had to offer to enhance our understanding of the impact of having a loved one go missing, in order that we might work insightfully with individuals who find themselves faced with this trauma.

However, reflecting more on how this may resonate with my own experience leads me to recount a time when I was aged fifteen and my parents and younger brother moved to live in America. I (predominantly through my own insistence) remained in the U.K., as did my older brother. I therefore fundamentally found myself ‘left-behind’. Whilst I knew where my family was and I knew that they were well, I missed them terribly. Whilst I knew they were coming back and that I could visit them, our family had changed, the boundaries were ambiguous. We were as a family separated and disjointed. They were, albeit temporarily, ‘lost’ to me.

Whilst a consideration of the impact and meaning of this for myself and my family is not new, reflecting on the ways in which this has led me to explore a particular topic for research is. I can conclude that seeing the pain of families who have had a loved one go missing, held echoes of my own experience. This may have motivated me to explore the
area in order that I might better understand myself and the ways in which I grew and changed over the years following this. My tendency is to attempt to understand and thus rationalise my experience and whilst I am not promoting this as a means of coping, I am acknowledging its role in my motivation to conduct this research.

Since this research does have personal relevance for me, it has been necessary for me to remain mindful of the ways in which this may have shaped the framework within which I reviewed and interpreted the literature. I have periodically asked myself whether I am attending to particular aspects of the data more than others, or whether I am attributing significance to certain experiences whilst minimising the significance of others. For example, my tendency may have been to focus on cognitive processes rather than feelings and so I made efforts to balance this. In this way, whilst my interpretative framework could not be eliminated, I could at least reduce the extent to which it might have biased and shaped this literature review.
References


Marriage and the Family, 7, 237-244.


*Family Relations, 49*, 285-286.


Appendix 1: Notes for contributors to Counselling Psychology Review

Notes for Contributors to Counselling Psychology Review

Submissions
The Editorial Board of Counselling Psychology Review invites contributions on any aspects of counselling psychology. Papers concerned with professional issues, the training of counselling psychologists and the application and practice of counselling psychology are particularly welcome. The Editorial Board would also like to encourage the submission of letters and news of forthcoming events.

Manuscripts should be typewritten, double spaced with 1” margins on one side of A4 paper. Each manuscript should include a word count at the end of each page and overall. Sheets should be numbered. On a separate sheet include author’s name, any relevant qualifications, address, telephone number, current professional activity and a statement that the article is not under consideration elsewhere and has only been submitted to Counselling Psychology Review. As articles are refereed, the rest of the manuscript should be free of information identifying the author. Authors should follow The Society Guidelines for the Use of Non-Sexist Language contained in the booklet Code of Conduct, Ethical Principles and Guidelines. Four copies of the manuscript should be submitted with a large s.a.e. A copy should be retained by the author.

Bibliographic references in the text should quote the author’s name and the date of publication thus: Davidson (1999). All references should be listed at the end of the text and should be double spaced in APA style. A guide to the presentation of references using the APA style is given in The British Psychological Society Style Guide, available at £3.50 per copy from The British Psychological Society, St Andrews House, 48 Princess Road East, Leicester LE1 7DR, UK.

Low-quality artwork will not be used. Graphs, diagrams, etc., should be supplied in camera-ready form. Each should have a title. Written permission should be obtained by the author for the reproduction of tables, diagrams, etc., taken from other sources.

Submissions should include abstracts
The abstract should be no longer than 250 words (depending on the length of the paper). It needs to be double spaced, on a separate sheet and headed ‘Abstract’. The British Psychological Society’s Style Guide provides the following information on writing abstracts:

The purpose of the abstract is to allow the reader to assess the content of the article prior to reading the full text. In addition to appearing immediately below the author’s name, the abstract will be used for indexing and information retrieval by such services as Psychological Abstracts. It should, therefore, be written so that it can be understood independently of the body of the paper (p.6).

Proofs of articles are sent to authors for the correction of typesetting errors only. The Editor needs the prompt return of proofs.

Contributors should enclose a 3.5” disk (either DOS or Mac format) with the document saved both in its original word-processing format and as an ASCII file. All diagrams and other illustrations should be saved in their original format and as a TIFF or an EPS.

Other submissions
Book reviews, letters, details about courses and notices of forthcoming events are not refereed but evaluated by the Editor. However, book reviews should conform to the general guidelines for academic articles. Contributors should enclose two hard copies.

Deadlines for notices of forthcoming events, letters and advertisements are listed below:

For publication in Copy must be received by
February 5 November
May 5 February
August 5 May
November 5 August

All submissions should be sent to: Dr Alan Bellamy, Editor, Counselling Psychology Review, Brynmair Clinic, Goring Road, Llanelli, Carmarthenshire, SA15 3HF.

Book reviews should be sent to: Kasia Stymanska, Book Reviews Editor, Centre for Stress Management, 156 Westcombe Hill, London SE3 7DH.
A Unique Loss: Four case-study analyses of the impact on family members of having a missing loved-one

Abstract

This paper reports a qualitative, ideographic study in which the cases of four people with a missing loved-one are presented. The analysis highlights their personal experience of loss and the impact this has on their coping strategies and their perceptions of support. The theoretical implications of their unique experience of loss are considered and the therapeutic implications of the analysis are discussed.
Introduction
An estimated 210,000 people are reported missing in Britain every year (National Missing Persons Helpline, 2002) and many family members are consequently left behind. There are various situations in which people can go missing. These range from more ‘intentional’ situations such as running away to escape difficulties at home to more ‘unintentional’ (and less frequently observed) situations such as abduction by a parent or stranger (Biehal, Mitchell & Wade, 2002). National and political events can also lead to multiple missing persons, such as the Vietnam War (Campbell & Demi, 2000) and the so-called ‘dirty war’ in Argentina (Robben, 2000).

In a review of the literature, Gibbard (2002) noted the predominant themes which appeared to be significant to the experience of having a loved-one go missing. Reactions such as anger, guilt and searching were particularly prominent and representative of a ‘grief response’. However, this experience seems to be fundamentally impacted by the uncertainty of whether the missing loved-one is permanently lost and thus hope often supersedes acceptance which might otherwise be achieved following a loss. The situation of having a loved-one go missing also appears to bring with it dynamics such as stigmatisation which in turn can impact on the social support received (Lloyd & Zogg, 1986).

However, Gibbard (2002) noted that there is relatively limited attention devoted to this experience of loss within the academic literature, with the majority of findings coming from research into mass disappearances through war and the relatively rare abduction of children. The majority of the literature therefore represents only a small proportion of those who go missing in Britain today. This could be problematic for practitioners, including Counselling Psychologists who come to work with clients in this situation, leaving them with little information to assist in understanding and theorising about their clients’ experience.
This study therefore aims to carry out in-depth case analyses of individuals in Britain today who have a missing loved-one. This is intended to promote an understanding of their personal experience of loss, the impact that this has on them and their personal coping styles adopted. In turn, it is intended that this could assist practitioners who come to work with such clients by gaining a sense of the uniqueness of their loss and thus enhancing the support available to individuals faced with such trauma.

Method
An ideographic case study design is adopted to explore participants' experiences in-depth and to capture the detailed and unique accounts of having a missing relative.

Participants
Potential participants were contacted via the National Missing Persons Helpline (NMPH), a charitable organisation that offers information and support to families of missing loved-ones and holds a large database of missing persons. The staff were informed about the nature and purpose of the study and asked to send out letters (see appendix 1) to those families who they thought might be willing to take part. Advertisements were also placed in the Guardian and on a website for missing people asking for volunteers. The only inclusion criterion was that participants currently did not know the whereabouts of their loved-one. The four individuals who took part in the study were all contacted via the NMPH. More information about the participants will be provided in the analysis section.

Data Collection
The data were collected using a semi-structured interview schedule in which there was significant scope for the participants to influence the direction of the interview. Two of the participants were interviewed in their homes, one on University premises and one, due to geographical constraints, was interviewed over the telephone. The interviews lasted for between one and a half and two and a half hours, were audio-taped with the participants' consent and transcribed verbatim. In order to protect confidentiality, the names of the
participants have been changed as have other identifying references.

Prior to the interview, participants completed a brief demographic questionnaire (see Appendix 2) and signed a consent form (see Appendix 3). The main areas covered in the interview schedule (see Appendix 4) were derived from Gibbard’s (2002) literature review and included: circumstances surrounding the disappearance of their loved-one, emotional and practical impact on them, their role in the family and family dynamics, social support and stigma and coping and perceived benefits. Given the sensitive nature of the subject, particular attention was paid to the psychological well-being of the participants during the interviews and follow-up calls were made the next day. All participants reported having found it ‘helpful’ to talk about their experiences which may be reflective of findings that using a counselling style within interviews of a sensitive nature can be helpful in containing participants’ anxiety and distress (Coyle & Wright, 1996).

Data Analysis

Data were analysed using Interpretative Phenomenological Analysis (IPA) (Smith, 1996; Smith, Flowers & Osborn 1997; Smith, Jarman & Osborn 1999). This is used for the analysis of qualitative data and attempts to ‘inhabit’ the participants’ phenomenological world through intensive engagement with the data and the participants’ perspective. It is assumed that through this process meaningful interpretations can be made about the participants’ experience and thinking (Smith et al, 1997). This approach was chosen because of the study’s specific interest in participants’ ‘experience’ of having a missing loved-one.

The process of analysis began by listening to the tapes and repeated readings of the transcripts. A rotation method was used to limit the extent to which analysis of one transcript would influence that of the others. Notes were made on the transcripts, highlighting apparent recurring themes for each participant, points of interest and making initial interpretations. These were then analysed for connections between themes before
they could be clustered into emerging themes and sub-themes for each participant.

This process assumes that the participants’ experiences are viewed through the researcher’s lens. It is therefore necessary to reflect on the researcher’s interpretative framework (Elliot, Fischer & Rennie, 1999) which will have been shaped by her role as a Counselling Psychologist in training who has worked with a client with a missing loved-one. Whilst the resulting dynamic between participants’ accounts and the researcher’s interpretative framework is not necessarily detrimental, the ‘evidence’ was extensively ‘checked’ to ensure that the interpretations were grounded in the data set and supportive quotations are provided. In addition, a validation check was carried out by an independent researcher who played no other part in the project. They read the transcripts to ensure that the themes were relevant to and grounded in the participants’ accounts. However, it will ultimately be for the reader to judge the persuasiveness of the interpretations.

Analysis
Throughout the analysis, the author refrains from discussing theoretical and practical implications arising from the participants’ accounts. This has been done so as to avoid detracting from the significance of their phenomenological experiences. However, such implications will be considered within the discussion section.

Some similarities between themes emerging from this analysis were found for some participants (e.g., hope, fears, guilt, searching and stigma). Due to limitations of space, themes which are discussed in some detail for one participant will be discussed more briefly for the others with only the ways in which their experience is unique being highlighted. As a result of this, some participants have less text devoted to them in the analysis. However, the author would like to stress that this does not imply that these contributions are any less significant. In the analysis direct quotes from participants are written in italics. ‘[…]’ refers to when a passage has been omitted from the original transcript and … indicates a pause in speech.
Participant One
Helen is a fifty-three year old woman whose thirty year old son Tommy went missing five years ago. She has three other children. Her husband died several years before Tommy’s disappearance. Tommy left work having been overheard on the phone arranging to meet someone. He has not been seen or heard from since. He has been officially declared ‘missing presumed murdered’ by the police.

Hope vs acceptance
Not knowing what has happened to her son seems to lead to a fluctuation for Helen between feelings of hope of finding him and acceptance that he may be dead. She highlights that despite her instincts that “something was wrong”, driven by her knowledge that her son “would never just take off like that for no reason”, hope remains of finding him alive: “way, way back in my mind, there is that little bit of hope that maybe, just maybe by some miracle he is still out there somewhere”.

This hope appears to lead to a creation of possibilities perhaps as a means of justifying its existence: “maybe he’s lost his memory, he can’t remember who he is or who he belongs to”. However, her words illustrate that such strands of hope are quickly replaced with an acceptance that this is unlikely: “deep, deep down I know he’s not gonna come back”.

Searching and suspicions
Given such hope of finding her son, it is perhaps unsurprising that Helen highlights the search to find him as paramount: “I will never stop, until my dying day, until I’ve found my son”. She also emphasises that the search is one for answers: “there’s so many questions need answering. I have asked and asked and asked and no one seems to be able to answer them”.

These questions seem to be made all the more poignant by the mysterious circumstances in
which her son went missing and the suspicions she has of others, including Tommy’s girlfriend, “there’s so many questions she needs to answer”, and her other son’s landlady, “she knows something, she must do”. These suspicions of others were further confounded by an anonymous phone-call she received saying “you have to forgive me [...] it was an accident”.

These suspicions and questions seem to bring a sense of helplessness and desperation for help in the search: “I have rung everyone to see if they would help me. I even phoned Mohammed Al Fayed’s office ‘cause I thought well he has a son that died, he believes he died under mysterious circumstances [...] and I thought well he’s a father that’s in the same situation as I’m in, maybe just maybe he would use his detectives to try and help me find my son”. She also viewed the interview as a potential tool in the search for her son: “I hope and I pray maybe this might help find Tommy, what happened to him”.

The primacy of the search and desperation for help in Helen’s account therefore seem adaptive given the ambiguity of the situation and seem to represent an attempt both to find her son and reduce the uncertainty of the situation.

A unique loss
A loss without closure
The ongoing search and the unanswered questions about her son’s disappearance appear to impact on Helen’s experience of loss: “it’s like being in a very, very long tunnel and you keep walking and walking and walking but there’s no end to the tunnel[...]You just, you can’t get to the end of the tunnel until you know where your child is”.

Helen further explained how the uniqueness of her loss is characterised by an impossibility to mourn: “I can go to my husband’s grave and I can sit there for an hour and talk to him, I know it sounds a bit silly, but I can sit there and talk to him, say a little prayer for him, put a few flowers down or whatever and I know his body is there ‘cause I laid him to
rest there. I can’t do that with Tommy because I haven’t laid Tommy to rest anywhere as yet”.

Helen appears to be highlighting the absence of ritual and recognised social response to loss triggered by having her son go missing. Our society’s desire to grieve and mourn seems also to motivate the advice of others that Helen has encountered, including those in helping professions: “it was my counsellor told me to do it; I have a little patch in my garden which I call ‘Harry’s Garden’, that’s Tommy’s dad. She suggested I take another little part of that and make it ‘Tommy’s Garden’, but how can I make it ‘Tommy’s Garden’ when I don’t know where Tommy is?”

However, she also expresses that mourning would be incongruous with the rest of her experience of him being missing and in particular, the on-going search: “you can’t go and put flowers in a bare spot, because you know next day you could be asked to go and make an appeal, you could get a phone-call to say that a reporter wants to speak to you. So you can’t, you can’t grieve until you’ve somewhere to go to grieve”.

A mother’s pain
Helen places her particular experience of pain firmly amongst her role as Tommy’s mother: “If they’ve taken my child,[...] that’s the worst kind of hurt [...] Nothing, nothing. If someone was to come and cut the hands off me, it couldn’t hurt as much as Tommy’s disappearance”.

She also emphasises her experience of loss as distinct from other members of her family: “nobody can understand, unless they’ve been through it. It’s different with a brother than it is with a son. You know what I mean, your brother’s your brother, but your child is someone that you gave life to. So I don’t expect my girls to understand, they couldn’t possibly, you can’t even tell them”.

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She reports her pain to be so extreme, that she has reached a kind of psychological ‘pain threshold’: “nothing can ever hurt me, I am a stronger person for that. If someone was to run past me and give me a slap in the face, it can’t hurt me [...] No one on this earth can ever hurt me again, they can’t”. This appears to indicate both a personal strength in being able to cope as well as the strength of her pain.

**Guilt**

Helen’s foregrounding her position as Tommy’s mother can also be detected in her feeling of guilt that as a mother she should have protected him: “It makes you feel useless as a mother, you didn’t, you weren’t there to protect your child when you should’ve. It makes you feel a bit like a failure. That I couldn’t keep him safe”.

Helen also describes a guilt for having possibly outlived her son: “I feel guilty because I’m alive and he may not be and that, that’s not right. You don’t outlive your children. You don’t. You expect your children to be here long after you’re gone”.

**Anger**

**Anger at the Assumptions of others**

Helen also highlights feelings stemming from reactions of others which she finds particularly offensive: “it’s not fair to make assumptions, because when people have said to me “oh, he’s stepped on someone’s toes or he’s got up the wrong side of someone”, that really makes me so angry, I want to lash out and thump them and say “how dare you assume such a thing when you don’t know””. These assumptions appear to reflect the lack of answers about what has happened to her son leading others to speculate on possibilities.

**Anger at the world**

Helen also expresses a general anger “with everyone” which she describes as being somewhat indiscriminate: “It comes from every corner and there’s times when you get really angry, you just feel like lashing out and you don’t know who to lash out at; the
police or the ones that the police suspect or even his girlfriend at the time”.

Anger at the injustice of losing her son is also fore-grounded: “there’s people out there that have done wrong, they’ve took lives, they’ve molested children, they’ve mugged old people and they’re walking the streets as large as life, so why, why my son?”

**Coping and support**

**Social Support: People still care**

Whilst the reactions of some induce anger, Helen highlights the support from others including neighbours who have been “a tower of strength”. She stresses the practical help they have given her but also that they still enquire about her son: “it makes me feel that there are still people out there that care, they care enough to ask. You know some people would think well “I’ll not ask in case it you know, it brings it all up again for her”, but the ones that think like that don’t realise that it’s always there, it never goes away”.

The above suggests that this experience of social support is particularly beneficial as it matches her needs in terms of being congruent with her reality of the experience being never ending.

**Support in the search**

Considering the primacy of the search, it is perhaps unsurprising that those who have been supportive in this are perceived as crucial. Speaking of the NMPH she said: “Brilliant. I couldn’t speak any more highly of those people. Absolutely fantastic. No matter what comes up, they always put Tommy’s name forward. [...] I know I could never have got as much out about Tommy without their help. I wouldn’t have known where to start”.

This help simultaneously leads to a sense of gratitude and indebtedness: “I just feel guilty because I’m not able to give them a donation, ‘cause I know they work off donations, but I always swore if I ever won anything on the Lottery or whatever, I would definitely put
something forward because they've been absolutely brilliant”.

**Availability and time**

Helen also stresses the importance of the availability of others including the lead detective on the case: “I can lift the phone and I can talk to Mr. Carter at any time of day or night, he’s always there” and her counsellor through Victim Support: “if I wanted I can go up to Victim Support office and I can say to them “I really need to speak to Anna” I know she’ll see me”.

Helen also highlights the importance of having the opportunity to talk and be listened to: “she’s there for me to talk to her. If I’m feeling angry or feeling depressed or even if anything you know things just getting on top of me, I know I can ring Anna and she will sit and listen”.

The comfort she gets from her counsellor also seems to be related to having someone try to understand her experience: “there’s someone on the other end that will sit and listen and try to understand what you’re going through. They can’t understand a hundred percent unless they’ve been through it, but there is always, always someone there to listen”.

**Participant Two**

Steve is a fifty-four year old man whose wife Maggie went missing eleven months ago. They have two sons in their twenties. Maggie was suffering from severe depression prior to her disappearance. She had gone missing several months before this last occasion and had been found the next day. On the day she went missing, her husband Steve had been taking a shower and came downstairs to find her gone. She has not been seen or heard from since.
Hopes and fears
Like Helen, Steve holds out a hope of finding his wife alive and highlighted that once she was gone, he began focusing on “her surviving out on her own”. He goes on to highlight the function of this hope in that the alternative is far worse and too painful to contemplate: “all the time she’s not found, there’s always a hope that she will be[...] I don’t want her to be dead, that’s all I can say to you, I don’t want her to be dead. However, there are times when this resolve flickers and his fears for her safety overwhelm his hopes: I’m thinking she’s vulnerable you know and then you start, all the things that she could be attacked, she could be molested, she could be abducted, you know all these things start going through your mind”.

Dilemma of the search
Like Helen, Steve describes the desire to keep searching for his wife: “you want to take out a full page ad in every magazine and every paper on every television station just saying ‘have you seen Maggie?’”.

However it seems that the possibilities he creates which make it feasible for her to be alive, simultaneously lead to a dilemma in the search for her: “If she saw posters of herself, I mean say for instance she’d gone away to be on her own and she wanted to have space to think things through and get her head straight and she thought she’d come back when everything settles down, things don’t settle down because I wanna find her, so I’m not gonna give up on that am I?”

A loss without protocol
Steve acknowledges a profound sense of loss for the “perfect life” that he had and stresses the difficulty of making sense of the loss under these circumstances: “if you lost your leg or you lost your arm or you went blind, you know these things are traumatic things to deal with, but you can cope with that if you’ve got help and you can cope with it and learn to live with it, I don’t see any way that I’m gonna learn to live with this you
Steve appears to be tapping into the sense of the loss being without protocol or example. He distinguishes it from other types of loss and highlights that its uniqueness leaves him stripped of a means of responding to it. He distinguished losing his wife in this way from losing her through death: “if she had died of cancer, I could have held her hand”. This loss without protocol also seems to permeate his experience of others including those in the helping profession: “they tell me that I should be feeling like this you know and news of the event and then you get despair and anger and depression and then seeing the light and then you know feeling okay and then moving on, you know what I mean, you have that sort of circle”.

Steve asserts that “they don’t understand”, indicating that this apparent attempt to fit his experience into existing models of bereavement is unhelpful and leaves him with a sense of “confusion” and a desire for guidance, something he appears to suspect could come from other families in his position: “if someone said to you “look Steve don’t worry about it, I didn’t work for three years, I didn’t work for four years, I felt guilty all the time, I cried all the time”, if they told you that that was gonna be alright. You know it might help, but there’s nobody, there’s nobody you can turn to”.

**Stigma and the assumptions of others**

Like Helen, Steve also appears to have experienced a sense of stigma from others driven by their assumptions about what may have caused his wife to disappear: “Counsellors I’ve spoken to, I mean they even ask me about whether there was ever any trouble in our marriage and I can’t tell you how awful that is [...] to sit in front of someone when you’re upset and have them say “was there anything in your relationship that could have made her go?”

However, Steve also foregrounds the stigma of mental illness which seems to exasperate
his sense of isolation: "you avoid the word depression and you avoid that word depression because you know in your heart that people are gonna say "they were a bit doo-lally, something wrong with them".".

**Desertion vs Support**

Steve reports others as distancing themselves from him and that apart from "four people", "everybody's flown out". Steve speculated that this desertion by others may be driven by their lack of knowing how to respond and that "they don't know what to say". This again appears to suggest that the unique and on-going nature of the loss leaves both the families and those in their support network ill-equipped to respond to it.

However, Steve does have a sense of those things which have been helpful to him and in particular that his sons can "understand more than anybody". He describes his son Matt as being "better for me than the counsellors". Steve has also found support in a friend of his and highlights the importance of him being "someone you can talk to".

Thus it seems that Steve also finds being able to talk and be listened to as crucial. He also suggests what he feels may be useful for counsellors working with people in his position to consider: "I think it's important to see things from the point of view of the person that's still here, from my point of view, you know asking questions like "was there anybody else, could she of run off with anybody else?" is not the thing to say. The better way of doing it would be to say "can you tell me about you and your wife?"".

