An evaluation of bereavement counselling using a single systems design

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AN EVALUATION OF BEREAVEMENT COUNSELLING USING A SINGLE SYSTEMS DESIGN

by

BERNADETTE LUKE NDA WIGHTMAN

A thesis presented to the University of Windsor in partial fulfillment of the requirements for the degree of MASTER OF SOCIAL WORK in THE FACULTY OF GRADUATE STUDIES AND RESEARCH through THE SCHOOL OF SOCIAL WORK UNIVERSITY OF WINDSOR

Windsor, Ontario, 1987

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UNIVERSITY OF WINDSOR
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Sept. 14, 1987
Abstract

The purpose of this study was to evaluate the effectiveness of individual bereavement counselling using a single system design.

A comprehensive review of the literature provided theoretical and practical knowledge regarding individuals who experienced bereavement. The review furnished an overview of the theory of attachment and loss, the importance of peer and family relations, characteristics of bereavement, tasks of mourning and the theory of bereavement counselling. The literature supported the importance of early identification of individuals who are at high risk of not successfully completing the bereavement process.

The participant in this study was a voluntary, self-referred client to a mental health association in southwestern Ontario. The client was a student in her early twenties who attended and completed a treatment program aimed at reducing levels of depression and stress and improving family and peer relations. The subject completed four standardized measures at four key periods during treatment as well as two self anchored scales carried throughout the eleven week program.

The main hypothesis and three sub-hypotheses were developed to evaluate the effectiveness and outcome of individual bereavement counselling.

The results of the study indicated that bereavement counselling did produce a difference to the variables of
depression and guilt as measured by the self-anchored scales and family relations and stress as measured by the Index of Family Relations and the Generalized Contentment Scale. Bereavement counselling did not produce a positive difference to the variable of helplessness as measured by the self anchored scale and the variable of peer relation as measured by the Index of Peer Relations. Statistical analysis of the mean scores of levels of depression, helplessness and guilt demonstrated significance for levels of depression and guilt but no significance for the level of the feeling of helplessness.

The researcher concluded that bereavement counselling is effective in producing a positive effect on levels of depression, guilt, stress and family relations. The main hypothesis and three sub-hypotheses were accepted. Recommendations were made in the areas of social work services, community services and future research.
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The completion of this thesis could not have been accomplished without the guidance, support and encouragement of many people.

I would like to thank Dr. Hansen for his support and patience throughout this project. Appreciation is extended to Dr. Wilf Gallant and Dr. Norm King, my other committee members.

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To Laura for her cheery disposition and prompt typing.

My sisters and especially my mother who taught me what family and love are all about.

To Karl, whose support and encouragement helped bring this project to completion.

Thank you.
Dedication

To
My Father

Michael E. Lukenda
1925-1982
# Table of Contents

## Chapter 1
**Introduction** ................................................................. 1

## Chapter 2
**Review of the Literature** .................................................. 3
  2.1 Introduction ............................................................... 3
  2.2 Attachment and Bonding .................................................. 3
  2.3 Family and Peer Relationships .......................................... 6
  2.4 Normal Grief Reactions ................................................ 10
  2.5 Phases and Stages of Bereavement .................................... 15
  2.6 The Four Tasks of Mourning ........................................... 17
  2.7 Bereavement Counselling .............................................. 19

## Chapter 3
**Methodology** ................................................................. 30
  3.1 Introduction ............................................................... 30
  3.2 Purpose of the Study .................................................... 30
  3.3 Research Question ...................................................... 31
  3.4 Hypotheses ............................................................... 33
  3.5 Assumptions ............................................................... 34
  3.6 Operational Definitions ................................................ 34
  3.7 Classification of the Study ............................................ 36
  3.8 Sample Source ............................................................ 38
  3.9 Data Collection Instruments ......................................... 38
    3.9.1 Generalized Contentment Scale (GCS) ............................ 40
    3.9.2 Index of Family Relations (IFR) ................................ 42
    3.9.3 Index of Peer Relations (IPR) ................................... 42
    3.9.4 Life Change Index Scale (LCIS) ................................ 43
    3.9.5 Self-Anchored Scale of Emotional Response to Bereavement 44
    3.9.6 Self-Anchored Scale of Behaviours and Physical Responses Related to Bereavement 45
  3.10 Bereavement Counselling Program ................................... 45
    3.10.1 Topic Content of Sessions ...................................... 46
  3.11 Data Collection Methodology ........................................ 51
  3.12 Data Analysis ........................................................... 52
  3.13 Limitations of the Study ............................................. 54

## Chapter 4
**Analysis of the Data** ...................................................... 56
  4.1 Introduction ............................................................. 56
  4.2 Description of Client .................................................. 56
  4.3 Analysis of Data ........................................................ 56
  4.4 Analysis of the Self Anchored Scales ................................ 57
  4.5 Self Anchored Scale of Emotional Response to Bereavement .... 58
  4.6 Self Anchored Scale of Behaviour and Physical Response to Bereavement 64
Chapter 1

INTRODUCTION

The experience of losing a loved one through death can seem earth shattering and insurmountable. The surge of emotions, feelings and behaviours that the bereaved individual encounters may seem frightening and uncontrollable. Although all individuals experience their own unique process of grief and bereavement, many common factors are shared.

Ours is a youth oriented society. The reluctance to deal with death is believed by many researchers in the field of bereavement to be least partially due to that orientation. To deal with the loss of a loved one means we must accept the inevitability of our own mortality. It also means we must sever the bonds created in relationships. As Raphael states "to understand bereavement it is necessary to have a conceptual framework in which to view two key elements: the human relationships that may be lost; the human deaths that may bring these losses" (1983,4).

It has been the general experience in our society that once the deceased is buried and the funeral ceremonies completed, the bereaved individuals are left, often unsupported, to pick up the pieces and pull their world back together. They are feeling helpless, confused, fragmented and alone. It is a period when
support is needed most, yet often a time when support is withdrawn as others resume their normal routine and expect the bereaved individual to do the same.

People have been grieving for thousands of years. For many individuals it is possible to pass through the stages of grief unassisted. Those who require assistance may turn to the mental health system. The social work profession has an opportunity to address the needs of the bereaved individual.

The focus of this research is to evaluate the effectiveness of social work intervention with a bereaved individual on: 1) levels of depression and stress, 2) feelings of helplessness and guilt, and 3) satisfaction with family and peer relationships. Chapter two reviews the literature that pertains to bereavement counseling. The methodology of the research is discussed in the third chapter. Chapter four provides an analysis of the data and discussion of the findings. The final chapter provides the summary, conclusion and recommendations from this research.
Chapter 2
REVIEW OF THE LITERATURE

2.1 INTRODUCTION

The purpose of this chapter is to present a comprehensive review of the literature with the intent of providing theoretical and practical knowledge regarding the bereaved individual. This review includes literature relating to the theory of attachment and bonding, family and peer relationships, normal grief reactions, phases and stages of grief and bereavement counselling.

2.2 ATTACHMENT AND BONDING

In order to fully understand the implication of loss caused by death or separation and the resulting behaviour, one must first understand the meaning of attachment.

John Bowlby (1980) has been credited with developing the attachment theory. Bowlby's theory maintains that affectional bonds or attachments will develop during the course of healthy development between child and parent and later between adult and adult. This is similar to Eric Erikson's concept of basic trust (1950). Erikson's theory explains the child's development of confident expectation. A child expects that when mother leaves, she will return, when she is needed she will be there and if the child cries out for her or searches for her she will be found. Various experiences at any stage in life can either destroy or
bond the person's basic trust. Attachment behaviour is considered to be instinctive and is mediated by homeostatic systems that are goal directed. The goal is to maintain contact, in whatever form, with the person to whom the individual is attached. The bond that is formed is said to "endure itself." When attachment behaviour systems are aggravated or aroused for example through separation, they can only be terminated by a response to familiar surroundings or the attachment figure. The threat of loss of these attachments produces the experience of anxiety and anger in the individual, eliciting actions to preserve the bond. The greater the threat to loss, the more intense and varied the reaction. The actual loss will lead to sorrow and anger. Bonds that are severed through separation result in attachment behaviour such as clinging, crying or protest. The subsequent result is physiological stress and emotional distress which are less adaptive responses. Once the bond is re-established, the attachment behaviours will disappear. If the bond is not restored, the attachment behaviour may have faded only to reappear under similar future circumstances. Bowlby believes that this behaviour remains in a steady state. Continued reactivation can lead to chronic stress and, if this persists, to ill health. If new bonds are formed, the behaviours are extinguished. The thoughts and behaviours of the grieving person are directed toward the lost object. The behaviour will depict anger, appeals for help or displays of despair. Eventually, the grieving person will direct their attention toward a new object.
Individuals acquire the capacity for intimate relationships and the sense of self-worth, belonging and trust within their family setting. Generally, it is within the family that the first experiences of frustration and the agony of loss occur. The individual’s developmental tasks are paralleled by the family’s developmental tasks (Scherz, 1970). And since it is the family that provides the individual with preparation for life as well as for death, the family’s adaptability, tolerance and reaction to stress will paint the picture for the individual’s methods of coping with stress.

Bereavement itself is considered a stressor. In most cultures, the loss of a principal attachment figure is identified as a major stress which can lead to a crisis. Caplan and Lindemann have been credited with developing definitions of crisis.

Caplan’s model of crisis is based on two major concepts: the threat to the unit and the disrupted state. It is this upset state which is considered to be the impetus behind maladaptive behaviour. Rapoport (1967, 276) defines crisis as "an upset in a steady state." The individual or family strives to maintain a state of balance or homeostasis through adaptive problem solving. The state of disequilibrium causes crisis. Crisis theory is useful in understanding bereavement.

Lindemann’s (1944) description of the symptoms of acute grief reactions include overactivity, acquisition of symptoms associated with the deceased, medical disease and agitated depression. Using Erikson’s model of developmental and accidental crisis (1956)
Caplan conceptualizes a developmental crisis as the transitional period in personality development and an accidental crisis as a serious behavioural or psychological upset brought on by life hazards. The framework of the crisis theory emphasizes that crisis is not pathological. It equips an individual with appropriate behavioral coping skills thereby changing the problem situation from unmanageable to manageable. As indicated by Bowlby (1980) from his research on bonding and attachment behaviour, there appear to be biological reasons for the individual to respond to a separation in an automatic and instinctive way which is displayed by aggressive behaviour. These responses operate on the assumption that losses can be recovered and are apparent in the behavioral response incorporated in the human grieving process. The basis of grief comprises resistance to change, the reluctance to give up possessions, people, status or expectations.

2.3 FAMILY AND PEER RELATIONSHIPS

Since most losses occur within the framework of the family, it is necessary to look at the impact of death on the family system. The family system strives to maintain a homeostatic balance within itself. Each of its members will adapt to the various stressors they may encounter in order to keep this balance. The loss of a member of the family will induce a crisis to which the remaining members must redefine and readjust their roles to restore homeostasis. When each member is functioning in a reasonably healthy and efficient manner, the homeostatic balance is in
equilibrium. When disruption occurs in that system causing an imbalance, the family system becomes dysfunctional to a greater or lesser degree.