**Coping and Resistance**

**Resistance to thinking**

The lack of protocol of how to respond to such a loss and the inconsistent support he gains from others appears to led Steve to find his own means of coping with the trauma. In particular, his fears for his wife's safety seem to have lead to him favouring a strategy of blocking out thoughts about her having come to some harm: "there are certain things that
you just have to put out of your head, you can't, I mean I couldn't cope if I sat and thought about this, it is so serious what's happening [...] because you don't like to think about the consequences of her being out there. You blank it out, you blank it out”.

Resistance to change

Another coping mechanism employed by Steve which seems to be linked to the hope of finding his wife, is a resistance against change: “Well you, in a strange sort of way, you want it to be the [date she went missing] because it's like she's popped out to the shops and you want everything to be the same[...] so that when she comes back, or you hope that she comes back, that she'll feel the same you know and you, I personally want to remain with the thoughts that I had when she went”.

Steve also describes the changes in his experience of his family since his wife went, sensing that they are “not the same people” as they are when she was there. However, he highlights resisting this change and that he does not “want her influence to wane on” them, whilst he acknowledges the dilemma of this particular coping strategy: “I think this is what holds you back from, from getting better because you don't wanna move on because you don't know what's happened to her”.

This seems to lead to an acceptance that coping will mean living with the suffering: “you get used to being melancholy, you learn to live, it's like I suppose it's like being beaten every day, you learn to live with it, it's not nice and you don't want it, but you learn to live with it”.

Participant Three

Eve is a seventy-three year old woman whose son Max was twenty-two years old when he went missing fifteen years ago. Eve has five other adult children. Her husband died several years after Max went missing. Eve returned from work one day to find Max gone. He had gone missing several times before this last occasion but had always returned voluntarily.
Max was spotted by a policeman a few weeks after he went missing. However, Eve and her family were not notified of this until years later. He has not been seen or heard from since.

**Hope not acceptance**

As with the others, Eve expresses the on-going hope she has of her son being alive and relates this to the uncertainty of the situation. She also highlights that whilst she might suspect her son is dead "*because he did once make a suicide attempt when he was sixteen*" she resists this in favour of hope: "*just knowing that to me is a high probability doesn't mean to say that I can...I can't carry on as if it is a fact...because there is still this chance that it's not so. And I hope that, that tiny little, what I think is this tiny little chance, I hope that, that is you know, there is something there*.”

Eve also suspected that her husband would have “*written off*” hope of Max returning by now but stressed that her role as his mother makes her unable to do this: “*that past that...just obliterated and I can't do that. Not once you've given birth to a child*”.

**Searching**

Eve also highlights the importance of the search and her hope that after her death her family will “*go on making enquiries like through the helpline*”. She expresses having been able “*to some extent*” to hand over “*the responsibility for looking for Max to the helpline*”. Eve also suggests at a dilemma of the publicity in that whilst she’s “*glad*” of it, she has a feeling of discomfort at the superficiality and sensationalised nature of it: “*a reporter wants to do a nice big sentimental sort of article...it's, they, they'll do a good job and next week they're doing, it's something else*”.

**Loss: a missing place in the family**

Eve describes her experience of having her son go missing as being “*really a question of loss and grief*”. She goes on to describe the loss and in particular places it within her
experience of her family: “my family’s not complete, I’m lucky, I’ve got this lovely big family and they’re all united, but that, nobody can substitute for that one that’s missing...there’s a sense of loss”.

However, there is also a sense that the experience has a gender divide and that her daughters might have a more similar sense of loss than the male members of her family: “to some extent I think the girls, his sisters had something of that feeling that, that the two brothers don’t [...] it just seems to be a gender thing [...] I think they would...perhaps have - to a lesser degree - but I think they had this feeling of loss”.

Coping and Support

Control over feelings

Eve highlights that in order to cope with the enormity of the situation, she has developed a means of controlling her feelings: “I haven’t cried at all, and that doesn’t mean just about Max, it’s any circumstance at all, even when my husband died or my mother died [...] It doesn’t worry me because I know that my, my feelings are there but it just doesn’t happen...I think I have this control over myself now, [...]I think it’s much more convenient to getting on with living”.

She also stresses that the pain is always there “at the back of my mind” and has a feeling of “respect” for herself that she has “been able to cope” whilst knowing that she is “devastated” inside. Eve also expresses a feeling that the passage of time has helped in her struggle to cope by removing the rawness of the pain that she felt in the beginning. She spoke of meeting a man whose wife had been missing for a month: “seeing him it really brought it home to me what it was like at, uh those first few weeks...it wasn’t anything he said, it was his looks, his eyes, I, I knew what he was going through...and that I suppose that I don’t have it like that now”.

Like Steve, Eve seems to have found a means of coping by lowering her expectations from
life: "I don’t expect any more ever - all the time this situation lasts anyway - ever to be completely happy again and I mean that [...] I don’t think I’ll ever know contentment again and I don’t think I’ll know real joy, but I can say that and not, not break my heart".

Support: The time to talk
Eve notes that whilst others were generally “sympathetic” and “well disposed” towards her, she felt that support was somewhat time-limited and that “after a while people don’t want to hear sob stories”. However, she felt that her family knew “instinctively” how she feels, whilst others could not understand the uniqueness of her loss. Referring to people in her social network she says: “I think you’ll never understand, it’s no good me talking, I might as well just pretend it’s all right... ‘cause you just don’t understand”.

However, Eve highlights that to cope “it is necessary to be able to talk to people” and acknowledges that: “if I didn’t have my big family, I would probably have to turn to others”. She explains that for talking to be helpful, she would need to be given the time and opportunity to “tell them everything, or she might as well just not bother”. Thus like Helen and Steve, Eve seems to feel that ‘talking’ is helpful but that others need to be perceived as ‘available’ and committed in order for it to be if use to her.

Participant Four
Sam is a sixty-four year old man whose daughter Becky went missing twelve years ago at the age of eighteen. His wife died several years before Becky’s disappearance. He has two sons and one other daughter. Becky had been staying with relatives and was making her way back home when she disappeared. She has not been seen or heard from since.

The horror of possibilities
Whilst others have referred to a fluctuation between hope and acceptance, Sam instead seems to describe a fear that can sporadically seize him: “you don’t know when it’s gonna
hit you. It's like I would pick up a paper [...] or they would come on television and they would say "we've found a body, we haven't identified it yet" and that is the worst thing they could ever do. It tore me apart until they found out who it was and during this time I'm actually thinking this person missing, is it Becky, is it Becky?"

Sam also explained how the last known movements of his daughter were of her hitching a lift on the motorway and reportedly getting into an "old banger" and noted that "this was when Fred West was driving about in his old banger picking up girls on the motorway and that - that, you know your stomach just goes drop".

In such a way it can be seen that the uncertainty of the situation leaves him speculating on possibilities about the fate of his daughter. However, it is notable that Sam himself did not refer to such events as causing him 'fear', something which seems related to his means of coping.

A unique loss

Wanting to grieve

Like Helen, Sam foregrounds the uniqueness of his loss and particularly being unable to grieve: "I want grief, I want to be able to bury her and that is the thing that's lacking, that is the difference between losing someone through accident or whatever, knowing they've died, been to the funeral, going through the grieving process. I cannot have a grieving process and everybody I think in the same boat as me that I've spoken to have said that's what they want, they want the grief, they want to feel the grief and get through that process, because it is it's a time process and you do actually get through it, you don't forget it but you get on with your life then".

Thus Sam seems to reaffirm the way in which his loss is distinct from other more conventional forms of loss and in particular loss through death, thus denying him a grieving process and being able to 'get on with life'.
Being her father

Sam indicates that his role as father made it harder for him to deal with Becky’s disappearance than his other children. In particular he felt that their youth made them “more resilient” and able to accept it as “part of growing up” and “part of life”.

However whilst Sam suspects that his other children may be better able to cope with the situation, he like Helen expresses a sense of responsibility stemming from his role as parent and desire to protect them from the intensity of his suffering: “I’ve tried to keep it out of the kid’s way ’cause at the end of the day, I’m an old man, they’re young, they’ve got their lives to live. Why should they have to suffer what I’m suffering? I’m the father”.

Guilt

Like Helen, Sam’s foregrounding his role as a parent seems to have brought with it a profound sense of guilt and self-blame: “Guilt very strong ’cause being a single father [...] I thought what have I done wrong? It’s my fault [...] I thought I’ve cocked the whole thing up, I’ve completely ruined it, it’s my fault and then you start feeling sorry for yourself, you really do”.

Support vs Desertion

Sam describes how differently people in his social network responded to Becky’s disappearance and that “you find friends that you thought were just casual acquaintances and people you thought were friends disappear out of your life”. Sam hinted at the aforementioned stigma commenting that people might think “you’re a bad influence”. Like Steve, Sam also suggested that people’s reactions might stem from their sense of not knowing how to help and that “they can’t find the words”.

However, Sam also described getting “a real lift” from the unexpected support that he would be offered such as from people whom he had not “seen for thirty odd years, asking
if there's anything they can do to help”. However, the most powerful sense of support was from his fellow musicians (he is a semi-professional musician) whom he described as “fantastic people for sticking together” and whom he felt had “held him together”.

Coping

Escape and expression in music

Sam highlighted how playing music helped him to “forget” and “concentrate on something” else and thus “detract from thinking about Becky”. However, Sam also highlights how it enables him to express feelings which may be harder to do verbally: “I can express myself through my instruments, I can get anger out, I can get hate out, I can get peace and quiet out, I can get anything out”. Sam therefore appears to find comfort in his own self-styled ‘music therapy’.

Resistance to thinking and feeling

As well as ‘sensory stimulation’ through music or attempts to “keep yourself occupied”, Sam like Steve appears to employ ‘thought stopping’ as a means of coping: “I think there could be some sod out there who’s done my daughter in who’s laughing and you think when?, where? and then you start going through and I consciously have to stop now, I’ve got to stop myself and think of something else”.

Consequently, Sam describes being able to “think of her fondly” rather than thinking “of the horror that’s possibly there still”. He describes this as having reached a “perspective” which has come in part through relinquishing his self-blame and focusing on his daughter as an individual: “it’s not my fault, she had her freedom, she’s got her freedom if she’s still alive [...] you must let go and you must treat them as individuals”.

Together Alone: comfort in common ground

Sam also spoke about the help he has gained from meeting other families with missing loved-ones: “you think you are alone, this has only happened to you and you don’t realise
there's quarter of a million people go missing every year […] I met people who could understand how I felt and I could understand how they felt, only everybody's circumstances is different, but we all have this thing in common; this intangible feeling of you don't know what's happened - you want to know and it for me, I didn't feel alone any more”.

It is perhaps not surprising given the feeling that 'nobody understands' which has permeated these accounts that Sam has found such comfort in meeting others “in the same boat” particularly in reducing his sense of isolation.

Discussion
This study offers a unique insight into the experience of having a missing loved-one for four individuals in Britain today. Whilst the case-study approach limits the degree to which the findings can be generalised, it offers an in-depth analysis of participants’ phenomenological worlds and helps to convey the experience of ‘being’ with such individuals thus providing important implications for practice. The self-selected sample included three parents of a missing adult child and one husband of a missing wife. Many relationship dyads are therefore not represented in this sample for which different themes may have emerged. In volunteering to take part, the participants were willing to discuss their loss and they highlighted the ‘need to talk’ about their experiences. They may therefore have distinct means of coping and different levels of ‘acceptance’ from those who did not come forward.

In considering the contributions of this study to the existing body of research, it is notable that many of the experiences of the participants reflect other findings of having a missing relative, albeit through distinct situations such as war or child abduction. The fluctuation between hope of finding their loved-one and acceptance of their loss is a commonly highlighted theme for families who have a loved-one go missing (e.g. Fravel & Boss, 1992; Hunter, 1986; Lloyd & Zogg, 1986; Smith 1978). The primacy of the search is also
frequently cited and Lloyd and Zogg (1986) suggested that for parents of a missing child, the search is fundamentally endless. The guilt expressed by Helen and Sam at having failed to protect their children has been identified as a typical response (e.g. Fisher, 1989; Hunter, 1986; Lloyd & Zogg, 1986; Robben, 2000) as has the ‘survivor guilt’ expressed by Helen. This usually refers to guilt for surviving when someone else has died (Rando, 1993) but has also been identified in families who feel guilty for surviving when a loved-one has disappeared (Beltehelm, 1979; Greif & Hegar, 1991).

Whilst following a death, cultures have a prescribed way of marking the situation through ceremony such as a funeral, when a person goes missing, the uncertainty means that this ritual does not take place (Boss & Greenberg, 1984; Doka, 1989; Rando, 1986). This is said to further exacerbate a grief response through lack of ‘closure’ to the loss (Boss, 1991). Bowlby (1980) and Parkes (1970; 1972) have suggested that the desire to search for the deceased is an innate part of mourning. However, for the families concerned, it is clear that the desire to search is also a very practical one maintained by the ambiguity of the loss and the hope of recovering the relationship.

The participants’ experience of loss and in particular the inability to mourn or grieve seem to confirm the hypothesis presented by Gibbard (2002), that established theories and models of loss, grief and mourning are inadequate in their application to families with missing loved-ones. This is particularly apparent given that the label ‘pathological grief’ could often be applied to the prolonged nature of the grief reaction and the lack of acceptance of the loss (Middleton, Raphael, Martinek & Misso, 1993). This seems particularly important for practitioners to consider given that Helen and Steve both perceived apparent attempts to fit their experience into traditional models of grief and rituals of mourning as inappropriate and unhelpful.

As well as the way that this particular experience of loss seems to challenge existing theory, participants’ experiences of the contrasting reactions of others have important implications for practice. The sense of stigma noted by Helen and Steve is also referred to
in the literature on missing loved-ones (e.g. Greaves, Currie & Carter, 1982; Lamplugh, 1992; Lloyd & Zogg, 1986) and appears to be increased by the ambiguity surrounding the loss leading others to question what may be ‘wrong’ with the family or missing person (Lamplugh, 1992).

Whilst general tact and sensitivity would lead a practitioner to avoid openly speculating on the fate of a client’s loved-one, Counselling Psychologists’ commitment to demonstrating empathy and foregrounding the subjective experience of the client seems of primary importance. In such a way, the support can be perceived as meaningful to the individual (Boss, 1999) by matching the perspectives they have adopted to manage their ambiguous loss.

The humanistic value-base of Counselling Psychology should also mean that the participants’ highlighted need to ‘talk’ and be ‘heard’ would be met by a commitment to ‘active listening’. However it has also been found that it is the perceived availability of support which is crucial (e.g. Reif, Patton, & Gold, 1995; Sarason, Sarason, Shearin & Pierce, 1987), which was emphasised by Helen. Practitioners may therefore need to pay particular attention to contracting and length of therapy whilst remaining mindful of boundaries and being cautious of fostering dependency in the relationship.

Whilst similarities may exist between themes of participants and existing research, important implications for practice can also be drawn from the differences that emerge from participants’ accounts. For example, fluctuations between hope of finding their loved-one and acceptance that they are not coming back may be common, but the ways in which they have managed this ambiguity is significant. Both Steve and Eve describe having reached some acceptance of the situation as it is and that their loss is one without closure. Sam also seems to have found a means of experiencing his loss which is less painful, by being able to think of his daughter ‘fondly’ rather than focus on the ‘horror’. Practitioners can therefore have an important role to play in helping clients to find a means of accepting
their loss whilst allowing them to remember their loved-ones in a way which does not exacerbate their pain.

The different coping strategies adopted by the participants also suggest that practitioners should, as always, assess the approach to therapy which may best suit the individual and consider referral if their expertise does not match the client’s needs. For example, the ‘blocking out of thoughts’ by Steve seems analogous to ‘distraction techniques’ employed within Cognitive Therapy which might be viewed as maladaptive in other approaches. Eve identified the ‘control’ she had over her feelings as necessary to ‘get on with living’ and thus practitioners would need to be cautious of disarming clients of such adaptive defence mechanisms. Sam also clearly found comfort in his own self-styled ‘music therapy’ allowing him to express emotions which may be too painful to vocalise. It may therefore be useful to explore whether clients have similar creative talents or instincts which could be utilised in other creative therapies or pursuits. This may help both as a means of distracting from their pain and fears but also as a means of expressing feelings which may be difficult to access verbally. In addition, the comfort Sam found in meeting others ‘in the same boat’ suggests that support groups where families could share their feelings and experiences and potentially reduce their feeling of isolation may be of use.

It can therefore be seen that an exploration of the participants’ experience of having a missing loved-one has helped to enhance an understanding of their unique experience of loss and the ways in which Counselling Psychologists can support this client group in the facilitation of coping strategies. However, perhaps Sam’s words best express how to conceptualise an overview of this research and its implications for practice:

*Treat each one as individual because everybody has got a different tale to tell [...] they’ve all got a different way of approaching it, different way of accepting it, or not accepting it.*
References


Gibbard, A. (2002). Being left behind: The impact on family members of having a loved one go missing. Unpublished manuscript, University of Surrey.


Smith, J.A. (1996). Beyond the divide between cognition and discourse: using


Personal reflections of the author: The use of self

The process of this research began in effect last year, when I conducted a literature review on the impact on families of having a missing loved one. My interest in this topic was triggered in the first instance by working with a client in this position. At the time, there was also growing media interest in the case of a missing girl and since then, there have sadly been numerous occasions when the media has reported that children have gone missing. Each time, and even more so since conducting my literature review, I have thought about the family as well as the child and wondered what trauma they were going through and who was there for them? I was also aware that there were many more people who went missing each year whose families' agony was not transmitted into our homes via television and newspapers. I wanted to learn from them to enhance an understanding of the impact of having a missing loved one in order that practitioners might work insightfully with clients in this position.

At the time of my literature review, I also reflected on how being ‘left-behind’ resonated with my own experience. This led me to recount a time when I was fifteen and my parents and younger brother moved to live in America. I (predominantly through my own insistence) remained in the U.K. as did my older brother. I therefore found myself ‘left-behind’ and whilst I knew where my family was and that they were coming back, my family had become separated and disjointed and I missed them terribly. In such a way I was probably motivated by my own experience to learn from families with missing loved ones. My tendency is to understand and rationalise my experience and whilst I am not necessarily promoting this as a means of coping, I am acknowledging it in my motivation to conduct this research and the ways it will have shaped my framework as a researcher.

Despite my initial enthusiasm for this research area, as the time grew nearer to carrying out my own qualitative research, I began to lose sight of this and feel more anxious and daunted by the task. Whilst I had began to feel more comfortable in my ‘shoes’ as a trainee
practitioner I began questioning whether research was indeed ‘for me’ as being a researcher somehow did not seem to ‘fit’ so well. This anxiety continued throughout the preparatory stages of writing proposals and drafting letters and was severely exacerbated by the difficulty I had in finding participants to take part.

However, conducting the first interview changed this and I was once again reminded of the interest which had motivated me to begin this research. I felt hugely privileged that these people were sharing their stories with me and also incredibly moved by their often harrowing experiences. However, I simultaneously felt somewhat of a ‘fraudster’, as if hearing their accounts through the process of research was somehow less legitimate than hearing them through the course of therapy. This led me to question the assumptions I make as a practitioner and in particular how I seem to have found comfort in adopting the power position as ‘helper’. In turn, I questioned my assumptions about being a researcher in that whilst I was motivated to carry out this particular piece of research, I seemed overall to view the research element of the course as somehow less important to gaining the qualification as Counselling Psychologist than the more practice focused elements.

However, this process of reflection and hearing the heart-felt words of my participants highlighted to me the important role that research has to play in the field of Counselling Psychology as a whole. I felt spurred on by their accounts, to do them justice and to present them in such as way so that I and other practitioners might learn from them. The process of research also encouraged me to consider and challenge my aforementioned assumptions about being a practitioner, whilst the skills I have developed as a practitioner where infinitely helpful to carrying out interviews of such a sensitive nature.

It was therefore through this process of research and reflection on it, that I have come to realise that my emerging identity as a Counselling Psychologist is one which integrates both the researcher and the practitioner in me, that the two are not mutually exclusive and in fact have a great deal to offer the other.
19th March 2003

Dear Sir / Madam,

My name is Amy Gibbard and I am a postgraduate student at the University of Surrey where I am doing a doctorate in Psychotherapeutic and Counselling Psychology. This is an advanced training course in the research and practice of psychological therapy.

As part of my research, I am carrying out a study into the experience of family members of having a loved one go missing. Whilst in some missing persons cases and particularly in recent months, the impact on families is focused on in the media, as you will be aware, the experience of many more goes unreported. There have also been very few studies addressing this issue in the UK and consequently, practitioners such as Counsellors and Psychologists, who come to work with clients in this situation have little information to assist in understanding their clients’ experience. This study therefore aims to allow the experience of family members who are faced with this trauma to inform the development of theory which is specific to the nature of their loss and so assist practitioners in their work with such clients.

The study involves interviewing family members in order to explore the ways in which having a loved one go missing has impacted on them and their family and I have asked the Missing Persons Helpline to forward this letter to individuals who they felt might be interested in taking part in this study. This could include parents, children, siblings, grandparents or anyone who has been impacted by the loss of a loved one and would like to have the opportunity to explain the way in which the loss is impacting on them. I recognise that it could be very difficult to talk about a missing loved one and the impact that it has had and indeed continues to have on those left behind. For this reason, the interview would be conducted in a sensitive manner and could be stopped at any time. Any contributions made would be extremely valuable in helping professionals such as Counsellors and Psychologists to understand the experiences and difficulties faced by individuals who have a loved one go missing and so may help these professionals to be better placed to offer support and therapeutic services to those affected during this time. I would also hope that those who take part in the research might find it helpful to talk about their experiences.

If you were to agree to participate in this study, I would be happy to travel to your home to conduct the interview or it could be conducted elsewhere (for example in a private,
soundproofed room at the University) if you would prefer. The interview would last for approximately one hour and would be recorded on audio-tape in order that I could cite people's experiences accurately. The interview would be confidential and any details that might identify you, your family or anyone else referred to would be removed from the transcript and the final report and the tape would be erased once it had been transcribed. I would also offer to send you a copy of the parts of your interview which are transcribed in order that you could amend, revise or make certain additions to it if you wished. You would have the right to withdraw from the study at any time (even after the interview) without having to give a reason for this and ask that all information referring to you be destroyed.

If you or any members of your family would be interested in taking part in this study, or you would like to find out more about it (with no obligation to participate), please do not hesitate to contact me (and leave a message for me to call you back);

Tel: 01483 879 176

E-mail: amygibbard@hotmail.com

Address: Department of Psychology
University of Surrey
Guildford
Surrey GU2 7XH

If you would prefer contact the my supervisor, Dr. Riccardo Draghi-Lorenz, he can also be contacted at the above telephone number and address.

Thank you for your time

Yours faithfully

Amy Gibbard
Counselling Psychologist in Training
Supervised by Dr. Riccardo Draghi-Lorenz
Appendix 2: Demographic Questionnaire

To begin with, I would like to get some demographic information about you. The reason that I would like this information is so that I can show people who read my research that I managed to obtain the views of a cross-section of people. Any identifying information will be changed to ensure confidentiality. However, if there are any questions you feel uncomfortable answering, please feel free not to answer.

1. How old are you? [ ] years

2. Are you male [ ] or female [ ]? (please tick)

3. Which (if any) of the following terms best describes your ethnic background?
   - Black-African [ ]
   - Black-Caribbean [ ]
   - Black-Other [ ]
   - Chinese [ ]
   - Indian/ Pakistani/ Bangladeshi [ ]
   - White [ ]
   - Other (please specify) _______________________

4. What is your occupation? ______________________

5. What is your highest educational qualification?
   - None [ ]
   - GCSE’s/ O levels / CSE’s [ ]
   - A level(s) [ ]
   - Diploma (HND, SRN, etc) [ ]
   - Degree [ ]
   - Postgraduate degree/diploma [ ]
   - Other (please specify) _______________________

6. What is your relationship to your missing loved one? (e.g. you are their...)
   - Mother [ ]
   - Father [ ]
   - Daughter [ ]
   - Son [ ]
   - Brother [ ]
   - Sister [ ]
   - Other (please specify) _______________________

7. How long have they been missing for? [ ] years [ ] months
Appendix 3: Consent Form

I the undersigned voluntarily agree to take part in the study on the impact on family members of having a loved one go missing.

I have read and understood the information sheet provided. I have been given a full explanation by the investigator of the nature, purpose, location and likely duration of the study, and what I will be expected to do. I have been advised about any discomfort and possible negative effects on my psychological well-being which may result. I have been given the opportunity to ask questions on all aspects of the study and have understood the advise and information given as a result.

I agree to comply with any instruction given to me during the study and to co-operate fully with the investigators. I shall inform them immediately if I suffer any deterioration of any kind in my psychological well-being, or experience any distress.

I understand that all personal data relating to volunteers is held and processed in the strictest confidence, and in accordance with the Data Protection Act (1998). I agree that I will not seek to restrict the use of the results of the study on the understanding that my anonymity is preserved.

I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice.

I understand that the University of Surrey holds insurance which covers claims for injury or deterioration in health which arise directly from participation in clinical trials but that it applies only in those situations where the University can be shown to be legally liable.

I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation and agree to comply with the instructions and restrictions of this study.

Name of volunteer ..................................................
(BLOCK CAPITALS)

Signed ..............................................................

Date .................................................................
Name of witness (BLOCK CAPITALS)

Signed

Date
Appendix 4: Semi-Structured Interview Schedule

Introduction

- Introduce myself and the nature and aims of my research. [e.g. whilst there is information and literature on loss and separation, I want to hear from you what it is like to go through this experience, rather than what others might assume or what they expect it might be like for other people, so that we might learn something about the impact of this specific situation].
- Explain that the interview will last for approximately one hour.
- Acknowledge the potentially distressing nature of the interview and explain that they can ask to take a break or to stop the interview altogether at any time. Explain that if they become upset, that is okay and I will be here to sit with them through that.
- Explain their right to withdraw from the project at any time (without giving a reason) and ask that all data referring to them be destroyed.
- Explain confidentiality.
- Address any questions that they may have.

Demographic Questionnaire and Consent Form

- Ask participants to complete demographic questionnaire.
[I would like to begin by asking you to complete this questionnaire. This is to give some information about you, your age, your occupation etc. This will not be used to identify you in any way, but will be used to show people who read my research something about the range of people that I have spoken to. If you don’t want to answer some of the questions then you do not have to.]

- Obtain signed consent to take part in research and to tape the interview.

Begin taping.

Circumstances under which their loved one went missing

Whilst I recognise that this might be a difficult place to start, I’d like to begin by asking you to tell me about the circumstances surrounding the disappearance of your (husband / wife / sister / brother etc) in order to get a picture of the context by which it has impacted on you.

Elicit information on;

- how long ago
- when they first realised
- involvement of agencies e.g police, MPH
- what the first few days involved
Immediate impact

Can you tell me about the impact that this all had on you in the first few days after they went missing?

Elicit information on;

-The emotions they experienced [what were some of the emotions that you went through]
-Thoughts and fears [can you recall some of the thoughts or fears that you had during these first few days?]

The impact and process over time

And in the weeks and months after they first went missing, did these thoughts and feelings change at all?

Were there other ways in which their disappearance was impacting on you?

What were your feelings towards them?

Elicit information on;

-Anger
-Guilt
[some people have reported a feeling of... when a loved one has gone missing. Has this been something that has been part of your experience?]
-Grief
-Hope and Acceptance
[some people have reported that the continued uncertainty of having a loved one go missing impacts in particular on their feelings of Grief / Hope - is that something you can relate to? Can you tell me about that?]

Impact and process in the present

Can you tell me something about where you are now in terms of the impact that them remaining missing has on you?

Have the feelings we explored before changed at all? In what ways are they different? In what ways have they remained the same?
Role in the family and family dynamics

Moving on now to think about how other factors may have impacted on your experience.

Can you tell me about how their going missing has affected your experience of the family as a whole?

Do you feel that there are ways in which your particular role or position in the family has impacted on your experience that may be different from other members of your family? [for example do you feel that as a child and sibling, the impact on you is different from the impact on your parents] [for example as a mother / father etc]

And are there any particular ways that you feel ....(missing person’s) role and position in the family has impacted on your experience? [for example as the husband / father / another sibling etc]

Social support and Stigma

What has been your experience of how those in your wider family have responded to ....going missing?

[How has this affected you?] And what has been your experience of how those in your social network have responded?

[How has this affected you?] Do you have an impression of how the public views missing persons cases or the families of missing people?

[some people in this situation have reported a sense of stigma from the public, whilst others have reported feeling a general sense of support from them - is this anything you can relate to?]

[How has this impacted on you?] Social Support and Coping

Have their been any particular things or particular people who have helped you to cope during this time?

[Can you tell me something about why that was / is so helpful?]
Is there anything that you feel you didn't get that would have helped you during this time?

Are there things that would be useful to you in the future?

Are there things that you feel those who might try to offer help and support to people who have a loved one who is missing should know?

Perceived benefits / learning

This may sound strange, but some people have said that in their struggle to cope with some of the most traumatic events, they have seen themselves as having changed in positive ways or somehow having learned something from it. Is this something that you can relate to?

Ending

I don't have any more questions now. I'd like to spend a little bit of time reflecting on what it's been like for you to take part in this interview. But first of all I wanted to check whether there is anything else you would like to talk about - perhaps something that you're surprised I haven't asked you about that seems important?

Were there any occasions when I seemed not to understand what you were saying or used language which seemed strange? [that might be useful for me to know when I talk to others].

Did you have any questions for me?

Debrief: Experience of interview - positive or negative. How left them feeling. If seem upset or say so, ask if they would like to spend some time talking about these feelings. Ask whether they have anyone they can talk to later on. Ask whether they would like for me to make a follow-up call. Indicate sources of support I could put them in touch with.

Is there anything else you would like to say or to ask me?

State that I will send them a copy of the transcript of their interview, to amend or comment on if they wished.

Thank them for taking the time to share their experiences with me.

Prompts

-Can you tell me more about that?
-Could you give me an example of that?
-How did that make you feel?
-How did that impact on you?

**Link to next section**

-Is there anything else you would like to say about that? Let’s move on to think about…

**Reassurance if questions do not reflect experience**

-It is not expected that you would have felt the same way.
-lots of other people would also say that they could not identify with that.
Appendix 5: Transcript of interview with Helen

N.B. All identifying information has been changed [...] indicates where passages have been omitted in order to protect confidentiality.

R = researcher
H= Helen

R1: Are there any questions that you have for me?

H1: Just, if, um, if reporters, can reporters get a hold of this to read it?

R2: Um

H2: Because it would, to me it would be a good thing for me and people like me you know in my situation

R3: Yeah. I understand that. Well potentially they could, I certainly wouldn’t stop anyone and what I will do is give a copy to the Missing Persons Helpline so they can use it if they find it helpful to help others to understand, then they can pass that on to other people as well.

H3: Yeah.

R4: Are there any other questions before we begin?

H4: No I just, I hope and I pray maybe this might help find Tommy, what happened to him. Maybe, I don’t know, I really don’t know.

R5: Okay I understand that. Well you know I can always, you’re very welcome to have a copy yourself when I’ve done it all and if you wanted to use it in any way well I’d be very happy with that.

H5: Yeah, that would be a help.

R6: Okay, whilst I recognise that this might be a difficult place to start, I’d like to begin by asking you to tell me about the circumstances surrounding the disappearance of Tommy in order to get a picture of the context by which it has impacted on you.

H6: He was at work when his mobile phone rang and it was some man called Rob and his girlfriend overheard Tommy saying “I just came through Bristol and the traffic is really bad”, and arranged to take the man out for a meal. So with that, whatever this Rob had said to him, Tommy said “alright I’ll come and I’ll give you a hand”, “or a lift”, something to that effect and he left. He left and has never been seen or heard of since. His girlfriend, that was on Saturday [date] and for some unknown reason, his girlfriend waited until the
Monday, the Monday night [date] to ring me and say, her very words were that “Tommy was missing”. I asked her what she meant, “he was missing” and then she told me about the phone call, so I asked her why, did she phone the police and she said “no [she] didn’t know what to do” and I told her her common sense would tell her this was completely out of context, that Tommy would never, ever do this and I did ask her had there been a phone call or anything from him and she said “no, nothing”. So it puzzled me that she hadn’t contacted the police knowing that Tommy would never just go off, without a reason. So I told her to phone the police immediately and tell them to ring me straight away.

R7: What did, how did that lead you to feel, what were you thinking after this first phone call?

H7: I knew straight away, once she said that he didn’t come back on the Saturday, I knew straight away something had happened, something was wrong. My son would never just take off like that for no reason. He, he was just, he was too close to me and to his family, because when his dad died, he sort of felt, he took the responsibility and felt that he was then head of the family, that he had to, he felt that it was his place to take care of me, his brother and his sisters.

R8: How old was he when his dad died?

H8: He was twenty-eight.

R9: So he felt very responsible for everyone?

H9: He did, he felt he was the one who had to do the things that his father did. He thought, well dad’s gone now, it’s my place to take care of the family, and any time I would ring him and tell him I had a problem or if I needed something doing that I couldn’t do, or the girls couldn’t do, he was straight down the next day.

R10: So this seemed completely out of character.

H10: Totally out of character. My, my Tommy would never just go off for no reason. No way, not in this wide world he wouldn’t.

R11: So how did that make you feel given that you knew how unlikely this was to happen?

H11: I felt numb, I felt in limbo, I didn’t know what to do, where to go and funny enough, the only one I really wanted was my mum. She always made everything alright and it was her, which surprised me, it was her I wanted. You know it shocked me to think it wouldn’t have been Tommy’s father that I wanted, it was my mum I wanted, ’cause she was always able to make everything alright.

R12: You wanted someone to take it away and to make it alright again.
H12: Yes, just someone to take the pain away and just say “look, he’ll be home tonight, stop worrying about it, you’re worrying over nothing” and deep down I knew Tommy wouldn’t come home because I knew he just wouldn’t, he just wouldn’t go away like that. But, when the police contacted me, they told “oh, men and women go away every day, just to get a break from life” and just, at the time they wouldn’t listen, they just, I know how they’ve dealt, because they’re dealing with things like this every day of the week, but no one knows their child better than their mother, even, even the father, the mother knows the child better even than the father and I knew my son just hadn’t gone off for a break from life.

R13: And what happened after that, what happened in the next few days?

H13: Well then the police in Avon contacted me and that’s exactly what they did say to me that “men and women want a break from life, that men and women every day of the week disappear because they want a break from life” and I kept telling them over and over and over, “not my child, my son would not do this, something has happened, you’ve got to listen to me”. This was near enough every day for six months and then eventually they did believe me. Now, my son, my other son went out every night after work with his landlady and some of Tommy’s friends searching and it was them that found the car. The landlady was driving them around and for some unknown reason, she was the one on this one particular night when she went out with them, she was the one that drove up into this cul-de-sac, way off the road and found the car. Now to me that is very, very, it’s too much of a coincidence. My son and his friends had been searching for over a month, found nothing and the landlady was out for one night, the landlady did know Tommy, because Tommy used to rent a room off her. She went out one particular night and only the one night and she drove them straight to the car.

R14: What did that lead you to think?

H14: That, it led me to believe that she knows something, she must do. The police when I went up to Avon, the police took me over to where the car was found and you have to go up a road and then turn to, it’s like a cul-de-sac and that’s where the car was found. Now there’s no way on this earth anyone would even of thought of driving into this particular place. It’s near a hospital and you just wouldn’t drive up there unless you were going home because there was no other way out. To me there’s questions that need answering by her, how did she know to drive my son and his friends into that cul-de-sac and then the car’s just sitting there like an ornament and it had been sitting there from the day, from the night Tommy went missing, because the police did house to house enquiries in the cul-de-sac and the house where the car was sitting outside, the people told the police that there was a man left there a few weeks earlier but the man didn’t give the description of my son.

R15: So the car had been there the whole time though?
H15: Yes, this man that the police talked to where the car was found said it had been there for quite a few, for a few weeks. So the police then had one of those, you know the police ambulance and they towed it to a police station and then it was taken to Scotland Yard and they did forensic on it, but they found nothing.

R16: What was that whole process like for you?

H16: Everything was going through my head; was there blood in the car? Was there, did there seem to be any sort of struggle in the car? And they told me “no”, that his leather jacket was sitting over the passenger side of the back seat. So whoever he, he did know them, but he took the time and how we know this is that he took the time to unscrew the C.D. system and lock it in the dash, but the car keys were not there, his mobile phone wasn’t there and there was a cheque, a giro cheque in the dash, so we know, we know he went off, whoever he met, he went off willingly, ‘cause there was no sign of a struggle. But we also know he would never of abandoned that car, he worked too hard to get the money together to buy it.

R17: What did all this mean to you?

H17: There’s still lots of questions I need answering and no one seems to be giving me the answers, no matter ho much I ask. I want to know why the police didn’t investigate Tommy’s girlfriend more thoroughly, because the lad that she moved into her house that she shared with my son less than three months after my son went missing. To me that was too quick and she allowed her little girl to call this man “dad”. Now to me she must have known that Tommy was never going to come back because she took the risk of Tommy walking in and hearing his daughter calling another man dad, to, to me she must have known that he was never coming back. She also told the police that her new partner and Tommy never knew each other and I found out that was a lie because Tommy and this lad and two other people worked together in a company, it’s something to do with sales, but she told the police that this new partner of hers didn’t know Tommy, and he did because he worked with him.

R18: So it all seemed very suspicious really.

H18: Very, very suspicious. And she got rid of everything out of the house belonging to my boy. I don’t know what she done with them, I asked her for them and she hung up. Now whether she was afraid of me discovering something or what I don’t know, but she quickly got rid of everything within a week. So everything went out of the house belonging to Tommy within a week. She definitely knew he wasn’t coming back. She knew he wasn’t, he hadn’t gone away just for a break and the landlady, this lad who is now, well I don’t know whether she’s still with him or not, that Tommy’s girlfriend had moved in with her, apparently he said he didn’t know this landlady either and he did because he rented a room off her...I went, when I went to Avon another time, I went to this pub where Tommy did weekend work [...] and I had his photo with me and I was
asking the bar staff if any of them knew what happened to him, where he went and nobody said anything. Now I found out that the ex, Tommy’s ex-girlfriend’s brother worked there as well and was very well known and he wasn’t a very nice person, but when I came out, I told the police all this, when I came out of that pub, two men followed me out [...] and [one of them] came over to me, big, tall, well-built man and he said “you’re his mum?” and I said “excuse me?” I said “who’s mum?” he said “Tom” I said “yes I am and I’m searching for him, can you tell me what happened to him?” and he turned his head with his hands and he was dripped in gold and I don’t know whether he said “oh, man” or “oh, mum” and I said “listen if you know anything, you can tell me in confidence” I said “I promise you I won’t tell the police if will help lead me to where Tommy is” and he said “talk to Tom’s ex-girl’s bro” and I’ll never forget those words ‘cause I said to him “I’m sorry I don’t understand that talk” and he said “talk to Tom’s ex-bird’s bro” I said “no”, I said “I don’t know what you mean”, I said “what do you mean?”, he said “Tom’s ex-girl” and I mentioned her name and he said “yeah, speak to her bro”, I said “what’s her bro?” and he said “brother, speak to her brother” and that funny enough was the police suspected. Now I rang Mr. Carter when I got home and I told him. Now he told me a week after that they did interview these two men and they couldn’t help them, well I don’t believe that because how could they have known who I was talking about without the person’s name, without knowing anything about them? I think I was just fobbed off. But whoever these two lads were, they knew something, they knew what had happened to Tommy when they told me to talk to his ex-girlfriend’s brother. But I went up again to see if I could see them and there was no sign of them, I went up there for a full weekend.

R19: And what were some of the, the emotions that you went through because of this, or some of the thoughts that you had?

H19: Everything was going through my head, I knew deep down Tommy was gone, but there was a little bit of hope and I think there still is a little bit of hope. But when those, when that lad said that to me, everything went through my head; what has he done to him? Where has he put him? Has he suffered? Or are they, is he keeping him prisoner somewhere? Just I didn’t know what to think, I just felt numb... and then when it, when I got into the taxi, to leave that pub, this white van followed me and I couldn’t see right if it was the same lad I was speaking to, but it followed me straight to where I was staying, well not right up to where I was staying, it stopped at the top of the road.

R20: And what did that do to you?

H20: The car following me, the van? It made me very, very nervous and it made me wonder, it made me, I, I knew they knew something and I’ll tell you, there was another time I got a phone-call here, I rang Mr. Carter and I told him. I got a phone-call and I didn’t recognise the voice, I knew it was a you know a [southern] accent and he, he mentioned me by name and I said “who’s speaking please?” and he said “you, you have to believe, you have to forgive me”, he says “it was an accident” and I said “what was an accident?” and he said “you have to forgive me” he said “it was an accident” and I said
"who’s speaking please?", he says “it’s David” and I said “David who?”, he said, he says “you have to forgive me”, he said “you need to forgive me and I need you to forgive me” he said “and you have to believe me it was an accident” I said “look I don’t have to forgive you anything” I said “and I certainly don’t have to believe you”, and I said “you have to tell me what was an accident” and he sounded as if he was drunk, you know slurring over his words...

R21: I can imagine how shocking that must have been, what did that do?

H21: I, I just hung up and I just flopped on the chair and I burst out crying and I phoned one of the girls, I can’t remember which one of them it was and I told them and they said “mum, you’ve got to phone the police straight away”. Now it wasn’t, I don’t think it was Mr. Carter at the time, I’m not sure, there’s been that many police involved and I’ve told them and someone rang again after, I think it was a few weeks after, now whether it was Mr. Carter um, trying to catch me out or whatever I don’t know, but some man rang and he said there was a job going in his place and I said “I’m sorry I think you’ve got a wrong number” and funny enough you know it did sound something similar to the call I got, but they weren’t slurring over their words if you know what I mean because if someone is slurring over their words you know that they’re drunk, the majority of them are drunk, but this second call they weren’t slurring over their words, they didn’t sound as if they were drunk and when I pressed 1471, the number was unavailable. So I don’t know what to make of that, I really don’t. But I know I got that first call from that lad whoever he was saying he was David, now I’m not saying it was his, Tommy’s ex-girlfriend’s brother, I don’t know, but he did say he name was David and I had to forgive him and I had to believe him that it was an accident, but what was an accident I don’t know and what I had to forgive him for I don’t know.

R22: What did you think he meant?

H22: Well my instincts straight away were that he had harmed Tommy but it was an accident and it must have been playing on his mind and he needed me to forgive him. I was angry and then I didn’t, I didn’t know what to think but I felt really angry, at this David, but I don’t know what David it was, but whoever it was I was really angry with them, like if it was this David in particular, how dare he ring me and ask me to forgive him, if he has harmed, if, and that’s only if he has harmed my child, how on earth can he expect me to forgive him. You can’t forgive someone for doing that. You know this is my child, I gave him life, no one on this earth had the right to take that life away from him.

R23: That sounds horrific to have heard that.

H23: It was, it was, I felt sick, I just, I felt like stone if you know what I mean, I just, I didn’t know where to, I wanted to run but I didn’t know where to run to. I think if he, if he harmed my boy, how on earth can he ever expect me to forgive him? I could never, ever forgive that.
R24: No, I can understand that... And so, what happened in these weeks and months following, how, did the experience change for you at all, in the ways it was impacting on you?

H24: Well up until today and still today, it’s like, it’s like being in a very, very long tunnel and you keep walking and walking and walking but there’s no end to the tunnel. Do you understand what I mean?

R25: Mm, mm.

H25: You just, you can’t get to the end of the tunnel until you know where your child is or you can go put flowers, say a little prayer. You can’t, you can’t even grieve and I’ll tell you what I even, I did try doing, it was my Counsellor told me to do it; I have a little patch in my garden which I call ‘Harry’s Garden’, that’s Tommy’s dad. She suggested I take another little part of that and make it ‘Tommy’s Garden’, but how can I make it ‘Tommy’s Garden’ when I don’t know where Tommy is? I know where his dad is but I don’t know where he is.

R26: So, it’s almost as if people are suggesting you grieve in some way but without knowing where he is, that’s, even that isn’t possible.

H26: You, you can’t, how can you grieve for someone when you don’t know where they are? You can’t and even, even my own family have said to me “mum, why don’t you do what the Counsellor suggested” and I said “but how can I put flowers down somewhere when I don’t know where to put them”, or even go and say a little prayer - I can go to the church and say one, but I can’t go to a grave.

R27: And what would it mean to you, if you did that, I wonder what it would mean if you did do that, if you did put flowers somewhere?

H27: It would feel as if that was the end, because when he is found and laid to rest, well that is the end, that’s the searching over, the appeals over and then you can sort of start to grieve and then try to get on with life best as you can. But you, you can’t, you can’t go and put flowers in a bare spot, because you know next day you could be asked to go and make an appeal, you could get a phone-call to say that a reporter wants to speak to you. So you can’t, you can’t grieve until you’ve somewhere to go to grieve.

R28: And until you know.

H28: Put it this way, I can go to my husband’s grave and I can sit there for an hour and talk to him, I know it sounds a bit silly, but I can sit there and talk to him, say a little prayer for him, put a few flowers down or whatever and I know his body is there ’cause I laid him to rest there. I can’t do that with Tommy because I haven’t laid Tommy to rest
anywhere as yet. But like you said there is still way, way, way back in my mind, there is that little bit of hope that maybe, just maybe by some miracle he is still out there somewhere. And there was one time there was a, um, I had the news [...] CHANGED TAPE...and there was these three men fixing a window and the one nearest the camera, he had flicked his head round, just for a couple of seconds and right away I though oh my god, that’s Tommy. So I watched the news again that evening and it didn’t show it again, there was some sort of a dispute or something about these flats and these men were fixing windows, so I thought that’s weird because Tommy worked with windows for a short period of time. So I rang Mr. Carter straight away and I told him, I said “I swear I think I’ve just seen Tommy on the television” so he said “where?” and I told him, gave him the details, I even wrote down the time that it was on. So he sent off for a copy of that tape of the news and he did study it ‘cause he rang me back and he said, I think it was about a week later he rang back and he said “now Helen which man are we talking about?” he said “Is the one kneeling down at the window frame?” and I said “yes” I said “the one nearest the camera, that turned straight around”, he said “yes well, that same man is shown again”, ‘cause they had a longer video of it up at a window and he said “it does look remarkably like him” he said “but it’s not him”. They went out to the place where these men were working and they spoke to the lad that I’d seen and he said “it definitely wasn’t him Helen” he said “but there is an uncanny resemblance”.

R29: What did all that do to you?

H29: Oh my heart just dropped and I thought well we’re off again. Got to keep searching ‘till I find him, one way or another. So there is, yes there is a little bit of hope that maybe he’s lost his memory, although the police said “no”, because someone would have spotted something wrong. But to me, the way I’ve put it down is that maybe he’s lost his memory, he can’t remember who he is or who he belongs to or who he’s related to and then again deep, deep down, I know he’s not gonna come back.