According to Worden (1982) there are three areas to consider when assessing the influence of the family system on the grieving process. These include "the functional position or role the deceased played on the family...the emotional integration of the family (and) how families facilitate or hinder emotional expression" (98-99). Undoubtedly, the way the family has reacted to previous crises, their ability to cope with stress and their level of interaction will set a precedent and pattern for their grieving process. The family must maintain open communication and patience with each other since their grief process will be dysynchronous due to the fact that certain roles and functions within the family that need to be performed are no longer performed.

According to Parkes (1972, 99) when a family member dies, one of four outcomes follows. First, the necessary roles may not be enacted. Second, some substitute for the dead member may be sought. Third, some other family member may have to take over unperformed functions. Fourth, the family unit may fall apart. One or all four reactions in some combination will occur.

The outcome of any psychosocial crisis is influenced by overall factors. These factors include the individual's problem solving ability and the type of crisis. According to Caplan (1974) "the quality of the emotional support and task-oriented assistance provided by the social network within which the individual grapples
with the crisis event" (4) is the most important factor affecting
the outcome.

Individuals have a variety of social contacts which they
maintain through relatives, friends, neighbours and colleagues.
They also receive emotional support, material aid and services,
information and new social contacts from these same sources, which
is their support network.

The individual's social network is characterized by its size,
strength of ties, density, homogeneity of membership and dispersion
of membership.

The relationship with each contact also varies by the amount
of time spent, the level of intimacy and the intensity of the
emotional contact. The network is complimented by the combination
of contacts between the group members independent of the individual.
The members are homogeneous to the extent they share common factors
such as age, sex, occupation, ethnicity or social class. The
dispersion of the group will be determined by the frequency of
face to face contact.

Caplan believes that the individual's support system acts as
a barrier to complexities and disorders of modern society. The
role of support systems is to "provide feedback, support and assist
tasks, evaluate performance of group members and distribute rewards"
(Caplan 1974, 3-4). Unfortunately, support networks may not be
capable of meeting all of the individual member's needs. "To
suggest that one specific type of network is universally most
supportive in a crisis situation is to ignore the diversity of
needs that can be experienced by an individual under stress."
(Walker, MacBrice and Vachon, 1977, 37).

The nature of the crisis, the time of crisis and the individual’s own internal and external resources will influence the type of need. If the crisis is a major psychosocial transition, normal expectations may be relaxed by other members allowing the individual the opportunity to temporarily relinquish normal activities and to openly display one’s grief. The individual must be allowed to act irrationally, disorderly and negatively. The individual will rely upon previous crises to draw upon resources to relate and react to the current crisis. The individual will react differently to crises at varying life stages thereby addressing the stage of life in which the crisis occurs. The individual’s internal and external resources will also determine their reaction to crisis.

Bereavement is a major disruption in the life of an individual. It also disrupts the individual’s support network and tests the supportiveness of those networks. The phases of bereavement elicit varying needs from the individual’s support network. The reaction to death will be greatest shortly after the loss. The initial phases are shock and denial of the loss. This is followed by intense grief and searching for the lost person. A gradual decrease in the intensity of the initial reaction leads to the reaction of deprivation. Depression, apathy and resignation follow until reorganization leads to resuming a normal life. Intense grief may require the most emotional support, since it is a period which
allows the expression of feelings. It is believed that failure to express feelings may result in pathological mourning. According to Dunlop (1978, 147-8) those who are most likely to experience difficulty in bereavement are those who become social isolates. The least likely persons to experience profound difficulty are those who will interact with family and friends and in so doing will complete the necessary grief work.

The individual will rely upon the support of the group to assist in returning to a normal social life thereby utilizing new information and social contacts.

Needless to say, the needs of the individual will depend upon the circumstances surrounding the death, the survivor-deceased relationship, the individual’s coping mechanisms and previous experiences with crisis. The ability of the individual’s social support network to fulfill the social and psychological needs in crisis is often lacking. Often those networks are not capable of providing for the individual’s needs over time since the needs, as well as the ability of the group, vary so widely.

Generally, bereavement is a family crisis. If the family is able to handle the loss with openness and feeling while maintaining strength, flexibility and mutual support, it increases the ability to rebuild a new and unified system.

2.4 NORMAL GRIEF REACTIONS

Grief can be described as the emotional response to a loss and encompasses a broad range of feelings and behaviours including
sadness, anger, helplessness, guilt and despair (Raphael, 1983, 33; Worden, 1982, 19). Normal grief behaviour can be generalized into four categories: (1) feelings; (2) physical sensation; (3) cognitions; and (4) behaviours.

(1) Feelings encompass sadness, anger, guilt and self reproach, anxiety, loneliness, fatigue, helplessness, shock, yearning, emancipation, relief and numbness (Worden, 1982, 20-23). The following are descriptions of those feelings as presented in the literature.

Sadness, the most common feeling, is often but not necessarily manifested by crying behaviour.

Anger is a frequent reaction, a confusing feeling and a source of problems in the grieving process. If not properly acknowledged, it can be turned inward or lead to abnormal bereavement. Anger stems from two sources: (1) "from a sense of frustration that there was nothing one could do to prevent the death, and (2) from a kind of regressive experience that occurs after the loss of someone close" (Worden, 1982, 20). Loss evokes regression, feelings of helplessness, feelings of being unable to exist without the deceased and feelings of anxiety.

Guilt and self reproach are common experiences after a loss. Often it centres around the circumstances of the death and is irrational. The survivors feel guilty for not doing enough to prevent the death. The counsellor can utilize reality testing to assure the survivor that they may in fact have done everything in their power under the circumstances.
Feelings of anxiety exist in varying degrees from insecurity to panic attacks. Anxiety is related to the realization of one’s own mortality or to the fear that one will not be able to take care of oneself on one’s own.

Loneliness is frequently mentioned by survivors particularly those accustomed to a close, daily relationship.

Fatigue occurs often and is also described as apathy or listlessness.

Helplessness is present in the early stages of the loss and is closely linked with anxiety.

Shock is observed most often when there is a sudden death.

Yearning, or pining as it is termed by Parkes (1972), common to survivors, is a normal response to loss and diminishes as mourning comes to an end.

Emancipation is not unusual and can be a positive feeling after a death for those who felt burdened and smothered by the deceased.

Relief that the deceased is no longer in pain is common for some survivors when a lengthy illness has ended.

The initial news of a loss can bring about numbness, or a lack of feelings. The survivor is overwhelmed with too many feelings with which to deal. Consequently, the numbness acts as a buffer.

(2) Physical sensations are frequently reported and play a significant role in the grieving process. Those described by Erich Lindemann (1944) include:

(1) hollowness in the stomach
(2) tightness in the chest
(3) tightness in the throat
(4) oversensitivity to noise
(5) a sense of depersonalization
(6) breathlessness, feeling of short breath
(7) weakness in the muscles
(8) lack of energy; and
(9) dry mouth.

(3) Cognitions are thought patterns that are common to grieving which usually last a brief time but, if persistent, can lead to depression or anxiety. Cognitions include disbelief, confusion, preoccupation with the deceased, a sense of presence and hallucinations (Worden, 1982, 24).

Behaviours common to normal grief include sleep disturbances, appetite disturbances, absent-minded behaviours, social withdrawal, dreams of the deceased, avoiding reminders of the deceased, searching and calling out, sighing, restless overactivity, crying, visiting places or carrying objects that remind the survivor of the deceased and treasuring objects that belonged to the deceased (Worden, 1972, 25-27).

The experience of grieving is unique to each individual. It can be mild or intense. It may begin when news of the loss is heard or it may be delayed.

According to Parkes (1972, 29) grief is related to the specific developmental stage and conflict issues of the individual involved. There are six determinants of grief (Worden, 1982, 29-31).

1) Who the person was. To begin with the most obvious, if you want to predict how someone will respond to a loss, you need to know something about the deceased.

2) The nature of the attachment. Not only do you need to know who the person was, but you need to know something about the nature of the attachment. This would include knowing something
about: (a) the strength of the attachment, (b) the security of the attachment, and (c) the ambivalence in the relationship.

3) Mode of death. How the person died will say something about how the survivor grieves.

4) Historical antecedents. In order to predict how someone is going to grieve, you need to know how previous losses were grieved.

5) Personality variables. These include the age and sex of the person, how inhibited they are with their feelings, how well they handle anxiety, and how well they cope with stressful situations.

6) Social variables. All of us belong to various social subcultures—ethnic and religious subcultures are only two such variables. They provide us with guidelines and rituals for behaviour.

According to Parkes (1972, 55), the reaction of a human being to a particular stressor is dependent upon various factors including the characteristics of the stressor, the individual’s repertoire of appropriate coping techniques, how this situation is perceived by the individual in a view of previous experiences, the capacity to tolerate anxiety and the need to maintain self-esteem.

Rando (1984) expands the list of factors influencing the grief reactions with four additional social factors and five physiological factors. The social factors include:

(a) the individual’s social support system and the acceptance and assistance of its members,
(b) the individual’s socio-cultural, ethnic and religious/philosophical backgrounds,
(c) the educational, economic and occupational status of the bereaved, and
(d) the funerary rituals.

The physiological factors include (a) drugs and sedatives, (b) nutrition, (c) rest and sleep, (d) physical health and, (e) exercise (54-57).
2.5 PHASES AND STAGES OF BEREAVEMENT

"Bereavement is the reaction to the loss of a close relationship" (Raphael, 1982, 33). Although bereavement and grief are sometimes used interchangeably, in this paper grief refers to "the emotional response to loss . . . mourning refer(s) to the psychological mourning processes that occur in bereavement: the process whereby the bereaved gradually undoes the psychological bonds that bound him to the deceased" (Raphael, 1982, 33).

Even though the bereavement reaction is made up of a series of phases which can depict the adaption to the loss, the phases are not changeless. The bereaving individual may pass through them in any order, becoming fixated at any stage or only partially or fully completing each stage.

Parkes (1970) defines four phases of mourning. The first phase, the period of numbness, is similar to the phase of shock, numbness and disbelief described by Raphael (1982).

Initially, the bereaved individual cannot believe the death has occurred and feels a more intense shock when the death was unexpected rather than anticipated through a prolonged illness. "It may be that the ego virtually closes its boundaries and defenses against the trauma that is perceived as overwhelming and a threat to its survival" (Raphael, 1982, 34). The passage of time, the first hours of which are presented with numbness and shock, enables
the ego to control stimuli thereby dealing gradually with the loss.

Denial of the loss is common but must eventually be given up to face the truth and reality of the loss. The bereaved experiences a need to talk about the loss, the circumstances surrounding the death, and preparations for the burial. These functions give way to lessening the denial. Being present at the death or seeing the body of the dead person assists in accepting the reality of the loss and in testing out death-related fantasies. Funeral rites make the death public and are a turning point in recognizing the full reality. The funeral process serves two functions according to Raphael (1982, 37). It separates the living from the dead, providing a final farewell for the living. Secondly, it provides contact with the social support network of the bereaved enabling them to pay respect and express support.

The second phase, the yearning phase, is depicted by anger and separation pain. The total environment of the bereaved is a constant reminder of the loss. The bereaved individual is consumed by intense longing for and preoccupation with the deceased. The bereaved searches for the lost object. The pain and emptiness affect sleep and daily functioning. The pain feels too great to endure and the bereaved feels living without the deceased is not possible. It rekindles memories of the earliest separation experiences. The finality of the loss must be accepted in order to affect successful mourning.
Once the loss is accepted as final, the bereaved can release
the processes which built that relationship. Past interactions
and emotions are replayed and relived. The bonds are gradually
untied. This review cultivates feelings of sadness, regret, anger,
guilt and relief. Also common are feelings of depression.

The bereaved enters the phase of disorganization and despair,
which is the third phase. It is difficult to function when
preoccupied with thinking and talking about the loss. The whole
environment of the bereaved seems disorganized. It is difficult
to fulfill basic daily functions. Life seems pointless without
the deceased. The bereaved wishes to achieve reorganization so
mourning may progress, freeing emotions to be reinvested. These
emotions have a roller coaster route indicating a road to recovery.
It is believed that mourning will continue for one year following
a major loss (Raphael, 1983, 47).

Family and social networks provide the most influence for the
bereaved by offering support and comfort. This enables expression
of grief thereby facilitating successful mourning. It enables
the bereaved to enter the final phase, the phase of reorganized
behaviour.

2.6 THE FOUR TASKS OF MOURNING

In order to re-establish equilibrium and complete the process
of mourning, the tasks of mourning as outlined by Worden (1982)
must be accomplished. The tasks align themselves with each phase
of mourning and describe, not exclusively, the behaviours enacted by the bereaving individual. Theories of human development suggest that completion of developmental tasks must occur before the individual can move on in order to complete tasks on a higher level, the bereaving individual must complete the tasks before mourning is complete. Further growth and development can be impaired by uncompleted mourning tasks. Although they do not follow any specific order, the tasks themselves lend to some order.

Task I: To Accept the Reality of the Loss

When a death occurs, there is always a sense of disbelief. In order to accept the reality of the loss, one must realize that the person is dead and gone, never to return. Not believing the death is real and denying the loss can exist in a variety of degrees. It is not unusual for survivors to hoard possessions of the deceased or to keep things the way they were. Survivors will also minimize the loss by underplaying the significance of their relationship with the deceased thereby protecting themselves.

Although it is normal to hope and wish that the deceased will return, this dream is usually short lived and allows the survivor to move on to the next task.

Task II: To Experience the Pain of Grief

Pain associated with grief includes both the physical, emotional and behavioral pain encompassing an individual after a loss. It is necessary to experience this pain and failure. To do so can prolong the course of mourning. Individuals experience
pain in their own way but it is vital that this experience is not denied by society which can complicate the grief process.

Often people will attempt to suppress or deny their pain. Avoiding painful memories or idealizing the dead will prevent accomplishing the second task. A supportive social system or experience with grief counselling can facilitate the survivor through this task.

Task III: To Adjust to an Environment in Which the Deceased is Missing

The survivor’s relationship with the deceased and the roles played by the deceased will determine the way in which the survivor will adjust. Often it is not until the loss has taken place that the roles of the deceased are evident. Coping mechanisms to redefine the loss will facilitate the creation and establishment of new roles for the survivor. An individual can stifle completion of this task by wallowing in self pity, helplessness and isolation.

Task IV: To Withdraw Emotional Energy and Reinvest it in Another Relationship

The final task involves emotional withdrawal from the deceased. This process enables the survivors to reinvest their emotional energy in another relationship. For some survivors, particularly those who have lost a spouse, this task is difficult. They feel they are abandoning the deceased and dishonoring their memory.

Worden believes that mourning is finished when the tasks of mourning are completed. There is no time period established to accomplish this as mourning is a long term process.
2.7 BEREAVEMENT COUNSELLING

Historically, individuals have been assisted in their grieving by family, church, funeral rituals and other social customs. For those who cannot deal effectively with their thoughts, feelings and behaviour, bereavement counselling helps them complete the tasks of grieving.

Grieving is something that takes time. Grief creates tasks that need to be accomplished. To persons in the throes of grief, this may seem overwhelming. With the facilitation of a counsellor, hope can be offered for completion of the tasks and for reaching the end point of their grieving. This is a powerful antidote to their overwhelming feelings of helplessness. For those who have difficulty resolving their feelings about the loss, counselling will assist their ability to complete grief, bring their grief to an effective conclusion and resume a normal life within a reasonable time frame.

Bereavement is a reaction to loss. It is not an illness but rather a psychologically appropriate and healthy reaction to loss. The bereaved individual does not need to be cured. They require assistance in learning to accept their feelings and to accommodate their loss. Bereavement is a transitional period for the survivor but the knowledge of how to work through this transition needs to be more readily available.

Bereaving individuals seek out treatment because they feel stuck in their grieving: they feel immobilized, sensing that their
mourning is enduring longer than it should. They want help so they can resume living. The survivor may be experiencing physical symptomatology whose origin is grief. According to Parkes during the first year following the loss, the bereaved suffer from more depressive symptoms than the non-bereaved (Parkes, 1972). Studies done by P.J. Clayton reveal that young bereaved persons use more drugs for the relief of symptoms and suffer more physical distress than married, non-bereaved young persons (Clayton, 1974, 747-750).

People tend to seek the help of professionals more today than in the past to complete their grieving. Traditionally religious institutions, family and neighbours helped people cope with their loss. The increasing social mobility and secularization have changed this focus for help.

Parkes identifies three types of grief counselling (Parkes, 1980). The first type provides support to a person who has suffered a significant loss from professional sources including social workers, psychologists, psychiatrists, doctors or nurses and can be done individually or in a group. The second type, available in this community through Canadian Mental Health Association, includes volunteers who are trained and supported by professionals. The last type, also available through C.M.H.A. makes use of self-help intervention both on an individual or group basis, with or without the support of professionals. People who have themselves experienced a major loss and have successfully completed the process may be particularly well qualified to help the bereaved.
Worden identifies three philosophies attached to bereavement counselling (Worden, 1982, 37). The first philosophy states that bereavement counselling should be offered to all survivors. Assuming that death is a very traumatic experience for all involved, counselling should be available to all. Although the intent is good, the cost involved may not make this possible. In addition, it may not be needed by everyone.

The second philosophy implies that people will wait until they are experiencing difficulty and recognize their need for help before they seek it out. The feelings of discomfort and distress must be experienced before help is offered.

The final philosophy, based on a preventative model, responds with early intervention for those predicted as having difficulty with the grieving process.

A therapeutic assessment, designed to explore a number of areas of grief, can help determine if the survivor is at risk for poor resolution of grief. Raphael identifies four areas to be explored in the assessment (1983, 362-367). Firstly, question the survivor about the death and how it occurred. This will give insight to the survivor's willingness to discuss the death and also imparts to the survivor the counsellor's willingness to discuss the death. Secondly, ask about the deceased person and their relationship with the survivor. By doing so, the history of the relationship will be revealed. Thirdly, question events that have occurred since the death as well as the survivor's current relationships with family and friends. This allows expression of
feelings and sources of support. Finally, talk about the survivor's previous experiences with loss and separation alerting the counsellor to how the individual dealt with previous stress. This will provide a history of coping strategies as well as indicate what coping mechanisms are presently being used.


**Principle One: Help the Survivor Actualize the Loss**

A sense of unreality always occurs when a person loses a significant other. Consequently, the first task involves affecting a more complete awareness of the reality of the loss. By accepting that the dead person will not return, the survivor is able to then deal with the loss and its emotional impact.

The survivor is directed to speak specifically about the death and the circumstances surrounding it. The counsellor is usually the one person who is detached from the survivor's support network and consequently can be more objective in helping the survivor deal with the loss. By patient listening, encouragement and facilitating awareness of the loss, bereavement counselling helps actualize the loss.

**Principle Two: Help the Survivor to Identify and Express Feelings**

Many survivors attempt to repress unpleasant, dysphoric feelings so they are not felt to the degree they need to be or are not recognized at all. Feelings of guilt, anger, anxiety and helplessness exist in varying degrees at different times.
It is not unusual to feel anger at the loss of someone close. It stems from frustration and helplessness. The true source is not always recognized and may be directed toward the deceased, the physician, the family or the hospital staff. If not displayed elsewhere, it can be turned inward and display itself as depression, guilt or lowered self-esteem. In extreme cases it may appear as suicidal behaviour.

For many survivors, it is difficult to admit to anger. The survivor needs to recognize the positive and negative aspects of the experience. Balancing the positive and the negative feelings brings about recognition of sadness of the loss and an adequate and healthy resolution of grief.

After a loss, guilt can surface because of feeling that inadequate medical care, delayed diagnosis or stresses in a relationship occurred. The survivor must realize that under the circumstances they did their best. Since the guilt is irrational and centres around death, reality testing is most effective to dissolve the feelings of guilt.

Feelings of helplessness and panic give rise to fear and anxiety. This regressive experience will ease with time and the counsellor can assist the survivor in noting how they survived prior to the loss, putting their fears and anxieties into better perspective. Worden (1976) identifies another anxiety source stemming from the recognition of one's own death and mortality.

What is usually at the lower level of consciousness suddenly becomes
a full blown reality. The counsellor can assess the client’s need to determine if confrontation and discussion are necessary.

Sadness and crying are grieving tools that need to be accepted and encouraged. Crying alone or with support are both helpful and the meaning of the tears will change as the grief work progresses (Simos, 1979, 89).

**Principle Three: Assist the Living Without the Deceased**

Survivors must learn to live without the deceased and make decisions independently. They must learn to adjust to the loss of the roles played by the deceased. A problem solving approach is quite effective. By learning effective problem solving and coping skills the survivor can fill the roles left empty by the deceased if possible.

Major decisions should not be made too soon following the loss since it is difficult to exercise good judgement when there is a good chance of a maladaptive response (Worden, 1982, 44).

**Principle Four: Facilitate Emotional Withdrawal from the Deceased**

In time, the survivor needs to form new relationships. It is not unusual to fear new relationships for many reasons including not being capable of sustaining another loss, dishonouring the memory of the deceased or feeling no one can fill the void left by the deceased. Filling the void too quickly may initially lessen the pain but may exclude experiencing the loss in its entirety. The new individual is not a replacement object but a person of their own worth and recognition.

**Principle Five: Provide Time to Grieve**
The process of severing ties is gradual. It takes time to accommodate a loss. Anniversaries, birthdays and holidays are times when extra support is required due to a resurgence of thoughts and feelings. These dates also help to further cut ties.

**Principle Six: Interpret "Normal" Behaviour**

Few survivors are aware of what they should and can feel after a significant loss. They sense they are going crazy and it is therefore important to help them understand and interpret normal grief behaviours. Reassurance of the normalcy of these feelings is extremely important.

**Principle Seven: Allow for Individual Differences**

All survivors will not grieve in the same manner and it is important for family members to recognize that each person and situation is unique.

**Principle Eight: Provide Continuing Support**

Continuing support (group or individual) is required for good bereavement counselling particularly during critical periods.

**Principle Nine: Examine Defenses and Coping Styles**

Helping the client identify and recognize defenses and coping styles both constructive and destructive is necessary in helping the client evaluate their effectiveness. This process leads to learning more effective skills which will lower distress and resolve problems.

**Principle Ten: Identify Pathology and Refer**
Grief counselling is not effective for all survivors and the counsellor must know when a loss creates more difficult problems which require special intervention.