R30: Just that terrible dilemma between those two.

H30: It’s just a no go situation, you can’t win one way or another. But that man I saw on the television, I froze and I thought if that’s not Tommy it just proves then what everyone says everyone’s got a double.

R31: What did it do to you when you saw it?

H31: I just froze and I kept switching over the stations to see if it would be on any other news programme that was on and then I turned it to Sky News, Sky News Extra, but it never, ever showed it again.

R32: I can imagine the hope it could have ignited again.

H32: Do you know what I felt angry, ‘cause I thought if that is Tommy, I’m going to slap
him one severe smack for putting me through this and then I thought to myself no, it can’t be him even though it looks very much like him, it can’t be him because he would never do this to me.

R33: And some people, some people have reported a feeling of anger and when a loved one has gone missing and it sounds like at times that’s been part of your experience to?

H33: Oh, I’ve seen me so angry when I threw things here on my own in the house, I threw things, the, the Counsellor told me the way to deal with that is to go out into the garden and wherever there’s weeds, pull them out and I did, I have done that and it, it has relieved it, I just pull - the neighbours next door must have thought I was mental, but I’d be pulling like crazy at these weeds until I felt a bit better and then I’d go on and sit at the patio table and have a drink of water or a drink of whatever - I don’t drink alcohol - but a drink of water or whatever and a cigarette just to calm down again. And I still get angry, but the way I deal with it now is I get up and I do something, just to keep myself busy from thinking about it. But that is so hard to do, it’s so very, very hard to do.

R34: It’s always there.

H33: It’s always there, even if there’s a family crisis, it’s still there and I had, I remember, not that long ago I had an argument with my daughter’s ex-partner, well ex-boyfriend and he was throwing all these accusations to me about this, that and the other and I said to him “you know something”, I said “you can’t hurt me” and he says “what do you mean Helen” he says “I wouldn’t want to hurt you” and I said “no, but even if you wanted to”, I said “you couldn’t”, I said “no one on this earth could ever hurt me again”, because by someone, if they’ve taken my child, I said “that’s the worst kind of hurt”, I said “now you’ve got a family of your own and I pray to God it never, ever happens to you”, I said “but no you can’t” I said “you or none else on this earth could ever hurt me again”, so if someone’s calling me names or whatever, just, I can walk away.

R35: Nothing will ever compare with that.

H35: Nothing, nothing. If someone was to come and cut the hands off me, it couldn’t hurt as much as Tommy’s disappearance. No, nobody could ever hurt me again. Whoever has hurt my Tommy, if they’ve hurt him, they could come and they could put a knife in my back and it wouldn’t hurt one bit. Nobody can hurt me now.

R36: The pain is just too great, you wouldn’t feel it anymore.

H36: Exactly. Nobody could hurt me anymore.

R37: And when you feel angry, Helen, who do you feel angry with, is there a sense of being angry at someone?
H37: I feel angry with everyone, because to me no one has helped me, I have, don’t get me wrong, the Police have helped, the Counsellor Anna has helped, but they haven’t found Tommy. So I feel angry with everyone, now that, that may sound silly, but I just, I feel angry with everyone, I really do. Now I’ve seen a mother last week giving out to her son, she’s a friend of mine and I said to her “do you know, if your son wasn’t here, you’d be sorry you shouted like that at him for such a trivial thing”, I said “it really is, what he’s done is trivial”, he took another bike from him and was going up and down the street on it and I said “if you were going through what I’m going through”, I said “you’d just take the bike off him and hand it back and say sorry, it won’t happen again”, I said “instead of going off at him the way you did”, I said “that alright he done wrong but “I said “it’s trivial”. You know things like that make me angry and what makes me even more angry, parents who have children and mistreat them. I’ve had my little grandson here for over three years, not my daughters son, it was my son’s ex-girlfriend. That little boy had been beaten, he’d been burned, he hadn’t fed properly, he just hadn’t been taken care of and I felt so angry with his mum. Her life comes first before her children, you know and I even said to the social worker that’s dealing with the mother, I said “how the hell could she do this to her son”, a little boy, only nine years old, I said “I would give my life to have mine back and she can treat hers like this”, and she said “I know Helen, some mothers don’t deserve to have children”, I said “no, they don’t”, I said “I’m not saying mine never got a smack but they got a smack when they’d done wrong, but they were never mistreated”. And that’s what make me angry.

R38: So kind of why your son, why did it have to happen to your son and to you?

H38: Yeah, there’s people out there that have done wrong, they’ve took lives, they’ve molested children, they’ve mugged old people and they’re walking the streets as large as life, so why, why my son? I remember my Tommy walking down the road with his friends and there was this man, an elderly man lying on the footpath, he he was drunk and Tommy, Tommy and his friends were walking up to him and Tommy said “come on let’s try and lift him up because he’s cut himself”, he said he cut his head when he fell. SO they lifted him up and they asked him like where did he live and it wasn’t too far from where they’d found him on the footpath and the children helped him home and he gave them the keys and Tommy opened the door and they took him in, sat him on the chair, Tommy’s friend went and made him cup of strong tea and Tommy went and got a basin of water and a cloth and washed his head for him and he asked him, he said “do you want to go to the hospital, we’ll take you to the hospital”, and he said “no, I’m alright son”, he said “thanks very much for your help” and Tommy said well “if you want, we’ll stay with you tonight” he said “would you?” and Tommy and his friends said “yes we will”, he said “it’s just that them blokes might have seen where I’ve lived” he said “and they might come back”. So the man was sort of scared to stay on his own, so Tommy and his friends sat the night until seven o’clock the next morning with the man and then they woke the man up and told him they were leaving, was he alright and he thanked them very, very much. You know little things like that, but I’m not saying Tommy was any angel, but he would never, ever harm anyone you know what I mean?
R39: Mm.

H39: He would have done a good turn before he would have done a bad one. Like why, why my child? You know what I mean and you've got so much evil running around the streets, Liverpool, London, Ireland, all over. You've got men, women, young lads, young girls that are out there to hurt people, hurt kids. To me they don't deserve to walk the streets, they deserve to be locked up, I'm not saying they deserve to be dead, no one deserves that, but just why?

R40: It seems so unfair.

H40: It is so unfair. It just, to me the world has gone to pieces. And we're so far back, like this is like, things like this happened way back in the 1920's, you know or way back when there was a famine, people were killing each other for food. But we're supposed to be a civilised country, civilised world. It's not civilised.

R41: And I imagine this must have felt even stronger since Tommy went missing?

H41: Yeah, but you know what annoys me even more - I brought my family, my husband and I brought our family over here for a better life and since we came over here, my husband - Tommy's father has died of cancer, firstly my mum died that lived with us for seventeen years, she died of complications due to high blood pressure and just eleven months after that, my husband died, and now this. 1970, my young brother of twenty-three was murdered in Kosovo for giving a dying soldier a drink of water and not long after that my older brother was found dead in a flat with his wife and baby, she was eight months pregnant, they were building their own house and it was a gas fire, they were suffocated.

R42: That's terrible.

H42: It's amazing how one person can take so much and still survive. And I can promise you one thing; I will never stop, until my dying day, until I've found my son, because someone, somewhere out there knows and how they can go to their bed at night and live with themselves is beyond me.

R43: That search never ends.

H43: It will never end until I can lay Tommy to rest. It will go on. If someone has harmed him, they're probably sitting back today thinking "well I got away with that", but do you know what, they may have got away with it here on earth, but they'll never get away with it up above, because on day they will be judged, and I hope to God they never have to go through what I'm going through - no matter how much I hate them, if they've got children of their own, I hope no one takes one of their lives the way they've done to mine. I would never wish that pain on anyone. This it's mental, it's mental pain because it's always,
always there; you’re making something to eat, you’re doing the garden, you’re decorating, you’re hoovering up and it’s always, always there. It never ends. It’s like an imprint on the brain.

R44: And as well as this pain and anger, some people have also spoken of feeling somehow guilty when a loved one has gone missing and I wonder if that was ever anything you felt.

H44: Oh yes I felt real guilt because with being his mum, I felt I should have been there to protect him… and I wasn’t. I wasn’t there to help him… I feel guilty because I’m alive and he may not be and that, that’s not right. You don’t outlive your children. You don’t. You expect your children to be here long after you’re gone…

R45: So it’s that mother’s instinct of always wanting to protect their children no matter how old they are.

H45: It don’t matter would age should he be thirty, forty even fifty, if you’re around, your, he’s still your child and you still have to protect them, it’s just like you said, I don’t know it must be instinct, but don’t matter what age they are.

R46: And that kind of ties into what I wanted to ask you next and it’s about how, how their going missing, or the particular role or position that you have in the family, so as the mother, that you feel may have impacted on your experience that makes it perhaps different from other members of the family.

H46: The other members of the family, they don’t understand and I couldn’t expect them to understand because they haven’t been through it - and please God I pray they’ll never have to, but I have been where they are, I’ve lost a brother, I’ve lost two brothers, on the same way possibly as Tommy, the other one a different way. But I have been where my family are and I know how they feel and I’ve told them that, I know exactly how they feel, but I pray to God they never know how I feel. I know now how my mum felt and I didn’t at the time, like my, my kids, they don’t know how I feel, I know how my mum felt and I didn’t on up ‘till Tommy went missing. I knew she felt pain, my God I knew that, but to the extent, no. None of us ever knew what she went through. But I know now what she went through and I say that to my girls when they say “mum you’ve got to get on with life” and I said “no, you can’t get on with life”, I said “your Gran went through what I’m going through, I never understood how she felt, but I do now” and I said to the girls, I said “I hope and I pray to God history does not repeat itself again because I wouldn’t want you to feel the way I’m feeling”. You, you can’t nobody can understand, unless they’ve been through it. It’s different with a brother than it is with a son. You know what I mean, your bother’s your brother, but your child is someone that you gave life to. So I, I, don’t expect my girls to understand, they couldn’t possibly, you can’t even, you can’t tell them… and it wouldn’t be fair to put it on them either because I know they’re, they’d be sitting thinking “well Gran went through this, history has repeated itself now with mum
and maybe it’s repeat itself again with one of us” and I wouldn’t want them to feel like
that.

R47: No, so in some ways it feels like you also need to protect them from the pain you
feel.

H47: Exactly and that’s why I don’t tell them everything. If Mr. Carter rings up and says
that “remains have been found,blah,blah,blah”, I don’t tell the girls, I tell them nothing
until I get news if there’s a possibility or if it isn’t. The only one I do confide in is my sister
in Liverpool. If um, if something has been found, it’s her I ring straight away and tell
her…and she has, she’s been a great source of help. But to tell my kids, no I don’t because
it’s not fair on them.

R48: You still want to protect them as well.

H48: Exactly. I don’t want them sitting - because they’ve got young children of their own
- I don’t want them sitting all day long thinking is it, is it Tommy, is it, you know what I
mean until the word would come, well I know the police wouldn’t tell me over the phone
they’d come to the door, you know what I mean they’d come to the house, but if it’s not
him they will ring me and say “no it’s not him Helen”. So no I don’t, I don’t tell the girls
anything unless I know it’s concrete. So you’re sort of carrying it on your own shoulders
until the news comes.

R49: It’s a big burden.

H49: It is, it’s a big burden and there’s, funny enough there’s times I get angry with his
dad ‘cause to me he should be here helping me with this, like it’s his son as well as mine
and I get angry with him for leaving me to deal with this on me own.

R50: I can understand that.

H50: The anger, you can’t even put into words the anger you feel.

R51: Mm.

H51: It comes from every corner and there’s times when you get really angry, you just feel
like lashing out and you don’t know who to lash out at; the police or the ones that the
police suspect, or even his girlfriend at the time - I did feel when I found out she had
moved someone in so quick - I wanted to lash out at her and ask her how could she do
this? You know because there has to be a grieving process, but she could have grieved for
the break-up of the relationship, because it’s completely different from my situation with
him being my son, but to me, it, it just didn’t seem to bother her that she could move
someone in so quick.
R52: Mm.

H52: I was livid. Words wouldn’t even, uh, I couldn’t even put in to words how I felt and that was a very long relationship, like it wasn’t a few weeks or a few months, that was a seven year relationship and how could she let someone take my son’s place so quick? And then she tried to tell me “but we weren’t together when Tommy disappeared Helen” and I said “excuse me”, I said “if you weren’t together when Tommy disappeared, why did you ring me on the Monday and tell me Tommy never came home, he was missing?”, I said “if you weren’t together then why would he come home?”. So that’s what I mean about the questions, there are so many questions need answering and no one seems to be giving me answers.

R53: It sounds so frustrating.

H53: It oh (sigh).

R54: Although that doesn’t come close I know, that’s an inadequate word for it.

H54: No, but you’re on the right lines. There, there’s so many questions need answering. I have asked and asked and asked and no one seems to be able to answer them. Like his house, Tommy had bought a house and even though he’d put [his girlfriend’s] name on the house just to make her feel secure, to give her some security, Tommy took out the mortgage on the house, ‘cause you don’t get a mortgage if you’re not working and she wasn’t working and Tommy was only missing about five, six weeks when she rang me and told me, she said would I agree to her selling the house, ‘cause it would set her little girl up for life in good schools and I said “but what happens if Tommy comes back?” “oh” she said “now Helen you know as well as I do he’s never gonna come back” I said “but how do you know that?” I said “you can’t sell his house” I said “no”. So from what I’ve been told, which I don’t really know the truth, I think from what I was told the house was repossessed, but I don’t know, because she never, ever contacted me after that. To me she was just the type of girl who was just out to get everything she could from different lads, she got, she got the final, she got the house, now whether she, well she can’t have sold it because you have to wait seven years, so I don’t, I don’t know what’s happened to that, but I do know all she was after was money because when the car was found, they um, the police only had the car for three and a half weeks, three or four weeks when she went down to the police station and tried to claim the car. She told the police that she wanted to sell it to pay off her bills and the police told her that the car had nothing to do with her, she wasn’t married to him. Now the car would come through me as his next of kin. She’s, there, there’s just so many unanswered questions about that girl.

R55: I can understand that from what you’ve said, why there would be so many questions still.

H55: If she, she could take anyone in so easily because she’s quietly spoken, she can be
very, very well mannered, so sweet and I told the police that, I said “don’t be taken in by her”, I said “she could talk to you like butter wouldn’t melt in her mouth” I said “but she has so, there’s so many questions she needs to answer” and they said “well like what Helen?” and I said “why”, to me “I want to know why she tried to claim the car less than three weeks after the car was found” I said and “why did she move someone in with her so quick after Tommy disappeared, why did she allow that little girl to call that man daddy?” I said “she must have known Tommy was never coming back, she would never have allowed her daughter to call this man daddy” I said because “how did she know that Tommy wasn’t gonna walk in and hear that little girl calling another man daddy and another man living in the house that he shared with her and why did she tell the police that this man she’s living with never knew Tommy when they work together?”. Now I know there are so many unanswered questions and I even said it to Mr. Carter and he said “well I don’t know” and I said “well don’t you think it’s your job to know?” I said “ask her”. Now I know she’d been interviewed but she’s the type of girl if she’s in her own home, she’ll feel safe, whereas if she had of been taken to a police station, I honestly believe she would of told more, but she felt so relaxed ‘cause she was in her own home. The police never, ever took her in, they only questioned her once, I think it was the once in her own house.

R56: So it, in some ways it feels frustrating that things were done in the way that….CHANGE TAPE

H56: I’m going back to this man, Tommy’s ex-girlfriend’s brother, there’s questions about him that need answering. Now the police knew Tommy fought the ex-girlfriend to get access to this little boy that Tommy always believed to be his and Tommy won the court case and won the right to have the little boy for an hour to begin with at weekends until the little boy got used to him again and then it stretched to one day and then over a period of time, from Friday to Sunday and one Sunday Tommy had pulled up at this lad’s house, to pick up the little boy, and they brought the little boy out and put him in the car with Tommy and this lad apparently ran out up the hill after Tommy with a machete knife, screaming all sorts of threats. To me the police should have looked deeper into that. One time he turned up at a hospital with his girlfriend this lad and he was covered in blood from head to toe [...]. The hospital immediately called in the police and this lad was arrested. Now I know they held him in the police station, I think it was a week or a couple of weeks and they tried to say, his family tried to say it was a severe nose bleed, but from what I’ve been told, the amount of blood that was on him… I’ve got someone here, can you ring me back in a few minutes.

TEN MINUTES LATER.

R57: The next thing I was going to ask you about was what’s been your experience of how those in your wider family have responded to Tommy going missing?

H57: They tried to deal with it by thinking they won’t accept that Tommy could be gone
for good. They, they deal with it by thinking that he’s gone away to work in another
country and he can’t get back home and that’s, that’s the way they deal with it. But deep
down they know something may have happened, because if they read anything in the
papers, they’ll ring up straight away to find out if this person has been identified. The best
way I could put that for you is that they, they’ve sort of imprinted in their own way that
he’s just gone away to work.

R58: Mm, how does that affect you, that they deal with it that way?

H58: Well that’s, I, I accept that because I wouldn’t like to see them lose it in any way,
shape or form because they’ve got young children of their own...you know so I just let
them deal with it in the best way they think is right.

R59: And who do you mean when you, who are these members of the family that do that?

H59: The girls do it, the girls just believe he’s gone away to work. His brother, he won’t
even talk about it, he won’t mention Tommy’s name. He blames himself because him and
Tommy were always very, very close and the way he thinks of it is, the one time that
Tommy may have needed him he wasn’t there.

R60: So he feels guilty as well.

H60: Very guilty, ‘cause there’s only the two brothers, they were like, my God, they were
like Siamese twins - where one was the other was.

R61: And how has all of this affected your experience of the family as a whole?

H61: There’s a place missing. A place that nobody else can fill.

R62: It’s not complete.

H62: It’s not, there’s an empty space. At Christmas when we all sit at the table for
Christmas dinner, Tommy’s chair is still there...but he isn’t in it. His Christmas presents
are still there from the year he went missing. His birthday presents are still there...and on
the [date he went missing] every year at twenty past three, I light a candle.

R63: And how does that help you?

H63: Well it, if Tommy can hear me, he’ll know I’m still thinking of him and I’m still
searching and he knows I will never stop searching until I find him. Even if he is out there
somewhere, he knows mum will not stop searching.

R64: It keeps that alive
H64: Oh, yes. Tommy’s still very much alive in my family. Very, very much alive.

R65: And what’s been your experience of how those in your social network have responded?

H65: In which way do you mean?

R66: Um, with friends maybe or neighbours, how have you found that they have responded to this or how has it affected you in the way they’ve been?

H66: Oh they’ve been, they’ve been a tower of strength. Any time I have to go away and make an appeal, “is there anything we can do to help Helen, um do you want me to take care of Taylor for you?”, that’s my cat or Yvonne and Clive next door, they take care of Oscar the dog, he’s an outside dog if you know what I mean, he’s got his own kennel and that. They will take care of him, feed, water him and take him for walks. Oh my neighbours, I don’t think I’d ever, ever get neighbours anywhere like them. And even at the shops, everyone in the row of shops on the main road, they all know me and they all know what’s happened and they still say to me “any news Helen?” and I’ll say “nothing, absolutely nothing”, it’s like he’s vanished off the face of the earth and no one vanishes, they’ve got to be somewhere.

R67: What does it mean to you that they still ask you?

H67: Well, it makes me feel that there are still people out there that care, they care enough to ask. You know some people would think well “I’ll not ask in case it you know, it brings it all up again for her”, but the ones that think like that don’t realise that it’s always there, it never goes away. Do you understand what I mean?

R68: Sure, that to have them validate that for you must help.

H68: Oh it helps because you think well that was nice because people are still thinking of him and they’re still thinking of me and my family. You know I have had people say to me “oh dear, he’s done somebody wrong” and I say “well what makes you think that?”, I say “well now what on earth would make you think that?”. Now funny enough about two weeks ago the electricians were round here and one of them recognised me from the television. He said “it was your boy that went missing presumed murdered” and I said “yes it was”, “oh” he says “he’s got up somebody’s nose hasn’t he” so I said to him “please leave” and he said “oh I’m sorry I didn’t mean to upset you”, I said “what makes you think that my son may have got up somebody’s nose?”

R69: Mm, and that leads me to something else I wanted to ask you about how, whether you have a feeling of how the public in general views missing persons cases, or the families of missing people?
H69: I would say the majority just think, oh they’ve gone off, there’s been an argument, they’ve gone off, they’ll be back, you know, just shrug it off sort of thing. Because it hasn’t happened to them, they couldn’t possibly know how people in my position feel. I know my son hasn’t just gone off for a break from life, the pressures of life, and no one would know that better than I would. Even the police wouldn’t know how it feels unless it were to happen to one of them, which I hope and pray it never does.

R70: And some people have said that there’s a sense of stigma from the public. I wonder whether that’s something you can relate to?

H70: In what way do you mean, stigma?

R71: Well, that it feels as if perhaps the public think, “oh well”, as you said “they’ve run off”, or you know that “the family may have driven them away”, that the public make up, that there’s a feeling that the public um, yeah makes, assumes these things about what’s happened.

H71: Oh yeah. They would assume, “oh they’ve just gone off, she’s out there running around searching for him, he’ll be back...or if he’s not back there’s a reason why he can’t come back”. They don’t understand, unless you go into your whole private life to explain that to them and I’m sorry but I’m just not prepared to go into my private life to...make them feel better, you know what I mean, to give them my life story which has got nothing to do with them. Like if they want to think bad things why Tommy has gone off or why he may have been murdered, well that’s not my problem, that’s their problem. What I do know is, my son was never in anything and he would never of gone off for a break from life. What I think did happen, I think my son has raised a boy that may not have been his and I think the real father is the one that may have caused harm to my son because of this and to add it all up together, my son is the one that suffered over that girls’ blunder...my son paid the price for it. Do you understand what I mean where I’m coming from?

R71: Sure and the public, people could never possibly know all of these things and know what he was like and know these details.

H71: That’s exactly my point, they don’t know. No one but no one should make assumptions when they don’t know the background and just to please them, to let them know my business, I’m not going to tell them, it’s none of their business. I’m sure other parents of missing children feel the same way. Why should I give out my child’s life story to make them feel good, to let them know what’s going on? It’s none of their business and if it makes them feel good to think whatever they want to think well that’s up to them. You know what I mean, like that electrician; “oh he must have stepped on someone’s toes” you know what I mean, automatically he’s made out to be the bad one because he’s missing. Not every person that goes missing goes missing because they’ve done something or been in something, they’ve gone missing, if murdered for, there’s other reasons as well.
And that's not fair, it's really not fair to judge someone unless it comes out in the papers for proof, it's not fair to make assumptions, because when people have said to me "oh, he's stepped on someone's toes or he's got up the wrong side of someone", that really makes me so angry. I want to lash out and thump them and say "how dare you assume such a thing when you don't know. I know but you don't know and I'm not prepared to tell you because it's none of your business, but if you want to assume that to make yourself feel good, well go ahead and do it". You know it does it makes you really angry. People have got so, so really rotten, dirty minds, they couldn't turn round and think "well maybe that poor lad just after doing a days work came home, got a phone call, thought he was going to help someone and he ends up dead". People never think like that.

R72: People seem to think the worst somehow.