Many believe that the knowledge obtained from any life experience is not only the best teacher but ultimately most beneficial when attempting to assist those persons going through a similar experience. If such is the case then those who have experienced a major loss and successfully completed the grieving process may be in the best position to assist the newly bereaved. Yet this may not hold true when considering the experience of grief.

Bowlby (1980) states:

The loss of a loved person is one of the most intensely painful experiences any human being can suffer, and not only is it painful to experience, but also painful to witness, if only because we’re so impotent to help (7)

Because of the dilemma causes by such a delicate human experience, the counsellor must be aware of his own strengths and weaknesses surrounding bereavement. As Worden (1982) states the experience of bereavement will personally touch the counsellor in three specific ways:

(A) Bereavement counselling will cause us to remember our own losses. If the counsellor’s own bereavement has been adequately integrated, resolved and completed, it will be of use and benefit to the client. Conversely, the counsellor’s unresolved grief or recent bereavement will impede beneficial intervention (Worden, 1982, 108).
Bereavement counselling can produce anxiety in the counsellor surrounding future losses. If consumed by that anxiety, the counsellor will not be of benefit to the client (Worden, 1982, 108).

Undoubtedly bereavement counselling brings to one's consciousness the inevitability of one's own death. Discomfort and anxiety about our own mortality will impede our effectiveness. One must be aware of personal coping skills, history of losses, resources available and time frame for grieving (Worden, 1982, 108-109).

The worker must recognize personal limitations. Not unlike any other field of specialty, the counsellor must know what type of client he works with best and whom he cannot work with (Worden, 1982, 109).

Bereavement is a traumatic and complex process which almost every individual will at some time experience. For those who have difficulty successfully completing the process, bereavement counselling is a solution. Early identification of such individuals allows for preventative measures to be implemented. Awareness of the characteristics of grieving and their importance are issues which are addressed in counselling and will in turn provide the opportunity and permission for the bereaved individual to move through the stages of bereavement. Unsuccessful and incomplete mourning can lead to an unsolved grief reaction.

Mental health professionals are in an ideal position to engage
their sensitivity, knowledge and skill to help those who mourn to resolve their grief in a healthy manner.

This chapter has reviewed the literature pertaining to bereavement counselling including the attachment theory and bonding, family and peer relationships, normal grief reactions, phases and stages of mourning, the tasks of mourning and bereavement counselling. The literature was found to contain common concepts. Evaluation literature pertaining primarily to group counselling was available. The following chapter will discuss the methodology of the study.
Chapter 3

METHODOLOGY

3.1 INTRODUCTION

In this chapter, the purpose of the study, the research questions and the assumptions are presented. Next the variables are operationally defined, followed by the classification of the study and a description of the sampling procedures. The content of the individual bereavement counselling program is summarized. Finally, the outline of the methodology of the study will be completed by the discussion of the data collection instruments, the data analysis procedures and the study's limitations.

3.2 PURPOSE OF THE STUDY

The purpose of the study was to assess the effectiveness of an individual bereavement counselling program with a young adult. The study had a test-retest format. The client completed standardized measures relating to levels of stress and depression and attitudes toward family and peer relations. Further, self-anchored scales were completed on a daily basis to establish intensity of feelings and characteristics common to the bereaving individual.
3.3 **RESEARCH QUESTION**

In order to achieve the purpose of the study, the following research questions were formulated.

1. **Did participation in an individual bereavement counselling program lead the individual to a healthy completion of the tasks of grieving within a reasonable time frame?**

Studies indicate that successful completion of the bereavement process varies from person to person but generally concludes within one year. A critical period for bereavement occurs between three and six months following the loss. It is during this time period that most individuals will request help and that intervention is believed to be most successful in facilitating an effective conclusion to the bereavement process.

2. **Did participation reduce the individual's level of stress and depression and improve the attitudes toward family and peer relationships?**

Relational factors, which define the type of relationship the person had with the deceased; circumstantial factors, which include circumstances surrounding the loss; historical factors, which include past grief reactions; personality factors, which relate to the person’s character; and social
factors, which include the social setting and the support network; all play an important role in the bereavement process. Each factor lends itself to particular responses which can be categorized as symptoms or problems of bereavement. The resolution of such behavioural roadblocks assists in successful completion of the bereavement process.

3. Did participation lessen the intensity of those problems identified by the client (as characteristic of grieving individuals)?

As the old adage states, "Time heals all wounds". Bereaving individuals will identify a number of similar problems they will encounter during their process of bereavement. The intensity and duration will vary with each individual. This question seeks to establish if intensity and duration change and why.

4. Did participation result in preventative measures avoiding abnormal grief reactions and complicated mourning?

There are those individuals who cannot cope with the broad range of reactions brought about by the loss of a significant other and who cannot work through the tasks of grieving on their own. For this reason it is vital for the mental health practitioner to intervene and provide the bereaving individual
those opportunities to deal with thoughts, feelings and behaviours. If left unresolved, this may lead to abnormal grief reactions. Studies reviewed by Parkes (1980, 9) suggest that professional intervention is capable of reducing the risk of psychiatric and psychosomatic disorders resulting from bereavement.

The following main hypothesis and three sub-hypotheses were developed from the review of the literature and discussion of the research question. It is the intent of this writer to show that accepting the sub-hypotheses will support the acceptance of the main hypothesis.

3.4 HYPOTHESES

Main Hypothesis

1. There will be a healthy completion of the tasks of grieving within a reasonable time frame associated with the individual's participation in an individual bereavement counselling program.

Sub-Hypotheses

1. There will be a positive change in levels of stress, depression and in the attitude toward family and peer relationships.

2. There will be a lessening in the intensity of those problems
identified by the client (as characteristic of a grieving individual) associated with their participation in the program.

3. Participation in the program will be perceived as helpful.

3.5 ASSUMPTIONS

Assumptions are those variables which are relevant to a particular study and, according to Lillian Ripple, are "proposition(s) that are taken as a given" (Ripple, 1975, 35).

In keeping with this definition, the researcher presented the following assumptions regarding the study.

1. Bereaving individuals are capable of benefitting from bereavement counselling.

2. Benefits, in the form of an individual's more positive attitude towards family and peer relationships and a reduction in levels of stress and depression, are a valid indication of the effectiveness of individual bereavement counselling.

3.6 OPERATIONAL DEFINITIONS

The following definitions are derived from the literature and used in this study.

Bereavement is the reaction to the loss of a close relationship. Mourning is the psychological process that occurs
in bereavement. Grief is the personal experience of the loss and emotional response to the loss.

Guilt can be defined as those feelings of self reproach which are manifested over something that happened or something that was neglected around the time of death. Guilt is derived from negative acts or feelings the bereaved had directed toward the deceased or from courses of action they omitted to take which they feel may have prevented the death and are associated with a specific aspect of the loss such as time of diagnosis, length of illness and time of death.

Feelings of helplessness and panic are present in the early stages of loss and are closely related with feelings of anxiety, nervousness and uncertainty and feeling closed in.

Depression is the feeling of intense sadness, discontent, unhappiness and anger precipitated by a loss which can serve as a defense mechanism against mourning. Depression may elicit poor appetite, loss of sleep, intense sadness and loss of weight.

Bereavement counselling is the process of helping people facilitate uncomplicated, or normal, grief to a healthy completion of the tasks of grieving within a reasonable time frame.

The loss of a principle attachment figure is a major stress. It is a crisis which invokes additional strain thereby hindering the resolution of grief.

Family relations incorporate the family network of support which allows for and shares the expression of grief and review the mourning process. Peer relations incorporate the network of friends
and their support which allows for and shares the expression of grief and review of the mourning process.

Those characteristics identified by the client such as crying, screaming, wailing, teary eyes, emptiness, irritability and restlessness encompass emotional release. Physical distress includes those characteristics identified by the client such as tightness in the chest, shortness of breath, sighing, lethargy, empty feelings in stomach, upset stomach and headaches. Illusions are those characteristics identified by the client such as visual and auditory illusions and dreams.

3.7 CLASSIFICATION OF THE STUDY

This single system design follows the classic AB design incorporating a time series design; A is the concurrent baseline phase (the non-intervention and observation period) and B is the intervention phase. Classified as an experimental design, the single system design evaluates a single system (client or group) utilizing reflexive controls and acts as its own control group. This design provides ongoing and continuous feedback of the effects of treatment which consequently shapes the intervention. It involves the planned comparison pre-intervention period with observations of the intervention or post intervention periods. "The assumption underlying the A-B design is that the problems observed during the baseline will likely continue in the same pattern if no changes are made in the system of forces acting on these problems" (Bloom and Fischer, 1982, 294).
Time series designs are studies which use series of measurements over time to predict or evaluate outcome. According to Fischer, "they provide a variety of grounds for caseworkers to begin both the evaluation of the success of their own practice and the laborious process of the technique and knowledge building" (Fischer, 1978, 124). Comparisons in the time series design are made between various phases of the process. AB designs are capable of clearly revealing when target events have changed.

This is vital information that can lead to a number of other practitioner reactions; monitoring of ongoing events lets the practitioner know whether to continue a given intervention or whether to modify one way or another including termination (Bloom and Fischer, 1982, 295).

This study included two basic phases with implementation of the standardized measures occurring at four strategic points including the beginning of baseline (A), the end baseline which is also the beginning of intervention (B), at the end of six weeks of treatment and upon the conclusion of treatment.

The sixth session of treatment coincides with the withdrawal of treatment for a three week period due to the client's schedule (The client was returning to the homeland of the deceased to visit relatives and partake in memorial services including interment of the ashes of the deceased). According to Bloom and Fischer (1982) the accidental removal of treatment due to vacation or illness occurs where intervention cannot be implemented for a brief period.
of time. This period enables the researcher to evaluate whether the intervention was responsible for the change in behaviour. This decreases the potential for interfering events, as possible causative factors, thus increasing the internal validity of the findings. The series of measures, including the ongoing self-anchored scale measurements, reduce the possibility of confounding maturational or developmental changes.

3.8 SAMPLE SOURCE

Participants in any of the programs offered by the Bereavement Resources Department of the Canadian Mental Health Association are voluntary referrals by self, family or agencies. The subject in the study was a self-referred, young adult female who requested individual counselling. Following an initial assessment interview with the bereavement resources co-ordinator, a counsellor was assigned to the client according to such characteristics as age, type of bereavement, identified problem and need, relationship to the deceased and the stage of bereavement.

3.9 DATA COLLECTION INSTRUMENTS

The study included the use of four standardized measures and two self-anchored scales. The standardized measures comply with the definition of a scale developed by Kerlinger; "a scale is like a test in that it has items which are designed to measure a particular construct, but it lacks the competitive flavour of a test" (1979, 31). All of these measures are designed to monitor
and evaluate the client's problems in terms of extent, degree and intensity. They include face valid, self-report items which suggest they record only what the client is willing to reveal about their feelings and beliefs. Three of these measures (the Generalized Contentment Scale, the Index of Family Relations and the Index of Peer Relations) which were developed by Walter Hudson and his associates are part of the Clinical Measurement Package (Hudson, 1978, 1981). They have been designed for use as a repeated measure specifically for single system design to monitor and guide the course of treatment.

The format and structure of each scale is the same consisting of twenty five items. According to Hudson, the repeated use of a scale with the same client requires characteristics desirable of that scale including shortness, easy administration, scoring, understanding and interpretation and free response decay (Hudson, 1982, 2). "Each of the CMP scales meet all of these psychometric requirements. Each scale has a reliability of .90 or better, and they all have good content, concurrent, factorial, discriminant, and construct validity" (Hudson, 1982, 2). Currently, a study is in progress to obtain the necessary data and information for the psychometric characteristics of the IPR scale. It is expected that the results elicited will correspond with the other eight CMP scales.

The Life Change Index Scale (LCIS) was developed by Thomas Holmes (1967) to rate life events on the degree of stress produced by each. These events include both positive and negative
experiences as both extremes produce stress. The scale focuses on feelings of fear and frustration which are believed to be the most common stress-producing situations. There appears to be a high relationship between the amount of life changes in the previous six months of a person's life and their likelihood of becoming ill.

Two self-anchored scales were constructed by the researcher to complement the standardized measures. According to Bloom and Fischer (1982, 48), self-anchored scales are capable of measuring problems and situations that no other measure can. Self-anchored scales reflect the evaluation of the intensity of thoughts and feeling, things about which only the client can report most accurately. When used in conjunction with other measures, self-anchored scales become more reliable and valid. Ongoing use of these scales provides feedback to both the client and researcher/practitioner regarding progress in treatment. The data collection instruments will now be discussed individually in more detail.

3.9.1 GENERALIZED CONTENTMENT SCALE (GCS)

Designed by Hudson "to measure the degree, severity, or magnitude of nonpsychotic depression", the GCS is a twenty-five item, five-point Likert-type scale. Developed for single subject designs in research, it asks the client to respond to statements concerning the degree of contentment they feel about their life and the surroundings by placing a number beside each item which
corresponds to the degree of feelings (where 1--rarely or none of the time; 2--a little of the time; 3--some of the time; 4--a good part of the time; and, 5--most of the time). "Some of the items are positively worded statements or descriptions, and others are negatively worded to partially control for response set biases. All of the items were randomly ordered within each scale" (Hudson, 1982, 17). The scale provides a single-dimension characterization of the problem but not information about the cause, origin, type or source of the problem. Since it measures the degree or severity of the problem, a high score would be interpreted as the presence of a more serious problem than would a low score.

The scale has a clinical cutting score of thirty, and although it is not deemed perfect, it is a good standard for evaluating treatment.

This measure was chosen over other standardized measures for depression due to its characteristics which are best suited for single subject designs.

The effectiveness of individual bereavement counselling in promoting the opportunity for a person to grieve and resolve the tasks of grieving can be better suggested if the individual's consecutive scores on this measure of depression, along with the scores on the Index of Family Relations and Index of Peer Relations were higher than the previous score and consecutive scores on the Life Change Index Scale were lower.
3.9.2 **INDEX OF FAMILY RELATIONS (IFR)**

This standard measure evaluates the degree, severity, or magnitude of the problem as that they have in the relationship with other family members as perceived by the client. As a measure of intrafamilial stress, it assists in evaluating the family environment and dealing with those problems relating to the whole family. Since it is one of the Clinical Measurement Package scales, its psychometric characteristics, format, scoring procedure and raw score interpretation are the same.

The characteristics of the bereaving individual include the emotional experience of separation pain. In seeking comfort and consolation from others, the bereaving individual often experiences a variety of intrafamilial stresses which affect those relationships. The loss of a significant family member can upset its homeostatic balance. As the world of the bereaved individual becomes reintegrated and the mourning process progresses, recovery commences and relationships are less strained. The Index of Family Relations was chosen to monitor the magnitude of those changes.

3.9.3 **INDEX OF PEER RELATIONS (IPR)**

This standardized measure can refer either to a global or a more specific peer group which is specified by the client and practitioner and measures the degree, severity, or magnitude of a problem that the client may be experiencing in their relationships with peers. Once again, its psychometric characteristics, format,
scoring procedure and raw score interpretation are concurrent with the other Clinical Measurement Package scales.

The index of peer relations was chosen to monitor the changes in the client's level of functioning in the peer environment. This support group can be vital to the bereaved individual's eventual adjustment or, paradoxically, can stifle the grief process. Just as they may inhibit the social isolation of the individual by involvement in activities and events, the unrealistic demands of modern society placed on bereaved individuals can be overwhelming and detrimental to the process of grieving.

3.9.4 LIFE CHANGE INDEX SCALE (LCIS)

Developed by Thomas Holmes to evaluate how life changes increase stress, the scale contains a list of forty-three items made up of types of life events. By checking off that event which is applicable to the client's situation covering the past twelve months, the client can determine where stress originates and how they react to it. Dr. Holmes has observed a relationship between recent life changes and future illness.

Being alerted to stress provides the individual with the opportunity to reduce stress and prevent illness. Research conducted by Holmes and his colleagues found that, in a group of 400 people, counting their life change units (LCU) over a six month and a twelve month period showed a high relationship between a total score of life change units over 300 and a high likelihood of developing a major health problem. This scale was chosen to
identify major changes in the individual's environment requiring
the individual to identify stresses and restructure their way of
looking at the world.

3.9.5 SELF-ANCHORED SCALE ONE OF EMOTIONAL RESPONSE TO BEREAVEMENT

This scale was constructed by this researcher for the purpose
of having the client rate herself on a daily basis on feelings
characteristic of bereavement such as feelings of helplessness
and panic (identified on the scale as 'H'), depression and sadness
('D'), and feelings of guilt ('G'). Using a seven point Likert-
type scale (whereby 1--rarely if ever; 2--very infrequently; 3--
infrequently; 4--neutral; 5--frequently; 6--very frequently; and,
7--all the time), the client gauges the intensity of the problem
each day beginning the first day of baseline and continuing
throughout treatment to termination.

This scale represents three key areas identified by the client
as problematic and measures the intensity of thoughts and feelings
that no other measure could elicit.

Self-anchored scales have high face validity but caution
must be used when assessing their reliability since clients are
rating themselves. This self-reporting may be obstructed or
distorted by their desire to appear "healthy". Appropriate
preparation and explanation of the scales will promote successful
use of the scales which will provide feedback regarding progress.

Each week the scale completed by the client for the previous
week was reviewed for clarification and comparison.
Bloom and Fischer feel that these direct measures most clearly approximate or reflect the actual problems or behaviour and are advantageous to single system design research since the more a measure approximates or in fact is a measure of actual functioning, the more useful it is to us and to our clients. Direct measures tend to be more related to actual functioning than indirect measures (Bloom and Fischer, 1982, 48).

3.9.6 SELF-ANCHORED SCALE TWO OF BEHAVIOURAL AND PHYSICAL RESPONSE TO BEREAVEMENT

Not unlike scale one, scale two was constructed to measure the intensity of behaviours and physical responses characteristic of bereavement, characteristics which were more concrete, and in some instances, were observable. Divided into three emotional categories (emotional release, physical distress and illusions), these characteristics were measured by the client on a daily basis according to their frequency or occurrence, beginning on the first day of baseline throughout treatment to termination. The client had the opportunity to revise the scale by adding new behaviours she was experiencing. The scale was reviewed each week to discuss, clarify and compare the frequency and intensity of the characteristics.

3.10 BEREAVEMENT COUNSELLING PROGRAM

The client attended two initial assessment sessions and eight weekly sessions which were one and one-half hours to two hours in duration for a total of sixteen to twenty contact hours. Each session was led by the researcher-practitioner who had previous
experience with bereavement groups. Following a baseline period of fourteen days, the intervention phase which included eight treatment sessions lasted nine weeks.

The program was structured around the task-centered and problem-solving modalities incorporating the tasks of grieving and their various components.

The program's structure focused on the tasks required to solve specific problems identified by the client. The treatment rests on the human capacity for autonomous problem solving.

The program utilized the self-anchored scales as progress indicators as well as relevant readings suggested to the client to provide additional information on the process of bereavement.

3.10.1 TOPIC CONTENT OF SESSIONS

The content of the sessions was derived from a program developed by CMHA and adapted to suit the needs of this particular client. The client was assessed to be emotionally healthy and intact and, through her professional training, had some knowledge and insight into the process of grieving. She recognized that she was having difficulty in the bereavement process.

1. Session one: The first session was employed to introduce the client to the program including an overview of the goals or treatment and research component. The client introduced herself and talked about her reaction to the loss, her views on death and how she was surviving without the deceased person. The client usually felt quite anxious wanting to cement
expectations while continually dealing with a sense of fear, uncertainty and anger. This session was also the beginning of the baseline phase.

2. Session two: This session marked the midpoint of the baseline phase. The client completed the four standardized measures. Self-anchored scales were presented and reviewed with the client for clarification and understanding. The client continued to feel anxious and uncertain but a sense of trust began to develop. She indicated that her fear and anxiety about the emotions she was experiencing had diminished as she began to understand their relevance and importance to her grieving process.

3. Session three: This session was the end of baseline. The second administration of the four standardized measures. A review of the self-anchored scales and results and interpretation of first scores were discussed. The client identified the expectations of treatment. First treatment session involved helping the client actualize the loss. The client discussed her relationship with the deceased, circumstances surrounding the death, survivor’s feelings towards death, changes encountered and review of the emotions of grief. She felt she had a small advantage in preparing for her father’s death as there had been a brief illness prior to the death. Her professional medical training enabled
her to maintain a realistic outlook about the quality of care received by the deceased and accept that nothing else could be done to prevent the death.

4. Session four: The topic involved helping the survivor identify and express feelings. The client expressed the depression and sadness she experienced. The relief she experienced from being able to have grief and depression enabled her to move forward and begin to repair what she felt had been destroyed. Major life changes and coping mechanisms were discussed as well as how family and friends were incorporated as support systems. The client spoke of displaying emotions in front of family and friends and the imminent reactions. The client discussed feelings of hope of repairing her life thereby assisting living without the deceased.

5. Session five: This session dealt with the client's view of religion and its importance in death. The client spoke about funerals, customs, cliches and faith and the importance and benefits of the funeral custom. She expressed her desire to attend the memorial service in her father's homeland and the interment of ashes which would assist in completing a phase of her grieving. She also spoke of her anxieties and fear surrounding this event, particularly the recurrence of intense emotional upheaval, which troubled the client to such an extent that she sought the assistance of her therapist.
6. Session six: A discussion of dependency and independency assisted the survivor in the emotional withdrawal from the deceased occurred in this session. The client moved toward self reliance, recognized her own strengths and goodness. The client also discussed memories and dreams about the deceased. She related painful memories were beginning to be happy memories. Her dreams, although not frightening, seemed to reinforce the reality of the death.

7. Session seven: A discussion of grief occurred during this session as well as an interpretation of normal behaviour assisted the survivor in regaining her old identity. By allowing for individual differences in the grieving process and examining defenses and coping styles the survivor learned from her own experience of bereavement. She learned to accept unanswered questions for which there will never be any answers. This acceptance was a sign of beginning to incorporate the loss of the dead person and beginning to relate to this painful experience.