H72: Oh yeah because it's a man, 'cause it's a boy. It's different when it's a girl, people from all walks of life will go out, they will search, they will do everything and anything to help that family find that girl. But when it's a boy, it just doesn't matter as much and that is so wrong. That is so very, very wrong. And that young girl who went missing a couple of months ago, the newspapers where putting up a reward to find her and then when they did find her, they put the reward up to find the one that harmed her, they even got their own detectives out on it. I have rang everyone to see if they would help me. I even phoned Mohammed Al Fayed's office 'cause I thought well he has a son that died, he believes he died under mysterious circumstances, he believes his son was murdered and I wasn't gonna, I wasn't asking him for money or anything like that, but I knew he had his own private detectives and I thought well he's a father that's in the same situation as I'm in, maybe just maybe he would use his detectives to try and help me find my son. But I got no help and I contacted (inaudible) office and all he ever does is write tiny little yellow letters back, he will not come and speak to people on the phone or come to their home.

R73: Who is that?

H73: Gerald Kaufman the M.P.

R74: So there's a real sense of many people not helping. I wonder whether there have been particular things or particular people who have really helped you cope during this time?

H74: Mr. Carter has helped me immensely.

R75: Is he the primary detective on the case?

H75: He's the Detective Chief Inspector and Anna, the Counsellor I was going to. I know Anna is always at the other end of the phone when I need her. She's always there.

R76: What other ways have you found them helpful? For example how has Mr. Carter
helped you?

H76: Mr. Carter got himself and me on to that Crimewatch Daily that used to be on
BBC1, he has spoke to reporters for me, any journalists or reporters that phoned me, they
would ask “would Mr. Carter speak to me?”, so I would ring him and ask him and he’d
say “yes Helen”, he would speak to them. He also told me that if...I asked him if I had to
go on any programmes where it’s one to one not with an audience you know what I mean,
because that would not be fair on Mr. Carter, he’d have the audience shouting down his
throat. So I asked him, if I’m asked on any programmes where there’s just one to one
talking, you know something like ‘This Morning’, would he go on with me and he said yes
he would.

R77: So again it feels as if he’s really there for you.

H77: He’s always been there, always been there and I know I can talk - I can lift the phone
and I can talk to Mr. Carter at any time of day or night, he’s always there.

R78: It must be comforting to have at least that.

H78: It is very, very comforting. Because, like that time I seen that lad on the television, if
I ever see anything like that again, on the television or in the papers, anyone even that
resembled Tommy, I know I can ring Mr. Carter ‘cause he gave me his mobile number, I
know I can ring him and he will look into it right away.

R79: And in what ways do you feel Anna was particularly helpful as your Counsellor?

H79: She was, she’s there for me to talk to her. If I’m feeling angry or feeling depressed or
even if anything you know things just getting on top of me, I know I can ring Anna and
she will sit and listen or if I wanted I can go up to Victim Support office and I can say to
them “I really need to speak to Anna” I know she’ll see me.

R80: And is it just in her listening that helps somehow?

H80: Yes just someone outside the family because you can’t, you can’t sit and talk to your
family about things the way you can with Mr. Carter or Anna. I know Anna’s there when I
need to talk to her, even when she goes to Scotland to visit her family, she gave me their
number, if um, I needed to contact her. She’s been a tower of strength.

R81: And what about the Missing Persons Helpline?

H81: Brilliant. I couldn’t speak any more highly of those people. Absolutely fantastic. No
matter what comes up, they always put Tommy’s name forward. Whenever that, that
programme Crimewatch, they agreed with Scotland Yard to do a small thing you know on
every other programme of people missing presumed murdered, you know disappearing
under mysterious circumstances and last month they picked out I think three people, well Tommy’s name did go forward for that but he wasn’t picked at that time. But apparently they’re going to be doing a thing like this on every Crimewatch, you know every month, so they will be, they say they’ll keep putting Tommy’s um photo and details in front, you know up with it. Oh they have been absolutely brilliant. I just feel guilty because I’m not able to give them a donation, ‘cause I know they work off donations, but I always swore if I ever won anything on the Lottery or whatever, I would definitely put something forward because they’ve been absolutely brilliant.

R82: And is it that they help so much in this on-going search?

H82: Oh they’ve been there from day one. Day one and no matter what reporters ring in, they always forward my phone number, which I told them they could do.

R83: And what about how, how do you find that they help with you, I imagine they have an understanding or a manner with which is helpful as well.

H83: It helped, it helped in a way that I couldn’t go out there personally and get it into the papers or go to the television stations, I couldn’t do that, but they could and I think it’s brilliant, because so many people are missing, I know the majority of them do turn up safe and well, but they, they still, they put Tommy forward, because even though we haven’t found him yet, he’s still classed as a missing person and they do, [names of people who work there] oh they’re brilliant. I could, I just say thank God they’re there.

R84: It must be fantastic what with the search being never ending and it being so wide, it must be so, such a help to have them helping you in that.

H84: Fantastic. They are fantastic, absolutely, I just couldn’t say enough about them. I know I could never have got as much out about Tommy without their help. I wouldn’t have known where to start.

R85: And are there things that would be useful to you in the future, other kinds of support or help that you feel would be helpful to get?

H85: Well I don’t even know how to answer that, I can’t answer that until I find Tommy and then I would know where to go somewhere to get, I would know how to sort of, well I would find out how to get the help I would need, do you understand what I mean? I can’t answer that question until I find him, but the support I’m getting at the moment from Mr. Carter, from Anna and from the Missing Persons Helpline has been fantastic.

R86: It sounds it, it sounds brilliant. I’m glad it’s been there for you.

H86: They’ve always been there.
R87: And I wonder are there things that you feel that those who might try to offer help and support to people in the future, so Counsellors for example who might come to try to help someone who’s got a loved one go missing, are there things that you feel would be helpful for them to know.

H87: I would love them to know and I know they probably would be told, there’s always someone there on the other end of the phone to speak to, you know what I mean, don’t sit in despair on your own when you know there’s someone on the other end that will sit and listen and try to understand what you’re going through. They can’t understand a hundred percent unless they’ve been through it, but there is always, always someone there to listen. If, if you don’t like me, if you don’t like to speak to your own family about it, there is always someone out there on the phone that you can talk to and that will listen.

R88: And what would you say to the Counsellors, what would you tell them that they might try and do to help?

H88: Well you know you can’t add to perfection, because they are perfect. I don’t really think you can add to that.

R89: Just to listen and be there and try to understand?

H89: Yes and that is exactly what they do, they will sit and listen, even if you break down, they’re there as a source of comfort.

R90: And how long did you see Anna for?

H90: I saw Anna for over three years, until my little grandson came to live with me and then the focus sort of went on him, but I still went to see Anna and I would take him with me if he wasn’t, if there was no school I’d take him with me and he would sit down in the waiting room. But Anna, oh the lady deserves a medal. I really don’t think the Counsellors get enough recognition, you know for the work they do and it is all voluntary. For someone to give up their spare time to listen to someone else’s problems, I think that’s amazing that.

R91: And that, is she a Counsellor through Victim Support?

H91: Yes she is. They are very, very special and you know no matter what you tell them, you know it’s confidential, you know it’s not gonna go any further. They are, they’re very, very special and they’ll always, always have a place in my heart along with Mr. Carter. Even if I was to find Tommy tomorrow, I could never forget those people or Mr. Carter for what they’ve done.

R92: And I’ve actually only got one more question and it may sound a bit strange, but some people have said that in their struggle to cope with some of the worst things in their
lives, that they see themselves as having somehow changed in positive ways or having learned something at least and I wonder if that's anything you can relate to?

H92: It's made, it's made me stronger in the way as I explained to you before; nothing can ever hurt me, I am a stronger person for that. If someone was to run past me and give me a slap in the face, it can't hurt me, alright the pain would be sore, but they can't hurt me. No one on this earth can ever hurt me again, they can't.

R93: It's knowing that it can't get worse.

H93: Exactly, it couldn't possibly get worse than to take my child away from me, the child that I carried for nine months and gave life to, someone has possibly took that life away from him. So how could anybody hurt you worse than that? No. No one can hurt me and I feel a stronger person for that.

R94: I can see that.

H94: If someone in the street picks an argument with me, I know I can walk away from them. I hope and pray to God no one ever does like, but I know I could just walk away.

R95: And it can't touch you, not in the way you've already been touched, nothing can.

H95: Well this is it. I, I've been hurt in the worst possible way you could imagine and nobody could top that, no one.

R96: Thank you, I don't have any more questions.

DEBRIEF

Is there anything else you wanted to say or you're surprised I haven't asked you about?

H96: Just if you know if there's anything else I can possibly do to try and find him or try to keep his name alive in the newspapers so the people in Avon don't forget. I don't want them to think that this has gone away because it hasn't and it never will until I find him.

R97: No, no okay I understand that. I also wanted to know how this has left you feeling.

H97: It makes you feel useless as a mother, you didn't, you weren't there to protect your child when you should've. It makes you feel a bit like a failure. That I couldn't keep him safe. It really does make you feel like a failure.

R98: And how has it been talking to me today, how has it left you feeling talking to me?

H98: It's made me think back to the day he went missing, like what has he gone through,
have they harmed him? Or someone's harmed him because he just wouldn't go off. But know when we finish I'm gonna go out and work in the garden and have a strong cup of coffee. In fact you know it makes me feel a bit better for talking about it, you know to talk to someone outside of the family.

R99: Well I'll switch the tape off now. Thank you so much for taking the time to talk to me and sharing your experiences with me.

END
Appendix 6: Letter granting ethical approval

N.B. Whilst the title of the research changed owing to difficulties with recruiting participants, no changes were made to the proposed study other than the method of analysis.

Ms Amy Gibbard
PsychD Student
Department of Psychology
University of Surrey

Dear Ms Gibbard

Theorising the experience of having a loved one go missing: A grounded analysis (ACE/2002/112/Psych)

I am writing to inform you that the Advisory Committee on Ethics has considered the above protocol (and the subsequent information supplied) and has approved it on the understanding that the Ethical Guidelines for Teaching and Research are observed. For your information, and future reference, these Guidelines can be downloaded from the Committee’s website at http://www.surrey.ac.uk/Surrey/ACE/.

This letter of approval relates only to the study specified in your research protocol (ACE/2002/112/Psych). The Committee should be notified of any changes to the proposal, any adverse reactions, and if the study is terminated earlier than expected, with reasons.

Date of approval by the Advisory Committee on Ethics: 05 March 2003
Date of expiry of approval by the Advisory Committee on Ethics: 04 March 2008

Please inform me when the research has been completed.

Yours sincerely

Catherine Ashbee (Mrs)
Secretary, University Advisory Committee on Ethics

cc: Chairman, ACE
Dr R Draghi-Lorenz, Supervisor, Dept of Psychology
Notes for Contributors to Counselling Psychology Review

Submissions
The Editorial Board of Counselling Psychology Review invites contributions on any aspects of counselling psychology. Papers concerned with professional issues, the training of counselling psychologists and the application and practice of counselling psychology are particularly welcome. The Editorial Board would also like to encourage the submission of letters and news of forthcoming events.

Manuscripts should be typewritten, double spaced with 1" margins on one side of A4 paper. Each manuscript should include a word count at the end of each page and overall. Sheets should be numbered. On a separate sheet include author's name, any relevant qualifications, address, telephone number, current professional activity and a statement that the article is not under consideration elsewhere and has only been submitted to Counselling Psychology Review. As articles are refereed, the rest of the manuscript should be free of information identifying the author. Authors should follow The Society Guidelines for the Use of Non-Sexist Language contained in the booklet Code of Conduct, Ethical Principles and Guidelines. Four copies of the manuscript should be submitted with a large s.a.e. A copy should be retained by the author.

Bibliographic references in the text should quote the author's name and the date of publication thus: Davidson (1999). All references should be listed at the end of the text and should be double spaced in APA style. A guide to the presentation of references using the APA style is given in The British Psychological Society Style Guide, available at £3.50 per copy from The British Psychological Society, St Andrews House, 48 Princess Road East, Leicester LE1 7DR, UK.

Low-quality artwork will not be used. Graphs, diagrams, etc., should be supplied in camera-ready form. Each should have a title. Written permission should be obtained by the author for the reproduction of tables, diagrams, etc., taken from other sources.

Submissions should include abstracts
The abstract should be no longer than 250 words (depending on the length of the paper). It needs to be double spaced, on a separate sheet and headed 'Abstract'. The British Psychological Society's Style Guide provides the following information on writing abstracts:

The purpose of the abstract is to allow the reader to assess the content of the article prior to reading the full text. In addition to appearing immediately below the author's name, the abstract will be used for indexing and information retrieval by such services as Psychological Abstracts. It should, therefore, be written so that it can be understood independently of the body of the paper (p.6).

Proofs of articles are sent to authors for the correction of typesetting errors only. The Editor needs the prompt return of proofs.

Contributors should enclose a 3.5" disk (either DOS or Mac format) with the document saved both in its original word-processing format and as an ASCII file. All diagrams and other illustrations should be saved in their original format and as a TIFF or an EPS.

Other submissions
Book reviews, letters, details about courses and notices of forthcoming events are not refereed but evaluated by the Editor. However, book reviews should conform to the general guidelines for academic articles. Contributors should enclose two hard copies.

Deadlines for notices of forthcoming events, letters and advertisements are listed below:

For publication in Copy must be received by
February 5 November
May 5 February
August 5 May
November 5 August

All submissions should be sent to: Dr Alan Bellamy, Editor, Counselling Psychology Review, Brynmair Clinic, Goring Road, Llanelli, Carmarthenshire, SA15 3HF.

Book reviews should be sent to: Kasia Szymanska, Book Reviews Editor, Centre for Stress Management, 156 Westcombe Hill, London SE3 7DH.
Therapists’ agreement with models of bereavement in conceptualising their work with clients who have experienced different types of loss (certain and uncertain).

Abstract
This study examined differences in therapists’ agreement with certain modern and post-modern aspects of bereavement theory, dependent on theoretical approach to therapy and whether loss is certain (when a loved-one dies) or uncertain (when a loved-one goes missing). 135 participants completed a purpose-built questionnaire that measured levels of agreement on a number of variables. The results indicated that when a client’s loss was uncertain, therapists agreed more with the view that it is understandable for a client to continue to search for their lost loved-one and that the client may have particular reason to feel that others cannot understand their loss, than when the loss was certain. They also agreed more with the view that it may not be necessary to detach from the lost loved-one than the view that they should. When loss was certain (irrespective of theoretical approach to therapy), they agreed more with the traditional concept that a client should work through feelings associated with their grief, than the post-modern suggestion that this may not be necessary. However, those taking a humanistic approach agreed more with a number of ‘new’ aspects of theory than the traditional equivalents. Limitations of the study and implications of the results are discussed.
Introduction

An estimated 210,000 people are reported missing in Britain every year and whilst the majority return home within seventy-two hours, thousands do not (National Missing Persons Helpline, 2002). Gibbard (2002) reviewed the literature on the impact on family members of having a loved-one go missing and carried out four detailed case studies of individuals with missing loved-ones, exploring their phenomenological experience of this loss (Gibbard, 2003). Both pieces of work indicated a significant level of distress caused by having a loved-one go missing, which seems in many ways to be indicative of a 'grief response' as family members frequently identify guilt, anger, searching and often name 'grief' itself as being part of their experience.

However, this research also highlighted that other aspects of the experience of having a loved-one go missing make this experience of loss fundamentally different to loss through the death of a loved-one. Specifically, the uncertainty of whether the loved-one is permanently lost to them seems to be extremely salient. For example, searching for them becomes a practical attempt to find them whereas when a loved-one has died, it is suggested from a psychoanalytic perspective that there may be more of an 'intra-psychic' urge to search (Parkes, 1972) and that continued searching is indicative of unresolved grief.

It could be argued that the unique nature of this loss leaves therapists with a lack of specific theory to inform their work with clients in this situation, which in turn might lead them to draw from traditional models of bereavement. Some participants in the study by Gibbard (2003) appeared to indicate that certain interventions made by the counsellors may have been driven by 'traditional' models of bereavement or social responses to loss, in ways which were not experienced as satisfactory. This seems to challenge the applicability of elements of traditional models of grief and bereavement to this unique form of loss. For example, a woman whose son went missing commented that:
"it was my Counsellor told me to do it; I have a little patch in my garden which I call 'Harry's Garden'; that's Tommy's dad (who had died). She suggested that I take another part of that and make it 'Tommy's Garden'. But how can I make it 'Tommy's Garden' when I don't know where he is?" (From Gibbard, 2003, p9-10, Text in brackets added. Names changed to preserve anonymity).

Independently of the above considerations a number of researchers have also questioned elements of the 'classical works' on grief and bereavement (e.g. Bowlby, 1979; 1980; Freud, 1917; Parkes, 1986). Many of these challenges have centred around whether there should be a 'detachment' from the lost loved-one and whether it is necessary to 'work through' this loss. The 'work of mourning' was a phrase coined by Freud (1917) who described it as the painful, intra-psychic process of severing "attachment to the non-existent object" (p.166). Walter (1996) and Bonnano and Kaltman (1999) have claimed that these early writings have led to an excessive emphasis on the importance of 'working through' thoughts and feelings related to the loss with a view to relinquishing the attachment bond to the deceased (e.g. Bowlby, 1980; Lazare, 1989; Raphael, 1983; Sanders, 1993). However, some of this emphasis may have prevailed as a result of 'selective reading' of prominent texts. Walter (1996) for example, highlights that whilst Freud (1917) described the task of mourning as to 'detach' from the deceased, he also wrote about the need for the bereaved to identify with the lost loved-one. Similarly, Bowlby (1979) suggested that mourning leads towards detachment, but later suggested that "Failure to recognise that a continuing sense of the dead person's presence...is a common feature of healthy mourning has led to much confused theorising" (Bowlby, 1980, p.100).

There are also empirical findings which suggest that there should be no expectation of 'letting-go' of the deceased. Schuchter and Zisook (1993) for example state that "the empirical reality is that people do not relinquish their ties to the deceased, withdraw their cathexes, or "let them go"."(p.34). Klas, Silverman and Nickman (1996) also found that
for both adults and children, maintaining a ‘connectedness’ “provided solace, comfort, and support, and eased the transition from the past to the future” (pp. xvi-xviii).

Walter (1996) also highlights that along with expectations of acceptance of loss and detachment seemed to come expectations of developing new attachments, almost as evidence of ‘healthy adjustment’, whereas the expectation of being ‘reunited’ with lost loved-ones in heaven is ‘pathologised’ (e.g. Raphael, 1984). However, Walter (1996) highlights that for certain groups such as elderly widows, this hope is “given age, length of marriage, and lack of availability of replacement partners - entirely rational” (p.10).

Worden (1991) has also suggested that the task of the practitioner is “not to help the bereaved give up their relationship with the deceased, but to...find an appropriate place for the dead in their emotional lives” (p16). However, he suggests that this may be “hindered by holding on to the past attachment rather than going on and forming new ones” (p16). However, Walter (1996) asserts that it should be “entirely up to the individual whether he or she chooses to go on and form new attachments, there being no clear evidence that forming new attachments is correlated with effective functioning” (p12). Several authors have highlighted that that this expectation of detachment is very much more a part of Western than Eastern culture, with a continued bond with the deceased being commonly accepted in most Asian, African and Hispanic cultures (Bonnano, 1998; Kastenbaum, 1995; Opuku, 1989).

Theorists have also criticised the idea of a ‘pattern’ of grief identified in clinical lore, whereby people move through ‘stages’ of grief and that deviations from this (including ‘excessive’ length of grief reaction) are indicative of ‘pathological’ or ‘unresolved’ grief. Stroebe (1992) for example suggested that there may be many and varied responses to grief and that theorists and practitioners alike should be cautious of labelling any one of them as pathological. Instead, it is felt that there should be a “post-modern individualising of loss and a rejection of grand theory. Different individuals grieve in different ways, and
counsellors should be aware of the diversity of such ways if they are to assist clients to follow their path of grief” (Walter, 1996, p.11).

There has also been speculation about the ‘process’ of grief and specifically whether it is necessary or even helpful to ‘work through’ the painful feelings associated with loss. Wortman and Silver (1989) highlighted that there was “relatively little empirical evidence relevant to the issue of ‘working through’” grief, but concluded that “early signs of intense efforts to ‘work through’ may portend subsequent difficulties” (p.352). Stroebe and Stroebe (1991) also concluded that “the view ‘Everyone needs to do grief work’ is an oversimplification” (p.481). Bonanno, Keltner, Holen and Horowitz (1995), also found that avoidance of painful affect related to the loss (as measured by verbal-autonomic dissociation), predicted ‘better adjustment’ in terms of overt grief symptoms.

Walter (1996) has also suggested that a ‘lasting keeping hold’ of the lost loved-one is achieved through dialogues rather than ‘working through’ feelings. Specifically, he felt that it was the external dialogues with others who knew the lost loved-one (focusing on the character of the deceased rather than feelings) which were helpful, rather than “internal dialogues with a deceased person” (Stroebe, Gergen, Gergen & Stroebe, 1992, p.1210). Walter (1996) even suggested that talking to others (such as a counsellor) who did not know the lost loved-one, would be “second-best” to talking to others who knew them. However, Walter concedes that for many reasons this may not be possible and in these instances, talking to others who have suffered the same ‘category’ of loss (e.g. children, spouses) or lost them in similar circumstances may be helpful.

Whilst it is acknowledged that the changes which are taking place in the bereavement literature are predominantly intended to be applied to ‘certain’ or irrevocable loss, many of them could be seen as helpful when conceptualising working with people who have had a loved-one go missing. For example, reluctance to detach or accept the loss as permanent, a hope of being reunited with the missing loved-one and no expectation of a particular
'pattern' or process of grief through which they should move would seem to be particularly applicable. Gibbard's (2003) study also found that participants felt a particular sense of isolation and lack of understanding from others about their loss. Thus in line with Walter's suggestion, they may find it helpful to talk to others who have suffered the same 'category of loss'.

However, Lindstrom (2002) noted that, despite there being significant scientific evidence which supports these new perspectives, the traditional 'grief work' perspective remains highly popular and indeed seems to have had some role in the interventions made by counsellors who worked with participants in the study by Gibbard (2003)¹. However, the current author suspects that a continued popularity of clinical lore may not be so clear-cut within the disciplines of Counselling Psychology and Psychotherapy where there is a commitment to place a respect for the uniqueness and diversity of individuals at the centre of practice (Woolfe, 1996). In addition, the discipline of Counselling Psychology takes a very different stance to that of the traditional 'medical-model', whereby practitioners are seen as 'doing' something to the 'patient' to 'cure' some kind of 'illness' (Woolfe, 1996) thus resisting the 'pathologising' of individuals.

Thus it would seem likely that Counselling Psychologists and Psychotherapists would reject aspects of clinical lore, were they not felt to be appropriate to the individual client. It would also seem likely that the viewing of certain 'grief reactions' as 'pathological' would be rejected. However, given the very nature of therapists' profession, it is suspected that there would still be greater agreement with the view that it might be important for a client to 'work through' difficult thoughts and feelings related to their loss. Whilst 'avoidance', 'denial' or 'suppression' of painful affect is not automatically viewed as 'a bad thing' (Bateman, Brown & Pedder, 2000), therapists might consider that if a client is in some

¹ However, the findings from the case-studies of Gibbard (2003) cannot be generalised and it is inappropriate to make assumptions about how interventions may or may not have been driven by traditional models of bereavement and responses to loss.