8. Session eight: Third administration of standardized measures occurred as well as preparing the client for the interruption in treatment and trip to the homeland of the deceased. A discussion of "death is not fair" elicited feelings of anger resembling sadness which enabled the client to share an acceptance, even though angrily, of the reality of loss.
Although she was very anxious about repeating the memorial service, the client recognized this service would allow her to proceed in her bereavement.

9. Session nine: This session resumed following three weeks of absence from treatment during which the client continued administering the self-anchored scales. The discussion centered around holiday times, anniversaries and birthdays. The client discussed the memorial service and indicated that preparation had greatly assisted her in reliving her loss. She stated that she now felt capable of completing her bereavement.

10. Session ten: Final administration of standardized measures. The client discussed the personal benefits and significance of individual bereavement counselling. Support and confirmation that she was not going crazy was initially the most important information she received. Overcoming roadblocks and being able to freely express her grief were also cited as important. The client felt every individual could benefit from some form of intervention during bereavement.

11. Session eleven: The collection of last seven days of self-anchored scales took place. Although treatment was terminated, the client was informed that bereavement would continue for an additional six to eighteen months. Even though it was
the belief of both practitioner and client that she did not require additional counselling she would initiate contact if she felt the need.

3.11 DATA COLLECTION METHODOLOGY

The client completed a total of four sets of questionnaires. The two self-anchored scales, which are direct measures of behaviour, were initiated at the beginning of baseline and extended throughout the intervention phase to termination. The standard measures, the Generalized Contentment Scale, the Index of Peer Relations, the Index of Family Relations, and the Life Change Index Scale, which were indirect measures of behaviour, were administered at the midpoint and the end of the baseline phase (seven days apart), following the sixth session of the intervention phase and again at the end of the intervention phase. The decision to conduct the third measure at the end of the sixth treatment session was made for two reasons. The intervention phase would be interrupted for a three week period at this point due to the client's vacation schedule. Significantly, this period of interruption was due to a trip to the deceased's native country where a burial service and a family reunion occurred. It was felt that this repetition of a funeral service (a resolution of another phase of bereavement) was significant to the client's grieving process. Consequently, it would seem more appropriate to administer the four standardized measures prior to vacation rather than at its completion. Secondly, the results of testing
at this point would assist in the ongoing assessment of the client’s needs and complement the course of intervention.

3.12 DATA ANALYSIS

According to Polster and Lynch, data analysis procedures for single subject designs are unique to the design and achieved by visually comparing the trend of each behaviour (problem) from one unit of observation to the next.

In single system designs, the most basic analysis of data involves a visual comparison of baseline and intervention periods, and meaningful change is characterized by a decrease or increase in the frequency of behaviour (1981, 414).

The data obtained from the self-anchored scales and the results of the standardized measures will indicate the effectiveness of intervention. The extent of meaningfulness of the data is determined by where the majority of data points fall, be it above or below the mean of the data baseline.

Jayaratne (1978) describes four analytical methods for data analysis within the single system design approach. Statistical procedures such as an analysis of variance and a t-test procedure provide predictive analytic methods and a statistical basis for considering the success or failure of treatment. It is important to determine whether or not the client’s problem has really changed.

The significance of client change can be evaluated by comparing the client’s present level of functioning with the level of functioning prior to intervention. Risley (1970) uses the term experimental significance to convey the notion that significance
is based on observed changes in the client which includes visual analysis and statistical techniques. "Experimental significance assesses the probability that the pattern of client behaviour observed during treatment may be viewed as an extension of the behaviour pattern prior to treatment" (Levy, 1983, 696).

Time series data contains four characteristics identified as level, trend, variability and autocorrection (Thomas, 1977) which must be accounted for and can be achieved through the ARIMA (autoregressive integrated moving averages) technique or the Shewart chart. These techniques complement visual analysis.

Shewart charts (1931) have been described by Gottman and Leiblum (1974) for use with single system designs where

the mean level of a set of baseline data is identified, and the two standard deviation levels are constructed above and below the mean line...if at least two successive observations during intervention fall outside of the two standard deviation bands, then there has been statistically significant change (Bloom and Fischer, 1982, 454).

Shewart charts are applicable for baseline points of less than ten since "the computation of the two standard deviation bandwidths take into account the actual number of baseline observations" (Bloom and Fischer, 1982, 455). It is also relevant to baseline data which fluctuates and presents no stable pattern. Autocorrelation must be tested for before data can be transferred to the Shewart chart.

3.13 LIMITATIONS OF THE STUDY

By their very nature, single system designs involve the repeated collection of objective information on a single system
over time. Data between intervention and non-intervention phases is compared. The limitations and statistical and logical considerations of such designs are not entirely clear to researchers but one area of concern is generalization. The researcher must clearly define and outline the design, identify optimal conditions for its use which in turn will reduce concerns of validity.

The planned withdrawal of treatment after six weeks of intervention may result in an unpredictable outcome. The effects of this course of events which occurred during this 'no treatment phase' (maturation) are not fully determinable. Single system designs are weak in controlling threats to internal validity, namely history and maturation.

Single system designs do not have a population that is randomly assigned. Only through replication, the repeated testing of the same intervention across relevant domains, will the benefits be determined and generalized.

The study is dependent upon the sensitivity of the standardized measures and the self-anchored scales to changes in the individual's levels of stress and depression and attitudes toward family and peer relationships. The four standardized measured consist of close-ended questions which may have restricted the opinions of the client. The answers the client had to choose from may not have been appropriate for this particular client. Some answers may have been selected to fill in a space or please the researcher rather than to provide an opinion.
The client who participated in the study was self-referred and voluntary candidate to a Canadian Mental Health Association in southwestern Ontario. The client may have been more highly motivated to seek professional assistance to successfully complete the tasks of grieving or in need of assistance more than those bereaving individuals who choose not to elicit professional help. There also is the likelihood that a voluntary client, in contrast to the non-volunteer, may "compromise the interpretation and general ability of the results" (Isaac and Mitchell, 1971, 147).

Summary

The chapter discussed the procedures of methodology implemented in the research study and examined the limitations. Chapter four will provide an analysis of the data.
Chapter 4

ANALYSIS OF THE DATA

4.1 INTRODUCTION

This chapter consists of three sections. The first section describes the client. In section two, the data obtained from the self anchored scales will be presented and compared with the stages of grieving as outlined in the review of the literature. In the last section, the scores of the three administrations of the four standardized measures will be presented and described.

4.2 DESCRIPTION OF CLIENT

The client was a self referral made to the Bereavement Resources Department of a Canadian Mental Health Association in southwestern Ontario. She was a student in her early twenties who had experienced the death of her father three months prior to seeking out the support of bereavement services. The client had recognized a period of stagnant grief and pursued professional assistance in dealing with her loss.

4.3 ANALYSIS OF DATA

The data was obtained from the two anchored scales as well as the four standardized measures Life Change Index Scale (LCIS),...
As indicated in the literature, the greatest reaction to death will occur shortly after the actual loss. The manifestation of grief will gradually decrease over time. At the time treatment was initiated, the client had been grieving for three months. The initial phases of shock and denial were no longer present. From the client's own description of how she was feeling and reacting she was assessed to be in the early stages of grieving. This period of intense grief demands the most emotional support.

In determining the criteria for the self anchored scales the client developed a list of symptoms at the first session that she was currently exhibiting. Inclusive of those feelings, physical sensations, cognitions and behaviours were crying, feeling empty, headaches, upset stomach and dreams about the deceased. Although these were not the only symptoms experienced by the client throughout the course of treatment, they are congruent with the symptoms experienced in early grieving.

4.4 ANALYSIS OF THE SELF ANCHORED SCALES

By their very nature, the self anchored scales are the clients' own evaluation of the intensity of her thoughts and feelings. As such they provide ongoing feedback to both client and researcher with information regarding the progress of treatment. Consequently, the best way to analyze such data would usually be to examine the frequency of occurrence, the duration of particular symptoms and
the period of treatment or phase of mourning in which they were exhibited.

4.5 SELF ANCHORED SCALE OF EMOTIONAL RESPONSE TO BEREAVEMENT

Through implementation of this scale, the client rated herself on a daily basis with regard to three key areas identified by the client as problematic: (1) feelings of helplessness and panic; (2) feelings of depression and sadness, and (3) feelings of guilt. (See Figure 1.)

The client described helplessness and panic as stemming from apprehension of the unknown thereby giving rise to a sense of vulnerability and heightened emotional and physical arousal which exacerbated feelings of helplessness.

Feelings of depression and sadness result from disorganized behaviour often apparent after a loss. Depression, in this instance, was more appropriately described as sadness, withdrawal, feelings of meaninglessness, loneliness.

Guilt centred around the circumstances of the death. The client experienced guilt related to their relationship with the deceased, the fact that they are still alive and not the deceased and feeling angry at the deceased for leaving them and the family.

During the first two weeks of treatment, as shown in figure one, the greatest amount of variation occurred in each of the three areas: helplessness, depression, and guilt. The first day of each week begins on a Saturday. In both week one and two, all three areas show marked fluctuation of one to five degrees on a near
daily basis. These fluctuations are consistent with one another. It was also evident that midweek (on Tuesday) all three areas show a marked decline. The client verbalized a wide range of feelings she experienced during this time period including boredom, discomfort, preoccupation, lack of interest and concentration, fear of being alone and lethargy. The literature supports the client’s experience of myriad emotions varying in intensity during the initial stages of grieving.

The beginning of week three, which is the second week of treatment, there appeared to be a levelling off in all three areas with less erratic change in each area occurring on a frequent basis. The client described what she felt to be a change in her perspective about the death admitting to feelings of anger, loneliness and dependency but not feeling responsible for the death and less guilty about being a survivor.

In week four, feelings of guilt had diminished to infrequent occurrences, feelings of helplessness had stabilized to a high rate of occurrence as had feelings of depression. She indicated she felt unhappy, discontented and had little energy. She ventilated frustration about the lack of support she felt from friends and school mates. As school was drawing to a close end and examinations began she experienced additional stress and frustration finding it difficult to concentrate subsequently increasing her level of anxiety.

Beginning at the end of week four and extending through to the end of week eight, the level of guilt is recorded by the client
as occurring rarely, if ever. This five week period included a three week period where treatment was interrupted when the client returned to their father's homeland for a family memorial and burial service. According to Worden (1982) guilt is common in the initial stages of grief and is generally resolved over time through reality testing. There is a minimal increase in the rating of guilt feelings at the beginning of the tenth week when treatment resumed after the client's return from the memorial service and again a slightly higher rating at the end of that week. In discussing this occurrence with the client she could not attribute this change to anything in particular.

At the midway point in week four, the areas of depression and helplessness began a pattern that remained similar through the remainder of treatment. These levels generally continued to occur on a "frequent" to "all the time" basis and to fluctuate concurrently. No significant change in circumstance is recorded by the client as not occurring during that six week period suggesting no specific source for those feelings.

As noted in the review of the literature, each individual will grieve in an individualized way. No pattern of grief is intentional. It is not unusual for an individual to experience a constant feeling of depression or helplessness over a period of time which does not vary greatly in its intensity as these feeling have a variety of origins.

By charting the mean and standard deviation of each of the
three components calculated on a weekly basis, the components can be compared over the eleven week period of treatment.