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distress, not to focus on such painful affect (albeit in a ‘timely’ and sensitive manner) would be tantamount to ‘collusion’ and ultimately unhelpful for the client. It also seems unlikely that practitioners would consider talking to a therapist as ‘second-best’, not least because by virtue of having been referred (assuming clients have requested such referral), it suggests that clients might like to have the opportunity to talk to somebody independent of their social network.

Given the prominence of psychoanalytic theorists (e.g. Bowlby; Freud) in the development of clinical lore, it would also be interesting to determine whether theoretical approach to therapy influences the degree to which therapists agree with such theory. For example, might practitioners taking a psychodynamic approach to therapy be more inclined to view such ‘traditional assumptions’ as useful in conceptualising work with clients who have suffered a loss as compared for example, to practitioners whose preferred approach to therapy is existential or humanistic (termed ‘third-force’ by Maslow, 1968)? Would practitioners practising from such humanistic approaches be more inclined through their commitments to be client-led, to agree more with post-modern theories of bereavement such as those which suggest that it is entirely dependent on the client as to whether they wish to achieve detachment from the lost loved-one?

This study therefore aims to use empirical enquiry to explore whether conceptualising work with a client with a missing loved-one would lead therapists to agree more with certain post-modern aspects of bereavement theory than other more ‘traditional’ perspectives. It will also explore practitioners’ levels of agreement with these aspects of theory more generally (such as whether they agree more with the view that a working through of feelings is necessary) and whether therapists’ theoretical approach to therapy influences the degree to which they favour these perspectives.

Specifically, it will explore whether differences in agreement exist between detachment
(old)² (there should be detachment from the lost loved-one) and detachment (new) (it may not be necessary to detach); working through (old) (it is important to ‘work through’ the feelings related to the loss) and working through (new) (such working through may not be necessary); process of grief (old) (there is a ‘normal process’ of grief, deviations from which are ‘pathological’) and process of grief (new) (there are many and varied responses to grief, none of which are pathological); dialogues (old) (internal dialogues with the lost loved-one are helpful) and dialogues (new) (external dialogues with others who knew the lost loved-one are helpful); searching (old) (on-going searching for the lost loved-one is indicative of unresolved grief) and searching (new) (on-going searching is understandable); commemorating (old) (commemorating the loss would be helpful) and commemorating (new) (commemorating may not be helpful) and lack of understanding (they have particular reason to feel a lack of understanding from others regarding their loss and talking to others who have suffered a similar ‘category of loss’ may be helpful).³

**Research Aims and Hypotheses**

1) This research therefore aims to examine therapists’ levels of agreement with certain aspects of ‘old’ and ‘new’ bereavement theory when conceptualising their work with a (hypothetical) client. Specifically, it is hypothesised that when the loss is uncertain (where a loved-one has gone missing) as compared to certain (where a loved-one has died):
   
   1a) there will be significantly greater agreement with detachment (new).
   1b) there will be significantly greater agreement with searching (new).
   1c) there will be significantly greater agreement with commemorating (new).
   1d) there will be significantly greater agreement with lack of understanding.

2) This research also aims to examine any difference in therapists’ levels of agreement

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² The expressions ‘old’ and ‘new’ will be used for reasons of brevity to refer to contradictory assertions about bereavement. However, it is acknowledged that this does not necessarily assume clear historical distinctions but rather distinctions by authors in the literature.

³ The variables of searching, commemorating and lack of understanding are drawn from the observations of Gibbard (2003) rather than from the bereavement literature more generally.
between old and new theory of bereavement, *when the loss is uncertain*. Specifically, it is hypothesised that:

2a) there will be significantly greater agreement with detachment (new), than with detachment (old).
2b) there will be significantly greater agreement with searching (new), than searching (old).
2c) there will be significantly greater agreement with commemorating (new), than with commemorating (old).

3) This study also aims to ascertain whether there is a difference in agreement *between certain aspects of ‘old’ and ‘new’ theory, when the loss is certain*. Specifically, it is hypothesised that:

3a) there will be significantly greater agreement with detachment (new), than with detachment (old).
3b) there will be significantly greater agreement with process of grief (new), than process of grief (old).
3c) However, it is hypothesised that there will be significantly greater agreement with working through (old), than with working through (new).

4) Finally, this study will explore whether there is a difference between the degree to which practitioners agree with the ‘old’ and ‘new’ theories of bereavement dependent on their theoretical approach to therapy.

4a) It is hypothesised that those practitioners whose approach could be placed within the humanistic, would agree significantly more with ‘new’ theories than those taking a psychodynamic approach.

No other specific predictions were made.
Method

Design
The hypotheses were tested through the use of an independent groups design where the independent variables were type of loss (certain or uncertain) and approach to therapy (psychodynamic, humanistic, CBT or integrative). The dependent variables were agreement with process of grief (old and new), detachment (old and new), working through (old and new), dialogues (old and new), commemorating (old and new), searching (old and new) and lack of understanding (which was uni-dimensional).

Participants
The participants for this study consisted of chartered or accredited Counselling Psychologists and Psychotherapists. There was no specification about age, sex or number of years practising but this information together with their theoretical approach to therapy was requested on the demographic information form. The researcher aimed to recruit 216 participants (based on a calculation of power using G*Power (Erdfelder, Faul & Buchner, 1996) whereby effect size = 0.25, alpha = 0.05 and power = 0.8).

Participants were selected randomly from the British Psychological Society register of Counselling Psychologists and the UKCP register of Psychotherapists. 600 questionnaires were sent out in total. 300 contained an ‘uncertain loss’ vignette and 300 contained a ‘certain loss’ vignette. 450 questionnaire packs were sent out initially, followed by a further 150 when the first batch yielded only 97 responses. Financial constraints (given the cost of materials and postage) meant that further distribution of questionnaires was not possible. A total of 135 participants returned the completed questionnaire (a response rate of 22.5%).

Measures
Levels of agreement with aspects of bereavement theory were measured using a purpose-
built questionnaire. The items were developed from the literature (as discussed in the introduction) of certain ‘old’ and ‘new’ aspects of bereavement theory and their potential implications for practice. The specific items and the categories in which they were placed (e.g. detachment; working through etc) are specified in Appendix 1. 39 items were included in the final questionnaire. The order of the items in the questionnaire was randomised and they were presented on a 7 point Likert scale ranging from 1= ‘strongly agree’ to 7= ‘strongly disagree’ (see Appendix 2).

Certain dimensions contain fewer items than others. This was a decision based on the perceived significance of the dimensions and the number of different ways in which the content areas of these dimensions might be manifested (Rust & Golombok, 1989). For example, it was felt that dialogues (old) could be represented by one item (‘Internal dialogues with the lost loved-one may be helpful for the client’), whereas for example, process of grief (old) was represented by four items. For each dependent variable, the participants were assigned one score which was calculated by averaging the responses to the items which represented each variable.

Two vignettes were developed to accompany the questionnaires. One represented ‘uncertain’ loss (Appendix 3, figure 1) and the other represented ‘certain’ loss (Appendix 3, figure 2). These vignettes took the form of a brief referral letter describing a (hypothetical) client who was being referred to their practice. The decision to use referral letters was based on the assumption that the participants would be used to receiving information about clients in this format. The information included in each vignette was exactly the same except for the circumstances in which the client’s husband had been ‘lost

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4 Internal consistency reliability of the dimensions of the questionnaire were measured using Cronbach’s Alpha. This revealed the following alpha coefficients: process of grief (old)=0.67; process of grief (new)=0.63; detachment (old)=0.73; detachment (new)=0.73; working through (old)=0.69; working through (new)=0.61 and lack of understanding=0.65. Searching (old and new) and dialogues (old and new) were only represented by one item and thus Cronbach’s Alpha cannot be applied. Nunnally (1978) suggests that an alpha coefficient of 0.65 is acceptable indicating that the internal reliability of the dimensions of process of grief (new) and working through (new) are questionable.
to them', with the 'uncertain' loss occurring through the sudden disappearance of the husband and the 'certain' loss occurring through the husband's death through prostate cancer (this particular illness being chosen owing to its high incidence in the male population). It was also decided to describe the husband as having suffered from prostate cancer prior to his disappearance in order that any difference between the vignettes was minimised.

The description in the vignette of the (hypothetical) client's subjective distress (e.g. depressed mood, guilt, anger etc) was drawn from both the bereavement literature on 'grief' reactions and from the findings from the work of Gibbard (2002;2003). Thus it was felt that the reactions could be representative of distress resulting from both the loss of a loved-one through death or through them going missing.

A demographic questionnaire (Appendix 4) requested information such as age and sex of participants, professional qualifications and preferred theoretical approach to therapy. It also included questions regarding whether the participant had ever had a loved-one go missing or had ever worked with a client with a missing loved-one. In line with the suggestion that there are three primary theoretical traditions in Counselling Psychology (Clarkson, 1996), the theoretical approaches to therapy in this study were initially specified as Psychodynamic, Cognitive-Behavioural and Humanistic. An 'Integrative / Eclectic' category was included once it was noted that many participants specified this as their approach.

**Procedure**

A pilot study was carried out prior to the main distribution of questionnaires. 10 people took part, six of whom were Counselling Psychologists in training, two were Counselling Psychologists and two were Psychotherapists. Following their feedback, some small changes were made to the questionnaire, principally surrounding the wording of certain items.
Each participant was sent a questionnaire pack through the post. This contained an information cover letter (Appendix 5), a consent form (Appendix 6), a demographic information form (Appendix 4), a vignette (Appendix 3, figures 1 & 2), a questionnaire (Appendix 2) and a stamped addressed envelope in which to return the forms. The information cover letter explained the purpose of the study and that should they choose to take part, they should read the enclosed vignette and then answer the questionnaire in regards to this. Once the questionnaires were returned, the consent forms were separated from the other forms and stored separately in order that anonymity could be retained.

Prior to the dispatching of questionnaires, ethical approval for the study was obtained from the University of Surrey Ethics Committee (see Appendix 7). Particular consideration was given to the fact that given the area of the research (loss and bereavement), there was some potential for the vignette or questionnaire to cause some distress. Whilst the profession of participants made it likely that they would be experienced at coping with such reactions and seeking support if necessary, the information cover letter included a small section advising participants of this potential impact.

Results

Demographic Information

Table 1 outlines frequencies and percentages of participants who answered the questionnaire in response to the certain or uncertain loss vignettes and frequencies and percentages of participants identified within the four categories of approach to therapy.
Table 1: Frequencies and percentages of participants categorised according to the independent variables of certain & uncertain loss and theoretical approach to therapy.

<table>
<thead>
<tr>
<th></th>
<th>Certain Loss</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage of total</td>
<td>Frequency</td>
<td>Percentage of total</td>
<td>Frequency</td>
<td>Percentage of total</td>
</tr>
<tr>
<td>Theoretical Approach, Psychodynamic</td>
<td>23</td>
<td>17.0</td>
<td>16</td>
<td>11.9</td>
<td>39</td>
<td>28.9</td>
</tr>
<tr>
<td>Theoretical Approach, Humanistic</td>
<td>25</td>
<td>18.5</td>
<td>21</td>
<td>15.6</td>
<td>46</td>
<td>34.1</td>
</tr>
<tr>
<td>Theoretical Approach, CBT</td>
<td>10</td>
<td>7.4</td>
<td>5</td>
<td>3.7</td>
<td>15</td>
<td>11.1</td>
</tr>
<tr>
<td>Theoretical Approach, Integrative</td>
<td>19</td>
<td>14.1</td>
<td>16</td>
<td>11.8</td>
<td>35</td>
<td>25.9</td>
</tr>
<tr>
<td>Total</td>
<td>77</td>
<td>57</td>
<td>58</td>
<td>43</td>
<td>135</td>
<td>100</td>
</tr>
</tbody>
</table>
Table 2 summarises the participants' background information.

Table 2: Participants' background information as requested in the demographic questionnaire.

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>49.2</td>
<td>11.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex, male</td>
<td>-</td>
<td>-</td>
<td>43</td>
<td>31.9</td>
</tr>
<tr>
<td>Sex, female</td>
<td>-</td>
<td>-</td>
<td>92</td>
<td>68.1</td>
</tr>
<tr>
<td>Experience (yrs)</td>
<td>8.2</td>
<td>5.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of client load where bereavement an issue</td>
<td>20.5</td>
<td>18.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participant had missing loved-one? No</td>
<td>-</td>
<td>-</td>
<td>122</td>
<td>90.4</td>
</tr>
<tr>
<td>Participant had missing loved-one? Yes</td>
<td>-</td>
<td>-</td>
<td>13</td>
<td>9.6</td>
</tr>
<tr>
<td>Worked with client with missing loved-one? No</td>
<td>-</td>
<td>-</td>
<td>111</td>
<td>82.2</td>
</tr>
<tr>
<td>Worked with client with missing loved-one? Yes</td>
<td>-</td>
<td>-</td>
<td>24</td>
<td>17.8</td>
</tr>
</tbody>
</table>

Differences between agreement with aspects of bereavement theory between uncertain and certain loss - Hypotheses 1a, 1b, 1c & 1d.

Mann Whitney U tests were used to analyse differences in agreement for aspects of bereavement theory between certain and uncertain loss. The results indicated that when

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5 Non-parametric tests were used in this study because many of the dependent variables had unequal variances, were not normally distributed and the group sizes were unequal.

6 Given that thirteen separate comparisons were performed, the accepted level of alpha was set at (0.05/13)=0.004, in order to reduce the chances of making a type I error (Bonferroni t, Dunn, 1961).
the loss was uncertain (n=58), there was significantly greater agreement, as compared to when the loss was certain (n=77) with searching (new) (U=1450.5, Z=-3.677, p<0.001) (*Hypothesis 1b*), and with lack of understanding (U=1224.0, Z=-4.532, p<0.001) (*Hypothesis 1d*).

The hypothesis that there would be significantly greater agreement with detachment (new) when the loss was uncertain, was not confirmed (U=2076.0, Z=-0.700, p=0.484) (*Hypothesis 1a*). Neither was the hypothesis that there would be greater agreement with commemorating (new) (U=1688.5, Z=-2.492, p=0.013) (*Hypothesis 1c*).

The results indicated that when the loss was certain, there was also significantly greater agreement with searching (old) (U=1310.0, Z=-4.221, p<0.001) as compared to when the loss was uncertain.
Table 3: Means, standard deviations, z values and level of significance of comparisons for the dependent variables between certain and uncertain loss. Significant results in bold.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Certain loss</th>
<th>Uncertain loss</th>
<th>Z Score</th>
<th>Level of significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process of grief (old)</td>
<td>3.46</td>
<td>0.87</td>
<td>-2.429</td>
<td>0.015</td>
</tr>
<tr>
<td></td>
<td>4.02</td>
<td>1.18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process of grief (new)</td>
<td>3.76</td>
<td>1.39</td>
<td>-2.811</td>
<td>0.005</td>
</tr>
<tr>
<td></td>
<td>3.14</td>
<td>1.03</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Detachment (old)</td>
<td>3.30</td>
<td>0.74</td>
<td>-2.167</td>
<td>0.03</td>
</tr>
<tr>
<td></td>
<td>3.59</td>
<td>0.74</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Detachment (new)</td>
<td>3.18</td>
<td>0.72</td>
<td>-0.700</td>
<td>0.484</td>
</tr>
<tr>
<td></td>
<td>3.09</td>
<td>0.79</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dialogues (old)</td>
<td>2.61</td>
<td>0.96</td>
<td>-0.349</td>
<td>0.727</td>
</tr>
<tr>
<td></td>
<td>2.71</td>
<td>0.88</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dialogues (new)</td>
<td>2.68</td>
<td>0.98</td>
<td>-1.273</td>
<td>0.203</td>
</tr>
<tr>
<td></td>
<td>2.45</td>
<td>1.01</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working through (old)</td>
<td>2.60</td>
<td>0.76</td>
<td>-2.051</td>
<td>0.04</td>
</tr>
<tr>
<td></td>
<td>2.37</td>
<td>0.87</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working through (new)</td>
<td>4.66</td>
<td>0.84</td>
<td>-0.946</td>
<td>0.344</td>
</tr>
<tr>
<td></td>
<td>4.75</td>
<td>0.72</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Searching (old)</td>
<td>3.23</td>
<td>1.06</td>
<td>-4.221</td>
<td>0.000</td>
</tr>
<tr>
<td></td>
<td>4.28</td>
<td>1.42</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Searching (new)</td>
<td>3.78</td>
<td>1.40</td>
<td>-3.677</td>
<td>0.000</td>
</tr>
<tr>
<td></td>
<td>3.05</td>
<td>1.39</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commemorating (old)</td>
<td>3.09</td>
<td>0.99</td>
<td>-0.016</td>
<td>0.987</td>
</tr>
<tr>
<td></td>
<td>3.12</td>
<td>1.09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commemorating (new)</td>
<td>4.96</td>
<td>1.30</td>
<td>-2.492</td>
<td>0.013</td>
</tr>
<tr>
<td></td>
<td>4.36</td>
<td>1.36</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of understanding</td>
<td>3.79</td>
<td>1.12</td>
<td>-4.532</td>
<td>0.000</td>
</tr>
<tr>
<td></td>
<td>2.82</td>
<td>1.17</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Differences in agreement between old and new aspects of bereavement theory - uncertain loss only - Hypotheses 2a, 2b & 2c.

A Wilcoxon matched pairs signed ranks sum test was conducted to explore the differences in agreement between old and new aspects of bereavement theory for the participants who answered in response to the 'uncertain loss' vignette (n=58). The results indicated that

---

7 Given that six separate comparisons were performed in the Wilcoxon tests in this study, the accepted level of alpha was set at (0.05/6)=0.008, in order to reduce the chances of making a type I error (Bonferroni t, Dunn, 1961).
there was significantly higher agreement with detachment (new) as compared to detachment (old) \((Z=-4.047, p<0.0001)\) \((\textit{hypothesis 2a})\), with searching (new), compared to searching (old) \((Z=-4.030, p<0.0001)\) \((\textit{hypothesis 2b})\) and with commemorating (new), compared to commemorating (old) \((p<0.0001)\) \((\textit{hypothesis 2c})\).

The results also indicated that for the uncertain loss sample, there was significantly higher agreement with process of grief (new) as compared to process of grief (old) \((Z=-3.281, p<0.001)\). However there was greater agreement with working through (old) than with working through (new) \((Z=-6.528, p<0.0001)\).

\begin{table}
\centering
\begin{tabular}{|l|c|c|c|c|}
\hline
Variable & Mean & Std. Deviation & Z value & Level of significance \\
\hline
Process of grief & Old 4.02 & 1.18 & -3.281 & 0.001 \\
 & New 3.14 & 1.03 & & \\
\hline
Detachment & Old 3.59 & 0.74 & -4.047 & 0.000 \\
 & New 3.09 & 0.79 & & \\
\hline
Dialogues & Old 2.71 & 0.88 & -1.190 & 0.234 \\
 & New 2.45 & 1.01 & & \\
\hline
Working Through & Old 2.37 & 0.87 & -6.528 & 0.000 \\
 & New 4.75 & 0.72 & & \\
\hline
Searching & Old 4.28 & 1.42 & -4.030 & 0.000 \\
 & New 3.05 & 1.39 & & \\
\hline
Commemorating & Old 3.12 & 1.09 & -4.408 & 0.000 \\
 & New 4.36 & 1.36 & & \\
\hline
\end{tabular}
\caption{Means, standard deviations, z values and level of significance of comparisons between old and new theory for uncertain loss. Significant results in bold.}
\end{table}

\textit{Differences in agreement between old and new aspects of bereavement theory - certain loss only - Hypotheses 3a, 3b & 3c.}

A Wilcoxon matched pairs signed ranks sum test was conducted to explore the differences between old and new aspects of bereavement theory for the participants who answered in response to the ‘certain loss’ vignette \((n=77)\). The results indicated that there was significantly greater agreement with working through (old) than working through (new) \((Z=-7.358, p<0.001)\) \((\textit{hypothesis 3c})\).
However, the hypothesis *(hypothesis 3a)* that there would be significantly greater agreement with *detachment (new)* than *detachment (old)*, was not confirmed (*Z*= -1.618, *p*= 0.106 n.s.). Neither was the hypothesis *(hypothesis 3b)* that there would be significantly greater agreement with *process of grief (new)*, than *process of grief (old)* (*Z*= -0.947, *p*= 0.343 n.s.).

The results also indicated that for the certain loss sample, there was greater agreement with *commemorating (old)* than *commemorating (new)* (*Z*= -6.227, *p*< 0.001).

Table 5: Means, standard deviations, *z* values and level of significance of comparisons between old and new theory for certain loss. Significant results in bold.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th><em>Z</em> Value</th>
<th>Level of significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process of grief</td>
<td>Old</td>
<td>3.46</td>
<td>0.87</td>
<td>-9.47</td>
</tr>
<tr>
<td></td>
<td>New</td>
<td>3.76</td>
<td>1.39</td>
<td></td>
</tr>
<tr>
<td>Detachment</td>
<td>Old</td>
<td>3.30</td>
<td>0.74</td>
<td>-1.618</td>
</tr>
<tr>
<td></td>
<td>New</td>
<td>3.18</td>
<td>0.72</td>
<td></td>
</tr>
<tr>
<td>Dialogues</td>
<td>Old</td>
<td>2.61</td>
<td>0.96</td>
<td>-0.577</td>
</tr>
<tr>
<td></td>
<td>New</td>
<td>2.68</td>
<td>0.98</td>
<td></td>
</tr>
<tr>
<td>Working Through</td>
<td>Old</td>
<td>2.60</td>
<td>0.76</td>
<td>-7.358</td>
</tr>
<tr>
<td></td>
<td>New</td>
<td>4.66</td>
<td>0.84</td>
<td></td>
</tr>
<tr>
<td>Searching</td>
<td>Old</td>
<td>3.23</td>
<td>1.06</td>
<td>-2.136</td>
</tr>
<tr>
<td></td>
<td>New</td>
<td>3.78</td>
<td>1.40</td>
<td></td>
</tr>
<tr>
<td>Commemorating</td>
<td>Old</td>
<td>3.09</td>
<td>0.99</td>
<td>-6.227</td>
</tr>
<tr>
<td></td>
<td>New</td>
<td>4.96</td>
<td>1.30</td>
<td></td>
</tr>
</tbody>
</table>

*Differences between agreement with aspects of bereavement theory between different theoretical approaches to therapy - Hypothesis 4a.*

A Kruskal-Wallis analysis of variance\(^8\) indicated that overall participants' level of agreement differed significantly between theoretical approaches to therapy for the aspects

---

\(^8\) Given that thirteen separate comparisons were performed using Kruskal-Wallis, the accepted level of alpha was set at (0.05/13)=0.004, in order to reduce the chances of making a type I error (Bonferroni t, Dunn, 1961).
of bereavement theory of **process of grief (new)** ($X^2(3)=31.598$, $p<0.001$), **searching (old)** ($X^2(3)=22.317$, $p<0.001$) and **commemorating (new)** ($X^2(3)=14.085$, $p<0.003$). Between group differences were subsequently assessed using Mann-Whitney U tests$^9$ which revealed the following:

For **process of grief (new)**, there was significantly greater agreement by those categorised as humanistic ($n=46$) than those identified as psychodynamic ($n=39$) ($U=515.0$, $Z=-3.383$, $p<0.001$) (**hypothesis 4a**) and for **commemorating (new)**, there was significantly greater agreement by those identified as humanistic as compared to psychodynamic ($U=556.5$, $Z=-3.112$, $p<0.002$) (**hypothesis 4a**).

For **process of grief (new)**, there was also significantly greater agreement by those categorised as third force as compared to integrative ($n=35$) ($U=290.5$, $Z=-4.273$, $p<0.001$), and CBT ($U=64.0$, $Z=-4.535$, $p<0.001$).

For **searching (old)** there was greater agreement by those identified as integrative than those identified as psychodynamic ($U=341.0$, $Z=-3.045$, $p<0.002$) and those identified as third force ($U=313.5$, $Z=-4.080$, $p<0.001$).

Finally, for **commemorating (new)**, there was significantly greater agreement by those identified as CBT ($n=15$) than those identified as psychodynamic ($U=137.0$, $Z=-2.847$, $p<0.004$) and by those identified as third force as compared to psychodynamic ($U=556.5$, $Z=-3.112$, $p<0.002$).

---

$^9$ Given that six separate comparisons were performed within each Mann-Whitney U test, the accepted level of alpha was set at $(0.05/6)=0.008$, in order to reduce the chances of making a type I error (Bonferroni t, Dunn, 1961).
Table 6: Means, standard deviations, Chi² values and level of significance of comparisons between different theoretical approaches to therapy. Significant results in bold.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Chi-square value</th>
<th>Level of significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process of grief (old)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychodynamic</td>
<td>3.58</td>
<td>0.72</td>
<td>11.869</td>
<td>0.008</td>
</tr>
<tr>
<td>Humanistic</td>
<td>4.13</td>
<td>1.03</td>
<td></td>
<td></td>
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<tr>
<td>CBT</td>
<td>3.43</td>
<td>0.76</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integrative</td>
<td>3.37</td>
<td>1.38</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process of grief (new)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychodynamic</td>
<td>3.63</td>
<td>1.17</td>
<td>31.598</td>
<td>0.000</td>
</tr>
<tr>
<td>Humanistic</td>
<td>2.7</td>
<td>1.02</td>
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</tr>
<tr>
<td>CBT</td>
<td>4.52</td>
<td>1.18</td>
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<tr>
<td>Integrative</td>
<td>4.03</td>
<td>1.19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Detachment (old)</td>
<td></td>
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<tr>
<td>Psychodynamic</td>
<td>3.47</td>
<td>0.64</td>
<td>12.937</td>
<td>0.005</td>
</tr>
<tr>
<td>Humanistic</td>
<td>3.68</td>
<td>0.7</td>
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<tr>
<td>CBT</td>
<td>3.21</td>
<td>0.93</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integrative</td>
<td>3.68</td>
<td>0.77</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Detachment (new)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychodynamic</td>
<td>3.18</td>
<td>0.7</td>
<td>7.590</td>
<td>0.055</td>
</tr>
<tr>
<td>Humanistic</td>
<td>2.94</td>
<td>0.76</td>
<td></td>
<td></td>
</tr>
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<td>CBT</td>
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<td>1.51</td>
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<tr>
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<td>6.923</td>
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<td>1.91</td>
<td></td>
<td></td>
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<td>Commemorating (old)</td>
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<td></td>
<td></td>
</tr>
<tr>
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<td>1.08</td>
<td>2.491</td>
<td>0.477</td>
</tr>
<tr>
<td>Humanistic</td>
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<td>1.09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CBT</td>
<td>3.07</td>
<td>1.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integrative</td>
<td>2.90</td>
<td>0.88</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Commemorating (new)   | Psychodynamic | 5.07 | 1.05 | 14.085 | 0.003   
Humanistic              |              | 4.26 | 1.45 |        |         
CBT                      |              | 4.21 | 1.12 |        |         
Integrative              |              | 5.01 | 1.48 |        |         

Lack of understanding   | Psychodynamic | 3.30 | 1.22 | 0.683  | 0.877   
Humanistic              |              | 3.51 | 1.56 |        |         
CBT                      |              | 3.12 | 1.15 |        |         
Integrative              |              | 3.40 | 0.61 |        |         

Other Exploratory Results - Differences in agreement between old and new aspects of bereavement theory for different approaches to therapy

Humanistic only

A Wilcoxon matched pairs signed ranks sum test was conducted to explore the differences between old and new aspects of bereavement theory for the participants who were identified in the humanistic category for preferred approach to therapy (n=46).

The results indicated that there was significantly greater agreement with detachment (new) than detachment (old) ($Z=-4.801$, $p<0.0001$), with process of grief (new) than process of grief (old) ($Z=-4.847$, $p<0.0001$), with working through (old) than working through (new) ($Z=-5.582$, $p<0.0001$), with commemorating (old) than commemorating (new) ($Z=-3.496$, $p<0.0001$) and with searching (new) than searching (old) ($Z=-2.997$, $p<0.003$).

Table 7: Means, standard deviations, z values and level of significance of comparisons between old and new theory for humanistic. Significant results in bold.
**Psychodynamic only**

A Wilcoxon matched pairs signed ranks sum test was conducted to explore the differences between old and new aspects of bereavement theory for the participants who were identified in the ‘psychodynamic’ category for preferred approach to therapy (n=39).

The results indicated that there was significantly greater agreement with working through (old) than working through (new) \( (Z=-5.770, \ p<0.0001) \) and with commemorating (old) than commemorating (new) \( (Z=-5.125, \ p<0.0001) \).

Table 8: Means, standard deviations, z values and level of significance of comparisons between old and new theory for psychodynamic. Significant results in bold.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Z value</th>
<th>Level of significance</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Old</td>
<td>3.58</td>
<td>0.72</td>
<td>-5.14</td>
</tr>
<tr>
<td></td>
<td>New</td>
<td>3.64</td>
<td>1.17</td>
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</tr>
<tr>
<td>Detachment</td>
<td>Old</td>
<td>3.47</td>
<td>0.64</td>
<td>-2.062</td>
</tr>
<tr>
<td></td>
<td>New</td>
<td>3.18</td>
<td>0.7</td>
<td></td>
</tr>
<tr>
<td>Dialogues</td>
<td>Old</td>
<td>2.58</td>
<td>0.97</td>
<td>-0.854</td>
</tr>
<tr>
<td></td>
<td>New</td>
<td>2.69</td>
<td>1.02</td>
<td></td>
</tr>
<tr>
<td>Working Through</td>
<td>Old</td>
<td>2.60</td>
<td>0.84</td>
<td>-5.770</td>
</tr>
<tr>
<td></td>
<td>New</td>
<td>4.68</td>
<td>0.74</td>
<td></td>
</tr>
<tr>
<td>Searching</td>
<td>Old</td>
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<td>1.00</td>
<td>-1.768</td>
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<td>New</td>
<td>3.27</td>
<td>1.19</td>
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</tr>
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<td>1.08</td>
<td>-5.125</td>
</tr>
<tr>
<td></td>
<td>New</td>
<td>5.07</td>
<td>1.05</td>
<td></td>
</tr>
</tbody>
</table>

**CBT Only**

A Wilcoxon matched pairs signed ranks sum test was conducted to explore the differences between old and new aspects of bereavement theory for the participants who were identified in the ‘CBT’ category for preferred approach to therapy (n=15).

The results indicated that there was significantly greater agreement with working through (old) than working through (new) \( (Z=-3.196, \ p<0.001) \) and with dialogues (new) than dialogues (old) \( (Z=-3.071, \ p<0.002) \).
Table 9: Means, standard deviations, z values and level of significance of comparisons between old and new theory for CBT. Significant results in bold.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Z value</th>
<th>Level of significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process of grief</td>
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<td></td>
</tr>
<tr>
<td>Old</td>
<td>3.43</td>
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<td></td>
</tr>
<tr>
<td>Old</td>
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</tr>
<tr>
<td>Dialogues</td>
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</tr>
<tr>
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<td></td>
</tr>
<tr>
<td>Working Through</td>
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<td></td>
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</tr>
<tr>
<td>Old</td>
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<td>0.56</td>
<td>-3.196</td>
<td>0.001</td>
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</tr>
<tr>
<td>Old</td>
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<td>1.01</td>
<td>-0.675</td>
<td>0.500</td>
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<td>New</td>
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<td>0.94</td>
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<tr>
<td>Commemorating</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Old</td>
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</tr>
<tr>
<td>New</td>
<td>4.21</td>
<td>1.12</td>
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**Integrative only**

A Wilcoxon matched pairs signed ranks sum test was conducted to explore the differences between old and new aspects of bereavement theory for the participants who were identified in the ‘integrative’ category for preferred approach to therapy (n=35).

The results indicated that there was significantly greater agreement with working through (old) than working through (new) ($Z=-4.79$, $p<0.0001$) and with commemorating (old) than commemorating (new) ($Z=-4.169$, $p<0.0001$).
Table 10: Means, standard deviations, z values and level of significance of comparisons between old and new theory for integrative. Significant results in bold.

<table>
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<tr>
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<th>Std. Deviation</th>
<th>New Mean</th>
<th>Z value</th>
<th>Level of significance</th>
</tr>
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<td>-0.408</td>
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<td>-4.169</td>
<td>0.000</td>
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Discussion

Before discussing the findings of this study, it is important to consider its limitations. Firstly, whilst the study intended to recruit 216 participants, only 135 responses were received. Thus the study was less statistically powerful than it might have been. However, stricter levels of alpha were employed which should go some way towards rectifying this limitation. Secondly, it is apparent from the tables of means, that whilst significant differences were found, the differences between mean scores were in some instances fairly small. Furthermore, mean scores often clustered around the value ‘3’ which represented ‘agree’, whilst the value ‘4’ represented ‘neither agree nor disagree’; thus whilst the analyses might indicate statistically greater agreement on certain dependent variables than others, these do not necessarily represent a large difference in qualitative agreement. It is also significant to note that the group sizes were unequal. Whilst non-parametric statistical tests were chosen partly because of this, the extent to which the sample is representative of this population as a whole must be questioned. In addition, almost 10% reported having had a loved-one go missing and almost 18% reported having worked with a client with a
missing loved-one (although their interpretations of these definitions is unclear). These percentages seem relatively high and might suggest that these people may have been more inclined to return the questionnaire. Thus again, the sample may not be representative of the research topic’s population as a whole. All such limitations need to be considered in the drawing of conclusions from this study.

A large amount of qualitative feedback was also received from participants which suggests that the questionnaire provoked strong, emotive reactions from respondents. Perhaps most commonly highlighted was a reluctance to answer the questionnaire items based only on a short referral letter, having therefore never had contact with the (hypothetical) client. Many therefore suggested that their response to the items would normally have been highly determined by the individual client and what the client wished to do or felt was appropriate to them. Whilst the study never claimed to represent how therapists work with clients more generally, but rather how they might conceptualise working with clients suffering these types of loss, there is significant indication that many of the respondents would only view assumptions about bereavement as useful if the client viewed them as such. This seems to highlight that the individual needs, wishes and process of the client are placed at the centre of the work and valued above and beyond theory. This reaffirms the commitment of Counselling Psychology in particular, to place a respect for the uniqueness and diversity of individuals at the centre of practice (Woolfe, 1996) and should be borne in mind when interpreting the results.

**Differences in agreement with aspects of bereavement theory between certain and uncertain loss.**

As hypothesised, the results indicated that therapists who completed the questionnaire in regards to the uncertain loss vignette agreed significantly more with searching (new) and with the lack of understanding variable than those in the certain loss group. In line with the suggestions of Gibbard (2003), the results suggest that therapists acknowledge that searching for the lost loved-one becomes a practical attempt to find them, which is quite
different from the more ‘intra-psychic’ urge to search, normally referred to in regards to a
grief reaction (in psychoanalytic theory at least e.g. Parkes, 1972). In regards to lack of
understanding, the results suggest that therapists conceptualising work with a client with a
missing loved-one acknowledge that this group might have a particular reason to feel a
sense of isolation and might benefit from the opportunity to talk to others who have a
loved-one go missing. These findings also seem to suggest that the therapists in this study
agree somewhat with Walter’s (1996) suggestion that people may benefit from talking to
others who have suffered the same ‘category of loss’ as them.

However, the hypotheses that therapists answering the questionnaire in regards to the
uncertain loss vignette would agree more with commemorating (new) and with
detachment (new) were not confirmed (although the means were in the expected
direction). For these variables in particular, it may be that therapists’ commitments to
respect the wishes of the client and what they would find helpful in regards to
commemorating or detachment, regardless of whether the loss was uncertain or not, meant
that no significant differences were found.

Differences in agreement between old and new theory for uncertain loss
As hypothesised, the results indicated that when the loss was uncertain, therapists agreed
significantly more with detachment (new) than detachment (old), with searching (new)
than searching (old) and with commemorating (new) than commemorating (old). As
previously discussed, in regards to searching, these findings seem understandable.
However, the findings also suggest that for this group in particular (of people with a
missing loved-one), therapists acknowledge that traditional reactions to the loss of a loved
one (such as commemorating through a memorial to them) may not necessarily be helpful.
These findings are in line with the observations of Gibbard (2003) in the case-study
analysis which found that for some participants, suggestions that they commemorate their
missing loved-one in a similar way to which we as a society commemorate the deceased,
felt inappropriate to them. The finding that therapists agreed significantly more with the
'new' detachment theory than the 'old', indicates that in their conceptualisation of this client group in particular, therapists acknowledge the difficulty for the client in accepting the loss and detaching from the lost loved-one. Whilst the post-modern theory developed around this concept was intended to be applied to loss through death, it seems from this study that therapists may also view it as applicable to those who have a loved-one go missing.

**Differences in agreement between old and new theory for certain loss**

As discussed in the introduction, a number of authors have suggested that many practitioners would still follow the 'clinical lore' of bereavement theory regardless of the empirical evidence which challenges such traditional assumptions (e.g. Lindstrom, 2002; Walter, 1996). The results of this study indicated that on the variable of 'working through' there was indeed significantly greater agreement with 'old' than 'new' theory (these differences also existed for all of the four groups of approach to therapy). This would therefore appear to confirm that therapists (regardless of theoretical approach to therapy), view a 'working through' of grief-related thoughts and feelings as necessary, and avoidance of such reactions as potentially unhelpful for the client. However, it seems significant to note that the vignettes described a client who was suffering significant distress (including 'depressed mood', 'guilt', 'anger'). As such, it is perhaps not surprising that therapists felt that it may be necessary for this client to 'work through' their pain. Had the client been presented in the vignette as 'functioning well' (and indeed such people may not be referred for therapy) agreement with this variable may not have been so great.

The items in the questionnaire which represented 'working through' also included those drawn from the suggestions of Walter (1996) that it may be 'talking about the lost loved-one' rather than 'working though' feelings which may be helpful and that 'talking to a therapist who did not know the lost loved-one, may be second-best to talking to others who knew them well'. Again, it is significant to note that the vignette described the client as feeling that they could not talk to others about their distress (e.g. her children) and that
they felt that others could not really understand their loss. Thus therapists’ disagreement with suggestions that ‘talking to others’ would be helpful and that ‘talking to a therapist’ would be ‘second-best’, seem understandable. Indeed these findings support the predictions made in the introduction that as a group, given the very nature of the profession of the sample, therapists would overall view a ‘working through’ of feelings as a ‘good thing’, particularly when a client is suffering considerable distress.

This study also predicted that those therapists answering in response to the certain loss vignette would agree significantly more with detachment (new) than detachment (old) and more with process of grief (new) than process of grief (old). The results did not support these predictions. However, it seems important again to examine the items included in the questionnaire when drawing conclusions from these results. For the variable of detachment in particular, it is significant to note that this included items regarding acceptance of the loss and the forming of new attachments, as well as those items more specifically referring to ‘detachment’ and ‘letting-go’. Given that all of these items were clustered together, it is not possible to ascertain whether therapists disagreed with suggestions that the client should detach from the lost loved-one, but agreed that they should ‘accept’ their loss (which was included for its relevance to people with missing loved-ones). It is therefore a flaw of this study which makes it difficult to draw conclusions about this dimension of ‘detachment’ for the certain loss group in particular.

However, for the variable of process of grief, the items in the questionnaire which were written for this dimension do not appear to be quite as invalid when clustered together and the finding of no significant difference in agreement between ‘old’ and ‘new’ theory should therefore be more reliable. Thus whilst ‘clinical lore’ does not prevail in this respect, neither does the move towards theory which suggests that there are many and varied responses to grief, none of which are ‘pathological’. However, some qualitative feedback can perhaps shed a little more light on this finding. A number of participants commented that whilst they agreed that there are many and varied responses to grief, which should not
be pathologised, they did feel that there could come a point whereby grief has ‘gone on too long’ in that it interferes with the individual’s ability to ‘function effectively’ in their life a long time after the death of their loved-one.

Differences in agreement with aspects of bereavement theory between different theoretical approaches to therapy.

In regards to theoretical approaches to therapy, it was found that those taking a ‘third-force’ approach to therapy agreed significantly more with process of grief (new) than those taking a psychodynamic approach (and than those taking integrative and CBT approaches). Those taking a humanistic approach (and those taking a CBT approach) also agreed more with commemorating (new) than did those taking a psychodynamic approach. It is possible that these findings are reflective of a particular commitment within humanistic approaches to be client-led and value the idiosyncratic nature of experience which is promoted more in the ‘new’ theories, which suggest that what may be appropriate for one client may not be appropriate for another. Whilst it is not being suggested that those taking a psychodynamic approach do not share similar commitments, it is possible that for this group the legacy of clinical lore may be stronger, perhaps as a result of much of the foundations of clinical lore having been laid down by prominent psychoanalytic theorists (e.g. Freud and Bowlby). However, these causal attributions cannot be assumed.

It is also interesting to note that irrespective of type of loss, those taking a humanistic approach, did agree significantly more with process of grief (new) than process of grief (old), with detachment (new) than detachment (old) and with searching (new) than searching (old). These findings are again perhaps a reflection of therapists taking this approach to therapy, being particularly likely to embrace a “post-modern individualising of loss and a rejection of grand theory” (Walter, 1996, p11).

However, it is important to note that for the comparisons of approach to therapy, the data on which the analyses were conducted included both those who had answered the
questionnaire in response to the uncertain loss vignette as well as the certain loss vignette and thus the results may have been different had they only been examined in response to certain loss. Indeed it is apparent that this study attempted to answer many research questions using the same design whereas it may have been more useful to conduct two separate studies. One study could have explored differences in agreement with theories for certain as compared to uncertain loss, whilst a separate study could have explored levels of agreement more generally with old and new theories of bereavement (examining only the dependent variables of detachment, working through and process of grief).

This study has also not explored the validity of the questionnaire used and the reliability analysis indicates that the dimensions of ‘process of grief (new)’ and ‘working through (new)’ would benefit from refinement to ensure internal consistency. Other limitations of the questionnaire have already been discussed and future research into this area would benefit from the development first of all of a robust questionnaire which makes use of principal component analysis to ascertain the extent to which individual items tap into particular dimensions. Certain limitations of the vignettes have also been highlighted and thus future research may benefit from the development of measures which may not be quite so ‘leading’ (or avoid the use of such tools altogether). Of course an adequate sample size is also required. However, given the amount of qualitative feedback received in this study which indicated that therapists found it difficult and restrictive to represent their attitudes in the form of a questionnaire, it may be beneficial for future research to use qualitative methods to explore this area. Such methods may have greater ability to reflect the richness and diversity of subjective experience which is central to the discipline of Counselling Psychology and Psychotherapy.

In summary, the present study goes some way towards ascertaining therapists’ levels of agreement with different modern and post-modern theories of bereavement. In particular, it suggests that for those suffering the loss of having a loved-one go missing, therapists are more inclined to agree with theories and their practical implications which acknowledge
the uncertainty and uniqueness of this loss, particularly in regards to the dimensions of searching, commemorating, lack of understanding and detachment from the lost loved-one. These findings suggest that therapists would make choices regarding what might be beneficial in their work with clients with missing loved-ones which are consistent with the phenomenological experience of this group (as determined by Gibbard, 2002, 2003). This study also suggests that overall and regardless of theoretical approach to therapy, therapists are likely to agree that it is beneficial for clients to ‘work through’ their loss (although the aforementioned limitations of this conclusion need to be considered). Finally, this study suggests that whilst overall, therapists did not agree more with post-modern theories of bereavement, perhaps suggesting some on-going legacy of clinical lore, those therapists taking a humanistic approach to therapy, did favour some of the more idiosyncratic ‘new’ theories regarding detachment and process of grief than the older theories on these dimensions. However, as previously indicated, future research is needed before any firm conclusions or generalisations can be made from this research.
References


Gibbard, A. (2002). *Being left behind: The impact on family members of having a loved one go missing*. Unpublished manuscript, University of Surrey.


Retrieved April 15th 2002 from the world wide web:


intervention (pp. 23-43). Cambridge: Cambridge University Press.


Appendix 1: Questionnaire items grouped by dependent variables.

Commemorating the loss (old)
Commemorating the lost loved-one should be helpful for the client.

Commemorating the loss (new)
It may be unhelpful for this client to commemorate their loss (for example by a memorial to them).

Lack of understanding
This client appears to have particular reason to feel a sense of isolation as compared to others who have lost loved-ones.

Talking to others who’ve lost loved-ones in similar circumstances may be particularly beneficial for this client.

Detachment (old)
The client should be supported in saying a ‘final goodbye’ to the lost loved-one.

The client may need to be supported in accepting the loss of their loved-one.

Failure to accept the loss of their loved-one may be indicative of unresolved grief in this client

The client may need to be supported in ‘letting go’ of the lost loved-one.

One of the tasks of therapy with this client would be to withdraw emotional energy from the lost loved-one.

It would be pathological for the client to hope for a renewed attachment with the lost loved-one.

The client should be supported in finding a less central place in their life for the lost loved-one.

The client should be supported in realising that although the lost loved-one cannot be replaced, it is okay to fill the void with another relationship.

Detachment (new)
It may be necessary to encourage the client to ‘let go’ of their lost loved-one, before they can achieve a lasting ‘keeping-hold’.

The goal of therapy with this client should not be to achieve detachment from the lost loved-one.

It is entirely rational for the client to hope for a renewed attachment with the lost loved-one.

The client should be given permission to sustain a continuing bond with the lost loved-one.

The client should be supported in evolving a new relationship with the lost loved-one.

The client should be supported in finding an appropriate place for the lost loved-one in their emotional life.
lives.
The lost loved-one should continue to play an important part in this client’s life.
It is entirely up to the client as to whether they go on to form new attachments.

**Dialogues (old)**

Internal dialogues with the lost loved-one may be helpful for the client.

**Dialogues (new)**

External dialogues with others who knew the lost loved-one may be helpful for the client.

**Working through (old)**

Helping the client to ‘work through’ their pain would be a major part of the therapeutic work.

The client should be supported in feeling the intensity and depth of their loss in order for grief to be completed.

It may be necessary for the client to experience thoughts and feelings which they have been avoiding.

The main focus of therapy with this client would be to centre around the feelings of the client rather than the character of the lost loved-one.

**Working through (new)**

It may not be necessary for this client to ‘work through’ their feelings related to the loss of their loved-one.

It is not the working through of feelings that would be helpful for the client, so much as talking about the lost loved-one.

Talking to a therapist who did not know the lost loved-one would be ‘second-best’ for the client to talking to others who knew them well.

The client should be supported in seeking out and talking to others who knew the lost loved-one.

**Process of grief (old)**

The duration of the grief reaction in this client appears to be indicative of unresolved grief.

The goal of therapy with this client would be to facilitate the completion of the tasks of mourning.