After the first week of treatment the weekly mean score of feelings of guilt was 3.3 (infrequently) and descended in the next four weeks to 3.0, 2.7, 2.4, and 1.0 respectively where the score steadied at 1.0 until week nine. At week ten the weekly mean score for guilt rose to 1.6 and at week eleven was 1.14.

The standard deviation scores for guilt began with 1.24 at week one, rising to 2.5 at week two and dropping markedly to 0.24 and 0.48 in weeks three and four respectively. Weeks five, six, seven, eight and nine had a consistent score of 0. Weeks ten and eleven had decreased scores of 0.63 and 0.14.

The pattern of decreasing scores for both weekly mean and standard deviation support the literature indicating diminishing guilt over time as reality testing comes into play.

The mean scores for depression and helplessness showed comparable peaks and valleys over the eleven week period as listed below.
Table 1
Mean of Daily Scores by Week of Treatment
Using Self Anchored Scale of Emotional Response to Bereavement

<table>
<thead>
<tr>
<th>Week</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helplessness</td>
<td>3.6</td>
<td>3.4</td>
<td>4.7</td>
<td>3.7</td>
<td>4.3</td>
<td>4.8</td>
<td>5.0</td>
<td>5.0</td>
<td>4.0</td>
<td>3.6</td>
<td>3.8</td>
</tr>
<tr>
<td>Depression</td>
<td>4.4</td>
<td>4.4</td>
<td>4.7</td>
<td>4.1</td>
<td>4.6</td>
<td>4.8</td>
<td>4.3</td>
<td>4.1</td>
<td>4.3</td>
<td>3.6</td>
<td>3.7</td>
</tr>
<tr>
<td>Guilt</td>
<td>3.3</td>
<td>3.0</td>
<td>2.7</td>
<td>2.1</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>1.6</td>
<td>1.1</td>
</tr>
</tbody>
</table>

Scale 1 = rarely, if ever 5 = frequently
2 = very infrequently 6 = very frequently
3 = infrequently 7 = all the time
4 = neutral

The scores for standard deviation share a similar pattern for each of the three components. They depict a general decline from week one through five, an increase at week six and a decline at week seven. At week eight, helplessness increases slightly and levels off until week ten, then declining at week eleven. The depression scale had a marked increase in score from week eight to nine and a marked decline to week ten and a further slight decline at week eleven.

Table 2
Standard Deviation Scores Calculated by Week of Treatment
Using Self Anchored Scale of Emotional Response to Bereavement

<table>
<thead>
<tr>
<th>Week</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helplessness</td>
<td>3.29</td>
<td>1.95</td>
<td>.57</td>
<td>.04</td>
<td>.90</td>
<td>2.47</td>
<td>.33</td>
<td>.67</td>
<td>.67</td>
<td>.62</td>
<td>.14</td>
</tr>
<tr>
<td>Depression</td>
<td>1.96</td>
<td>.95</td>
<td>.90</td>
<td>.48</td>
<td>.29</td>
<td>1.14</td>
<td>.90</td>
<td>.48</td>
<td>1.84</td>
<td>.29</td>
<td>.24</td>
</tr>
<tr>
<td>Guilt</td>
<td>1.24</td>
<td>2.50</td>
<td>.24</td>
<td>.48</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>.63</td>
<td>.14</td>
</tr>
</tbody>
</table>

Scale 1 = rarely, if ever 5 = frequently
2 = very infrequently 6 = very frequently
3 = infrequently 7 = all the time
4 = neutral
4.6 **Self Anchored Scale of Behaviour and Physical Response to Bereavement**

The second self anchored scale identified particular characteristics of grief as were experienced by the client and which were divided into three categories (emotional release, physical distress and illusion). The categories were derived from the literature and incorporated with a bereavement evaluation form created by the Canadian Mental Health Association. The client monitored the frequency with which she experienced these three individual characteristics. Also recorded during the baseline were the highest occurrences of crying and feeling empty.
Figure 1

Intensity of Feelings of Guilt, Depression and Helplessness as Self Rated by Client on a Daily Basis
### SELF ANCHORED SCALE
of Behavioural and Physical Response to Bereavement

#### Weekly Frequency of Identified Characteristics of Grief

<table>
<thead>
<tr>
<th>CHARACTERISTIC</th>
<th>WEEK</th>
</tr>
</thead>
<tbody>
<tr>
<td>i) Emotional Release</td>
<td>1 2 3 4 5 6 7 8 9 10 11</td>
</tr>
<tr>
<td>Crying</td>
<td>6 3 1 3 3 5 3 2 2</td>
</tr>
<tr>
<td>Irritable</td>
<td>3</td>
</tr>
<tr>
<td>Restless</td>
<td>4 5 4 4 6 2 3 2</td>
</tr>
<tr>
<td>Lack of concentration</td>
<td>4</td>
</tr>
<tr>
<td>Anxious</td>
<td>3</td>
</tr>
<tr>
<td>Sadness</td>
<td>2</td>
</tr>
<tr>
<td>Depression</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ii) Physical Distress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sighing</td>
</tr>
<tr>
<td>Empty feeling in stomach</td>
</tr>
<tr>
<td>Upset stomach</td>
</tr>
<tr>
<td>Headache</td>
</tr>
<tr>
<td>Lethargy</td>
</tr>
<tr>
<td>Panic</td>
</tr>
<tr>
<td>Nausea</td>
</tr>
<tr>
<td>Sleeplessness</td>
</tr>
<tr>
<td>Tightness in chest</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>iii) Illusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visual</td>
</tr>
<tr>
<td>Dreams</td>
</tr>
</tbody>
</table>

i) Emotional Release.

According to the literature, crying often occurs when the bereaved recalls the lost person. Crying serves a cathartic function and brings a sense of relief. Just as a child cries to attract and recover their primary caretaker, it is believed that this same objective, to recover the lost person, occurs either consciously or unconsciously in grief as well (Bowlby, 1980, 90).

65
During the baseline the client documented the highest occurrences of crying and feeling empty.

Over the next five weeks before the interruption of treatment for three weeks, the frequency of crying occurred on an average of 2.2 times per week. The first week of vacation was marked by the second highest number throughout treatment and gradually diminished to the previous average of 2.4 times per week and occurred only one time in the last week of treatment. It is not surprising to have the frequency of crying increase during the first week of vacation when the client re-lived the death and the funeral ceremonies.

The emotional release identified by the client as restlessness is not recorded as occurring in the first week yet in the next five week period prior to the three week absence from treatment, it was recorded on an average of 4.6 times a week. It was absent during the first two weeks of vacation and reappeared in the last week of vacation and the last two weeks of treatment (average of 2.9 per week). The client indicated that the two week absence of feeling restless during her vacation may have been due to the business of events during that time period. As the "vacation" came to a close and there was a decrease in events, she reported feeling more restless.

Lindeman (1944) described restlessness as an "inability to sit still, moving about in an aimless fashion, continually searching for something to do." The clients' search for something to do generally fails because what they can do is not what they want to do. They cannot find the lost person. "Restlessness is part of
this alarm reaction (and is) also associated with anger." (Parker, 1972, 66)

ii) Physical Distress

With the exception of two weeks, the client experienced headaches on a frequent basis with the most occurrences in week one an increase occurring during the first two weeks of "vacation" and a marked decrease during the following three weeks which were the last three weeks of treatment. According to Parkes, almost always health suffers during bereavement. Headaches, anxiety, tension and fatigue are very common.

iii) Illusions

Dreams related to the deceased occurred on a sporadic basis and ceased after week five with the exception of one occurrence during the client's vacation. This may have been the result of a resurgence of memories brought on by the visitation with relatives and the memorial service. The literature indicated the dreams are an attempt at recovery of the lost person. Hadfield (1954) describes dreaming as a problem solving behaviour, a process of recreating and reliving the mental images that occupy the bereaved during waking hours. The dreams have a vivid and realistic quality and are happy as well. But as in her waking hours, the dreamer awakes to find that the lost object is not recovered.
4.7 **ANALYSIS OF STANDARDIZED MEASURES**

The standardized measures were administered at four key periods during treatment; the beginning of baseline, the end of baseline, prior to the interruption of treatment when the client attended a memorial service for the deceased and at the termination of treatment. The scores obtained are shown in Table 3.

<table>
<thead>
<tr>
<th>Standardized measure</th>
<th>Week 1</th>
<th>Week 2</th>
<th>Week 6</th>
<th>Week 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Test 1</td>
<td>Test 2</td>
<td>Test 3</td>
<td>Test 4</td>
<td></td>
</tr>
<tr>
<td>Mid-Baseline</td>
<td>Baseline</td>
<td>Interruption</td>
<td>Treatment</td>
<td></td>
</tr>
<tr>
<td>Life Change Index</td>
<td>306</td>
<td>296</td>
<td>325</td>
<td>287</td>
</tr>
<tr>
<td>Index of Peer Relations</td>
<td>21</td>
<td>15</td>
<td>21</td>
<td>22</td>
</tr>
<tr>
<td>Generalized Contentment Scale</td>
<td>59</td>
<td>59</td>
<td>55</td>
<td>56</td>
</tr>
<tr>
<td>Index of Family Relations</td>
<td>50</td>
<td>56</td>
<td>54</td>
<td>50</td>
</tr>
</tbody>
</table>

1) **Life Change Index Scale (LCI)**

The Life Change Index scale translates the total score in terms of life change units. A score of 300 or over indicates a major life crisis level with an eighty per cent chance of illness (Aero and Weiner, 1981, 46). The probability of illness is also dependent upon how the individual deals with stress as it arises.

A score of between 200 and 299 indicates a moderate life crisis level with a fifty per cent chance of illness (Aero and Weiner, 1981, 46).
In analyzing the scores of the first two administrations of the LCI scale there is only a ten point difference between the scores. The second, lower score falls into the category of a moderate life crisis which indicates a reduction in the chance of illness by thirty percent from the category of major life crisis. This decrease occurs before the baseline period during which time treatment has not yet commenced. In LCI (Test 1), the client rated the death of a close friend as a significant factor, which she did not rate in any other administration. This rating increases the total score by thirty-six points. In LCI (Test 2) the client indicated ceasing formal schooling. Scoring this event increases the total score by twenty-six points. These two events account for the ten point difference in the two scores.

Between LCI (Test 2) and LCI (Test 3) there is a twenty-nine point spread. The difference lies in the indication that additional stressors have occurred from the beginning of week two until week six when vacation begins (major business readjustment, revision of personal habits and vacation). Two stressors were removed (ceasing formal schooling and major change in working hours).

From LCI (Test 3) to LCI (Test 4), there is the most significant spread of thirty-eight points. This was precipitated by the removal of only one stressor (a major business readjustment).

In comparing LCI (Test 1) to LCI (Test 4), there is a nineteen point decrease, moving from the highest chance of illness (eighty percent) in a major life crisis to a moderate life crisis with a fifty percent chance of illness.
2) **Index of Peer Relations (IPR)**

The four scores obtained from the IPR scale all fall in the range 0-30 indicative of below average scores (Aero and Weiner, 1981, 165). The score range is not significant and indicates comfort with the present peer group and a high level of satisfaction. The peer group serves as a source of emotional support and personal reward.

These relatively consistent scores are congruent with the clients' acknowledgement that their peer group has been a strong source of support and there is the absence of peer related difficulties.