There is more or less a predictable process in response to the loss of a loved-one through which the client would be expected to go.

Deviations from the ‘normal’ pattern of grief may be indicative of unresolved grief.
Process of grief (new)

There are many and varied responses to grief, none of which are pathological

There should be no expectation about the process of grief which this client might move through

The length of time that this client has been grieving cannot be said to be indicative of unresolved grief.

Searching (old)

Continued searching for the lost loved-one would be indicative of unresolved grief

Searching (new)

It would be entirely understandable for this client to continue to search for their lost loved one.
Appendix 2

Questionnaire

Please read the vignette provided before answering this questionnaire.

Please read each of the statements below carefully, then indicate the extent to which you agree with each statement by circling a number on the scale below each statement. Your responses should be based on your initial conceptualisation of the client drawn from the information in the vignette, also perhaps drawing on your general perceptions of working with clients who present with issues of loss.

The numbers on the scale indicate:

1) Very Strongly Agree 5) Disagree
2) Strongly Agree 6) Strongly Disagree
3) Agree 7) Very Strongly Disagree
4) Neither Agree nor Disagree

1) The client should be supported in finding a less central place in their life for the lost loved-one.

2) This client appears to have particular reason to feel a sense of isolation as compared to others who have lost loved-ones.

3) The client should be supported in saying a ‘final goodbye’ to the lost loved-one.

4) It would be pathological for the client to hope for a renewed attachment with the lost loved-one.

5) The client should be supported in feeling the intensity and depth of their loss in order for grief to be completed.

6) External dialogues with others who knew the lost loved-one may be helpful for the client.
7) There are many and varied responses to grief, none of which are pathological.

Very Strongly Agree    Very Strongly Disagree
1  2  3  4  5  6  7

8) The lost loved-one should continue to play an important part in this client’s life.

Very Strongly Agree    Very Strongly Disagree
1  2  3  4  5  6  7

9) It may not be necessary for this client to ‘work through’ their feelings related to the loss of their loved-one.

Very Strongly Agree    Very Strongly Disagree
1  2  3  4  5  6  7

10) Commemorating the lost loved-one should be helpful for the client.

Very Strongly Agree    Very Strongly Disagree
1  2  3  4  5  6  7

11) The goal of therapy with this client should not be to achieve detachment from the lost loved-one.

Very Strongly Agree    Very Strongly Disagree
1  2  3  4  5  6  7

12) There is more or less a predictable process in response to the loss of a loved-one through which the client would be expected to go.

Very Strongly Agree    Very Strongly Disagree
1  2  3  4  5  6  7

13) The goal of therapy with this client would be to facilitate the completion of the tasks of mourning.

Very Strongly Agree    Very Strongly Disagree
1  2  3  4  5  6  7

14) The client should be supported in realising that although the lost loved-one cannot be replaced, it is okay to fill the void with another relationship.

Very Strongly Agree    Very Strongly Disagree
1  2  3  4  5  6  7

15) The duration of the grief reaction in this client appears to be indicative of unresolved grief.

Very Strongly Agree    Very Strongly Disagree
1  2  3  4  5  6  7

16) It may be necessary to encourage the client to ‘let go’ of their lost loved-one, before they can achieve a lasting ‘keeping-hold’.

Very Strongly Agree    Very Strongly Disagree
1  2  3  4  5  6  7
17) The length of time that this client has been grieving cannot be said to be indicative of unresolved grief.

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<th>Very Strongly Agree</th>
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18) Talking to a therapist who did not know the lost loved-one would be ‘second-best’ for the client to talking to others who knew them well.

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19) It is entirely rational for the client to hope for a renewed attachment with the lost loved-one.

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20) Talking to others who’ve lost loved-ones in similar circumstances may be particularly beneficial for this client.

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21) The main focus of therapy with this client would be to centre around the feelings of the client rather than the character of the lost loved-one.

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22) The client should be supported in evolving a new relationship with the lost loved-one.

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23) The client may need to be supported in ‘letting go’ of the lost loved-one.

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24) The client should be given permission to sustain a continuing bond with the lost loved-one.

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25) Deviations from the ‘normal’ pattern of grief may be indicative of unresolved grief.

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26) It may be unhelpful for this client to commemorate their loss (for example by a memorial to them).

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27) The client should be supported in finding an appropriate place for the lost loved-one in their emotional lives.

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219
28) It is entirely up to the client as to whether they go on to form new attachments.

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<th>Very Strongly Agree</th>
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29) Internal dialogues with the lost loved-one may be helpful for the client.

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30) One of the tasks of therapy with this client would be to withdraw emotional energy from the lost loved-one.

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31) Helping the client to ‘work through’ their pain would be a major part of the therapeutic work.

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32) It would be entirely understandable for this client to continue to search for their lost loved one.

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33) There should be no expectation about the process of grief which this client might move through.

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34) It is not the working through of feelings that would be helpful for the client, so much as talking about the lost loved-one.

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35) Failure to accept the loss of their loved-one may be indicative of unresolved grief in this client.

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36) The client should be supported in seeking out and talking to others who knew the lost loved-one.

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37) It may be necessary for the client to experience thoughts and feelings which they have been avoiding.

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38) Continued searching for the lost loved-one would be indicative of unresolved grief.

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39) The client may need to be supported in accepting the loss of their loved-one.

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<th>7</th>
<th>Very Strongly Disagree</th>
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If you wish to comment on any aspect of this questionnaire, please do so in the space provided below.

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Thank you for taking the time to complete this questionnaire
Appendix 3

Figure 1: Uncertain loss vignette

Dear ...

I would like to refer the following client to your service/practice for help with the difficulties they have been experiencing.

Mrs. Harper is a thirty-eight year old woman who has been suffering from depressed mood since the disappearance of her husband three years ago. Mrs. Harper’s husband had been suffering from prostate cancer for two years prior to his disappearance, but had appeared to be recovering well before his sudden disappearance.

Mrs. Harper’s husband did not return from work at the usual time one day after work. When he did not return by that evening, and she could not make contact with him, she telephoned the police. He did not appear to have taken any belongings with him and has not been seen or heard from since that day. Mrs. Harper reports that her husband had not given her any indication that he wished to leave or to harm himself.

Mrs. Harper describes being ‘devastated’ by her loss, having felt in a state of ‘limbo’ since his disappearance and having difficulty ‘accepting’ her loss. She reports being frequently tearful and feeling guilty, angry at him, herself and ‘the world in general’ and missing her husband terribly. She also highlighted feeling a sense of ‘isolation’ from friends and family and society in general, feeling that they ‘cannot fully understand’ what her husband’s disappearance means to her. She has two sons aged eighteen and sixteen and whilst she reported having been able to talk to them to some extent about their loss, she reports feeling that she should not ‘burden them’ with her distress. Mrs. Harper reports no suicidal ideation, however, she spoke of feeling unable to ‘get on with her life’.

Mrs. Harper did take six months leave from her job as a primary school teacher, to which she has since returned. She described finding no satisfaction in this work since the disappearance of her husband and feeling that she operates on ‘auto-pilot’.
Appendix 3

Figure 2: Certain loss vignette

Dear ...

I would like to refer the following client to your service / practice for help with the difficulties they have been experiencing.

Mrs. Harper is a thirty-eight year old woman who has been suffering from depressed mood since the death of her husband three years ago. Mrs. Harper’s husband had been suffering from prostate cancer for two years prior to his death, but had appeared to be recovering well before his sudden decline.

Mrs. Harper describes being ‘devastated’ by her loss, having felt in a state of ‘limbo’ since his death and having difficulty ‘accepting’ her loss. She reports being frequently tearful and feeling guilty, angry at him, herself and ‘the world in general’ and missing her husband terribly. She also highlighted feeling a sense of ‘isolation’ from friends and family and society in general, feeling that they ‘cannot fully understand’ what her husband’s death means to her. She has two sons aged eighteen and sixteen and whilst she reported having been able to talk to them to some extent about their loss, she reports feeling that she should not ‘burden them’ with her distress. Mrs. Harper reports no suicidal ideation, however, she spoke of feeling unable to ‘get on with her life’.

Mrs. Harper did take six months leave from her job as a primary school teacher, to which she has since returned. She described finding no satisfaction in this work since the death of her husband and feeling that she operates on ‘auto-pilot’.
Appendix 4: Demographic Information Form

Please complete this form and return it with your questionnaire in the envelope provided. The reason that I would like this information is so that I can tell my readers about the range of people who took part in this study in terms of the criteria below. I would also be interested to determine whether any of these factors are correlated with the responses given to items in the questionnaire. If there are any questions you feel uncomfortable answering, please feel free not to answer.

1. How old are you? [ ] years

2. Are you male [ ] or female [ ]? (please tick)

3. Which professional qualification do you hold?_________________________

4. For how many years have you been accredited? [ ] years

5. If you are not yet accredited but are currently in training, which professional qualification are you training for?_________________________

6. If you are in training, which year of training are you currently in?______________

7. What is your preferred theoretical approach to therapy?_________________________

8. What is the estimated proportion of your past / current client load in which bereavement has been an issue? [ ] %

9. Have you ever worked with a client who had a loved-one who had gone missing?

   Yes [ ] No [ ] (please tick)

10. Have you ever had a loved-one go missing?

    Yes [ ] No [ ] (please tick)
Appendix 5: Information cover letter

Dear Sir / Madam,

My name is Amy Gibbard and I am a postgraduate student at the University of Surrey where I am doing a doctorate in Psychotherapeutic and Counselling Psychology.

As part of my research, I am carrying out a study into therapists' perceptions of models of bereavement in conceptualising their work with clients who have experienced loss. My interest in this area has developed from research I carried out last year in which I interviewed individuals who had a family member who had gone missing. This indicated that there is a lack of specific theory to inform therapists in their work with clients in this situation. I am therefore interested in determining how therapists perceive the usefulness of certain assumptions of models of bereavement, in conceptualising their work with clients suffering a loss. In particular, I am interested in determining whether there are any differences in the perceived usefulness of these models between conceptualising clients who have 'lost' a loved-one as a result of them going missing and conceptualising clients who have lost a loved-one through death.

Should you choose to take part in this study, it would first of all involve you reading the vignette provided regarding a (fictional) client who would like to come to therapy following the loss of a loved-one. You would then be required to complete the enclosed questionnaire in reference to the vignette you have read. This should take approximately half an hour to complete. The vignette and questionnaire are related to issues of loss and bereavement. Whilst your profession as a Psychotherapist or Counselling Psychologist make it probable that you have worked with such issues before, there may be some details which resonate with your own experience and thus might potentially cause some distress.

If you were to decide to take part in this study, I would also ask that you complete the enclosed demographic information form and consent form. Both of these forms and the questionnaire should then be returned to me in the stamped addressed envelope provided. Once returned, the signed consent form will be stored separately from the other forms, thus your responses will be kept anonymous.

You would have the right to withdraw from this study at any time without having to give a reason. You will notice that there is a number in the top left hand corner of this letter. This number is also recorded on the demographic form and questionnaire which I have sent you. If you wished to withdraw from the study after you have returned these forms and questionnaire to me, you can telephone or e-mail me, the details for which are provided below. In this instance, you would simply need to tell me the number corresponding to the
forms you had returned and they would be removed from the data-set and destroyed.

If you wish to receive a copy of this research report once it is completed, you can contact me by telephone or e-mail and I would be happy to send you a copy. I expect that the report should be completed by the end of 2004.

If you have any further queries about any aspect of this research, either prior to deciding whether to take part, or after you have returned the forms, please do not hesitate to contact me or my research supervisor using the contact details provided below.

Tel: 01483879176

E-mail: amygibbard@hotmail.com

Address: Department of Psychology
         University of Surrey
         Guildford
         Surrey GU2 7XH

Research Supervisor: Dr. Riccardo Draghi-Lorenz

E-mail of Research Supervisor: r.draghi-lorenz@surrey.ac.uk

Address of Research Supervisor: As above

Thank you for your time

Yours Sincerely

Amy Gibbard

Amy Gibbard
Counselling Psychologist in Training
Supervised by Dr. Riccardo Draghi-Lorenz

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Appendix 6: Consent Form

The role of uncertainty in the loss of a loved one: Therapists’ perceptions of the usefulness of models of bereavement in conceptualising their work with clients who have experienced different types of loss.

I, the undersigned, voluntarily agree to take part in this study on therapists’ perceptions of models of bereavement in conceptualising their work with clients who have experienced loss.

I have read and understood the information sheet provided. I have been given a full written explanation by the investigator of the nature, purpose and likely duration of the study, and what I will be expected to do. I have been advised about any discomfort and possible negative effects on my psychological well-being which may result. I have been given the opportunity to ask questions via telephone or e-mail on all aspects of the study and have understood the advice and information given as a result.

I understand that all personal data relating to volunteers is held and processed in the strictest confidence, and in accordance with the Data Protection Act (1998). I agree that I will not seek to restrict the use of the results of the study on the understanding that my anonymity is preserved.

I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice.

I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation and agree to comply with the instructions and restrictions of this study.

Name of volunteer ............................................

Signature or volunteer ................................................

Date ...............................................

Name of witness (researcher) ................................................

Signature of witness (researcher)............................................

Date ................................................
Appendix 7: Letter of ethical approval

16 April 2004

Ms Amy Gibbard
PsychD Student
Department of Psychology
School of Human Sciences

Dear Ms Gibbard

The role of uncertainty in the loss of a loved one: Therapists' perceptions of the usefulness of models of bereavement in conceptualising their work with clients who have experienced different types of loss (EC/2003/137/Psych)

I am writing to inform you that the Ethics Committee has considered the above protocol (and the subsequent information supplied), and has approved it on the understanding that the Ethical Guidelines for Teaching and Research are observed and the following condition is met:

- That the Consent Form includes space for name, signature and date to be completed by a witness/yourself.

For your information, and future reference, the Guidelines can be downloaded from the Committee's website at http://www.surrey.ac.uk/Surrey/ACE/.

This letter of approval relates only to the study specified in your research protocol (EC/2003/137/Psych). The Committee should be notified of any changes to the proposal, any adverse reactions, and if the study is terminated earlier than expected, with reasons.

I should be grateful if you would confirm in writing your acceptance of the condition above, forwarding the amended document for the Committee's records.

Date of approval by the Ethics Committee: 15 April 2004
Date of expiry of approval by the Ethics Committee: 14 April 2009

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Cont'd ...
Please inform me when the research has been completed.

Yours sincerely

[Signature]

Catherine Ashbee (Mrs)
Secretary, University Ethics Committee
Registry

cc: Professor T Desombre, Chairman, EC
Dr R Draghi-Lorenz, Supervisor, Psychology
Appendix 8: Notes for contributors to Psychology & Psychotherapy: Theory, Research and Practice.

Notes for contributors

Psychology and Psychotherapy: Theory, Research and Practice is an international journal with a focus on the psychological aspects of mental health, psychological problems and their psychotherapeutic treatments. Its aim has been to bring together the psychiatric and psychological disciplines and this is reflected in the composition of the Editorial Team. Nevertheless, we welcome submissions from mental health professionals and researchers from all relevant professional backgrounds. The traditional orientation of the journal has been toward psychodynamic and interpersonal approaches, which have defined its core identity, but we now additionally welcome submissions of original theoretical and research-based papers of any theoretical provenance provided they have a bearing upon vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological disorders. The journal thus aims to promote theoretical and research developments in the fields of subjective psychological states and disorders, values and relationships, and psychological therapies (including both process and outcome research) where mental health is concerned. Submission of systematic reviews and other relevant approaches, which carry important theoretical implications, is also welcomed. Clinical or case studies will be considered only if they illustrate particularly unusual forms of psychopathology or innovative forms of therapy which carry important theoretical implications.

Contributing Psychology: A special section on counselling psychology has been created in the journal in recognition of the importance of this area within psychology and psychotherapy. This section aims to promote theoretical and research developments in the field of counselling psychology. Authors who wish to submit their papers for consideration in this section should state this in their covering letter.

1. Circulation
The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length
Pressure on journal space is considerable and papers should be as short as is consistent with clear presentation of the subject matter. Papers should normally be no more than 5,000 words, although the Editor reserves discretion to publish papers beyond this length.

3. Refereeing
The journal operates a policy of anonymous peer review. Papers will normally be scrutinized and commented on by at least two independent expert referees (in addition to the Editor) although the Editor may process a paper at his or her discretion. The referees will not be made aware of the identity of the author and all communication between author, editor and referees is confidential. Authors are responsible for acautious assessment of the referees' comments and constructive suggestions made for manuscript production. Authors are encouraged to incorporate a substantial number of changes made by referees.

4. Submission requirements
(a) All manuscripts must be submitted online via Editorial Manager at www.bpsjournals.co.uk. Submission of a paper implies that it has not been published elsewhere and that it is not being considered for publication in another journal.
(b) Contributions must be typed in double spacing with wide margins. All sheets must be numbered.
(c) Tables should be typed in double spacing, each on a separate piece of paper with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.
(d) Figures can be included in the end of the document or attached as separate files, carefully labelled in initial capital/low case lettering with symbols in a form consistent with text size. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate page. The resolution of digital images must be at least 300 dpi.
(e) All articles should be preceded by an Abstract of 200 words, giving a concise statement of the intention and results of conclusions of the article.
(f) Bibliographic references in the text should quote the author's name and the date of publication thus: Smith (1994). Multiple citations should be given alphabetically rather than chronologically (Jones, 1970; King, 1996; Parker, 1997). If a work has two authors, cite both names in the text throughout: Page and White (1995). In the case of reference to three or more authors, use all names on the first mention and et al thereafter except in the reference list. N.B. Whilst this suggests that tables should not be included in the text but that it should be indicated where the tables would be placed, they have been left in the main body of the text to assist ease of reading of results.

5. Brief reports
These should be limited to 1,000 words and may include research studies and theoretical, critical or review comments whose essential contribution can be made briefly. A summary of not more than 50 words should be provided.

6. Publication ethics
Any study published in this journal must pay due respect to the well-being and dignity of research participants. The British Psychological Society's Ethical Guidelines on Conducting Research with Human Participants must be followed. The guidelines are available at https://www.bps.org.uk/about/descripts/. Before submitting an article to the journal, it is recommended that all authors read Principles of Publishing which is available on the BPS website: www.bps.org.uk/documents/principlesofpublishing.pdf.

7. Supplementary data
Supplementary data too extensive for publication may be deposited with the British Library Document Supply Centre. The journal requires numerical data, computer programs, fuller details of case studies and experimental techniques. The material should be submitted to the Editor together with the article, for simultaneous refereeing.

8. Post-acceptance
PDF page proofs are sent to authors via email for correction of print but not for rewriting or the introduction of new material. Authors will be provided with a PDF file of their article prior to publication for easy and cost-effective dissemination to colleagues.

9. Copyright
Authors and journals are concerned about unauthorized reproduction of articles. The British Psychological Society requires copyright to be assigned to itself as publisher, on the express condition that authors may use their own material at any time without permission. On acceptance of a paper submitted to the journal, authors will be requested to sign on an appropriate assignment of copyright form.

10. Checklist of requirements:
- Abstract (100-200 words)
- Title page (include title, authors' names, affiliations, full contact details)
- Full article text (double-spaced with numbered pages and anonymized)
- References (APA style). Authors are responsible for bibliographic accuracy and must check every reference in the manuscript and proofread again in the page proofs.
- Tables, figures, captions placed at the end of the article or attached as a separate file.

N.B. Whilst this suggests that tables should not be included in the text but that it should be indicated where the tables would be placed, they have been left in the main body of the text to assist ease of reading of results.
Appendix 9

Personal reflections of the author: The use of self

The journey I have been on with this research project has been a difficult and turbulent one. Emotions have see-sawed between confident and inspired to frustrated and despondent. Personal therapy has been particularly helpful through this time, not only in allowing the expression and acceptance of such feelings, but also in helping me to make some sense of some of the processes and motivations which were perhaps running unconsciously through the journey. I had already considered that my choice to research in the area of missing ‘loved-ones’ was highly influenced by my own experience of having my parents and younger brother move to live in another country when I was a teenager. They were thus in many ways (as I reflected in my second year research paper) lost to me. Even my choice of title for my research last year, “being left behind” was probably more reflective of my own past experience than I recognised at the time.

This process seems to have continued this year. One respondent for example highlighted that in using the word ‘loved-one’, I was placing a value on the nature of the relationship and they therefore suggested that using the term ‘family member’ may have been more appropriate. This made sense to me and I realised that again my choice of word had probably been influenced by my own experience where they had very much been ‘loved-ones’ who had gone.

However, more than this, I have considered why I have branched into exploring perceptions of aspects of bereavement theory. This leads me to think back to interviewing the participants in my research last year and hearing that on a couple of occasions, counsellors they had seen, had commented on such things which I interpreted as ‘stages of grief’ or commemorating a lost son in a similar way to which our society might commemorate the deceased (e.g. through memorial). I remember having a powerful emotional reaction to this, feeling angry and annoyed that (as I interpreted it) attempts had been made to ‘fit’ their experience into ‘model of bereavement’. However, I believe that
my response was also triggered by the participants’ assertions that they had found this unhelpful. Would I have been motivated to carry out this research if they said they had found this helpful? I doubt it.

Interestingly, I (through the medium) of my questionnaire, seem to have provoked a similar emotive response from many of those who completed my questionnaire and potentially many more who did not complete or return it. I have considered (with the help of my own therapist) whether I may have in some way unconsciously played ‘devils advocate’ when I constructed the questionnaire. Did I perhaps want other therapists to respond as vehemently as I had to attempts to apply aspects of theories to clients? I feel that this is a possibility. I also believe that it is possible that in my attempt to be an ‘objective’ researcher (something I don’t believe can truly be achieved, as my inclusions of specific words and choice of titles are testament to), I had ‘down-played’ philosophies and ‘assumptions’ which I see as helpful, for fear perhaps of being ‘biased’ by my own beliefs. For example, there are not many items in my questionnaire which I ‘strongly agree’ with, however, they include those which reject viewing any grief reaction as ‘pathological’, and those which suggest that it is for the client to decide whether it would be helpful for them to ‘detach’ from the lost loved-one, or go on to form new attachments. I know that this for me comes from my commitment to respect the uniqueness of every individual client and their ability to know what it is right for them. Thus whilst I seem to have found agreement with this philosophy from many respondents, I have experienced it as a discovery through powerful angry and frustrated emotions rather than through any ‘smug’ and contented sharing of one another’s beliefs.

This was also interesting and personally significant to me, as it again highlighted to me that I have a need to feel that I have ‘pleased’ others. Thus receiving responses from participants who reported disliking my questionnaire was difficult and led me to feel that I was being personally criticised (which was of course not the case). I even felt that I wanted to ‘sky-write’ that I agreed with much of what they were saying, particularly
regarding how they would determine how to work depending on the individual client’s wishes! This all led me to consider both whether my desire to please was leading me to focus on and remember ‘negative’ comments, but also whether there had been some more unconscious process running through this. In particular, it was interesting that I seemed to have given the impression that my philosophy regarding client work is the opposite of what it is! Sabotage? A sadistic attempt to learn to deal with negative feedback? The jury is still out!

However, despite all such difficulties on my personal journey with this research, it was also in many ways a highly interesting and rewarding one. I felt that this study had helped to uncover some interesting results regarding therapists’ perceptions of changes in bereavement theory both in relation to missing loved-ones but also more generally. I also felt a personal sense of pride and achievement, knowing as I did, how much time and effort I had put into this piece of work.