3) **Generalized Contentment Scale (GCS)**

Generalized Contentment Scale (GCS) scores are very similar throughout treatment. This scale measures "feelings about a number of behaviours, attitudes, events, affect states and conjunctions that are associated with depression" (Aero and Weiner, 1981, 133). Scores of between thirty and one hundred represent above average scores and are highly related to complaints of depression. Scores in the lower part of this range, similar to those obtained by the client, indicate an awareness of the depressive feelings and behaviours and may have stemmed from acute life concerns (Aero and Weiner, 1980). These scores match with the client's self-rated levels of depression of the self anchored scales.
4) **Index of Family Relations (IFR)**

The Index of Family Relations measures the way you feel about your family as a whole. When a family is experiencing grief, the family situation can be a source of stress and frustration (Aero and Weiner, 1981, 133). The four scores show little variation (50, 56, 54, 50) and in fact, IFR Test (1) and IFR Test (4) have the same score. Scores of between thirty and one hundred are considered high. The higher the score, the more dissatisfaction being reported. It is not uncommon for families to lose their homeostatic balance and cohesiveness during a time of crisis thereby lessening a source of support.

4.8 **ANALYSIS OF RESEARCH HYPOTHESES**

This section will review the main hypothesis as well as the three sub-hypotheses in terms of the statistical analysis performed and the results which were obtained.

The main hypothesis was:

There will be a healthy completion of the tasks of grieving within a reasonable time frame associated with the individual's participation in an individual bereavement counselling program.

A t-test of significant difference between means was conducted in order to determine if there was a significant difference between scores on levels of depression, helplessness and guilt obtained at three key points in the following combinations:
1. at the beginning of baseline prior to treatment (week one) and at mid-baseline which was also prior to the beginning of treatment (week two),

2. at the beginning of treatment (week two) and at the interruption of treatment (week six), and

3. at the beginning of treatment (week two) and at the end of treatment (week ten).

As directionality was stated, a one tailed test was used in all instances. The confidence level was set at .05 level.

With respect to the first subhypothesis, the following results were found.

1. There will be a positive change in the levels of stress, depression and in the attitude toward family and peer relations.

The score obtained for the change in depression from the beginning of treatment to termination of treatment was $t(12) = 2.0, p < .05$. This was significant at the .05 level.

Also, the Generalized Contentment Scale scores decreased from 59 at the beginning of treatment to 55 at the termination of treatment.

Therefore it can be stated that there was evidence of a positive change in the level of depression.

The Life Change Index Scale scores decreased from 296 at the
beginning of treatment to 287 at termination indicating evidence of a positive change in the level of stress.

The Index of Peer Relations shows a score of 15 at the beginning of treatment and a score of 21 at termination indicating no positive change in attitude toward peer relations.

The Index of Family Relations shows a slight decrease in scores from the beginning of treatment with a score of 56 to termination with a score of 54 indicating a positive change in attitude toward family relations.

Based on these findings and information the first subhypothesis was accepted.

With respect to the second subhypothesis, the following results were found.

2. There will be a lessening in the intensity of those problems identified by the client as characteristic of the grieving individual associated with their participation in the program.

The score obtained for the change in feelings of guilt from the beginning of treatment to the interruption of treatment was $t(12) = 4.0, p < .05$. This was significant at the .005 level. Also, the score obtained for the change in feelings of guilt from the beginning of treatment to the end of treatment was $t(12) = 1.92, p < .05$. This was significant at the .05 level.

The score obtained for the change in feelings of depression
from the beginning of treatment to the end of treatment was \( t(12) = 2.0, p < .05 \). This was significant at the .05 level.

The score obtained for the change in feelings of helplessness from the beginning of treatment to the end of treatment was \( t(12) = -0.33, p > .05 \). This was not significant at the .05 level.

The frequency of occurrences for the variables of emotional release, physical distress and illusion indicated a decrease in each category from the beginning of treatment to termination of treatment.

There is evidence of positive change in the lessening in the intensity of the characteristics of grieving identified by the client with the exception of feelings of helplessness. Therefore the second sub-hypothesis was accepted.

With respect to the third sub-hypothesis, the following results were found.

3. Participation in the program will be perceived as helpful.

The client verbalized the importance of the availability of and participation in a bereavement counselling program stating that ongoing support, encouragement and education were important to the healthy completion of the grieving process. The client felt that bereavement counselling afforded her the opportunity to discuss those issues which were impeding her ability to grieve successfully. It provided her with information which helped her understand and accept her feelings as normal and meaningful. Based on the client's
perception of her participation in the program as being helpful, the third subhypothesis was accepted.

Through the provision of data which supports the acceptance of the three subhypotheses, the main hypothesis can be accepted. Therefore it is accepted that:

There will be a healthy completion of the tasks of grieving within a reasonable time frame associated with the individual's participation in an individual bereavement counselling program.

This chapter described the population used in the study and the research hypotheses were analyzed and presented. The final chapter will deal with the conclusion, summary and recommendations of the study.
5.1 SUMMARY

The purpose of this study was to assess the effectiveness of an individual bereavement counselling program with a young adult. The conclusions were based upon evidence of a positive change in the levels of depression, stress and attitude toward family and peer relationships as well as successful completion of the tasks of mourning. The client population consisted of a young adult female who was a self-referred, voluntary client to a mental health agency in southwestern Ontario. The client had experienced the death of her father three months prior to intervention.

The literature was reviewed and topics relevant to the research project were discussed. These topics were: the theory of attachment and bonding, family and peer relationships, normal grief reactions, phases and stages of bereavement, four tasks of mourning and bereavement counselling.

In order to be of help, the mental health practitioner must identify and address the complex phenomenon of bereavement. The research conducted by Eric Lindemann in the early 1940's followed by the contributions of Colin Murray Parkes has helped unravel the problems of grief and mourning. Aaron Lazare (1979) estimated that 10 to 15 percent of patients who have passed through the
mental health clinics of Massachusetts General Hospital were diagnosed with an unresolved grief reaction. This phenomenon is supported by Bowlby (1980) who believes "that much psychiatric illness is an expression of pathological mourning" (23).

A number of studies exemplify the impact of grief on morbidity and mortality. Grief aggravated both physical and psychiatric morbidity and according to Parkes (1972) bereaved people tend to die more readily than the non-bereaved and newly bereaved people consult their doctors more often than they did before bereavement (31-35).

Since many bereaved people are surprised and frightened by the intensity of their emotions during bereavement, it is important for them to obtain reassurance that they are not going mad, that such feelings are natural, crying is not indicative of a nervous breakdown and the counsellor is not alarmed or frightened by their grief (Parkes, 1972,193). Just as it is important for the bereaved to know what is normal, it is also important for the mental health practitioner to identify the symptoms and provide treatment for the bereaving individual.

According to Parkes (1972), grief is at its height when the funeral is over, the family and friends have dispersed and the bereaved is left alone. It is at this point that intervention is perceived to be most helpful thereby facilitating healthy completion of the grieving process. If help is given at a time when pathological patterns of thought and behaviour may be developing, it
is more likely to be accepted and effective than help given after the pathological patterns have become secured (207).

The method to evaluate the effectiveness of individual bereavement counselling was a single system design. The data collection instruments included four standardized measures and two self anchored scales. The Index of Family Relations, Index of Peer Relations and Generalized Contentment Scale were developed by Walter Hudson (1982). The Life Change Scale was developed by Thomas Holmes (1967) (see Appendices A, B, C, D, E, and F). The two self anchored scales were developed by the researcher utilizing information obtained in the literature as well as from the client to measure emotional responses related to bereavement and behaviour and physical responses related to bereavement. The client rated herself on a daily basis throughout the eleven week study. In addition qualitative data was collected in the form of interview notes recorded during each session.

5.2 CONCLUSION

The researcher found that at the conclusion of treatment, the client's level of stress indicated a positive change. The sources of stress experienced by the client related to negative as well as positive experiences. Selye (1980) indicated that the individual must be aware of the impact of positive as well as negative life changes. It is also important to recognize how the individual responds to and copes with change.
The client showed a positive change in the levels of depression and guilt which were statistically significant. Depression is a common symptom expected to be found in a bereaved individual. Parkes (1983) states that the absence of depression after bereavement is considered "abnormal". Lindemann (1944) indicates that two thirds of the patients in his study had ideas of guilt or self blame in relation to the deceased. Parkes (1972) reports that guilt diminishes as the tasks of mourning are completed.

The client's level of family satisfaction showed a slight positive change from the beginning of treatment to termination. According to Parkes (1972,124), when a family loses a member the social system may break up. There is an upset in the homeostatic balance which can result in a loss or shift in family roles. This significant source of support is often lost and obtained elsewhere.

According to the scores obtained on the Index of Peer Relations at the beginning of treatment to termination, the client's level of peer satisfaction did not show a positive change as a result of bereavement counselling. Yet, the client identified her peer group as her source of emotional support and perceived the relationships as healthy and mutually satisfying. As noted by Caplan (1974), this support system provides feedback and support and assists with tasks. On the contrary, some authors (Walker, McBride and Vachone, 1977) believe one group cannot be exclusively supportive in a crisis situation as to meet the individual's diversity of needs.
On the basis of the findings which are in support of the three subhypotheses, the main hypothesis was accepted.

5.3 RECOMMENDATIONS

The following recommendations made for bereavement counselling are based on the review of the literature and the research findings and should be considered within the context of those limitations. They are divided into the following areas:

1. Social work services
2. Community services
3. Suggestions for future research.

5.3.1 SOCIAL WORK SERVICES

1. The review of the literature and research findings indicate that some individuals are at high risk of not successfully completing the bereavement process. It would seem advantageous to formulate a set of predictors to determine who is at risk and provide appropriate intervention for those individuals. The set of predictors should include an assessment of the individual's attitude toward death and acceptance of their own mortality and death.

2. Although the goals of bereavement counselling are specific, the means to achieve the goals must be aligned to the individual's own experience of bereavement.

3. Some level of bereavement counselling should be considered for all individuals who experience a loss. It would seem advantageous to utilize the benefits of self help groups and networking.
in conjunction with individual counselling to meet the needs of bereaving individuals.

5.3.2 COMMUNITY SERVICES

1. Community professionals involved with individuals (such as doctors, mental health workers, social workers, teachers, lawyers and funeral directors) who are anticipating a loss or who have suffered a loss should develop and have an understanding of a humane and consistent treatment approach. Such a concerted effort may lead to early identification and intervention for those bereaved individuals who are having difficulty successfully completing their grief work.

2. Community professionals should be encouraged to offer preventative information on bereavement to their clients who are anticipating or experiencing a loss.

3. It is not necessary to establish a whole new profession of bereavement counsellors. We require more thought, sensitivity and activity concerning the issue of bereavement on the part of existing professionals.

5.3.3 SUGGESTIONS FOR FURTHER RESEARCH

1. There should be further research to establish a profile of the bereaved individual who is at risk of not successfully completing their grief work.
2. This study should be replicated but using a control group and a larger sample. Such research will likely provide data of greater generalizability.

3. There should be further research on the effectiveness of bereavement counselling programs. Longitudinal research would provide data which would help ensure more effective service.

4. There should be further research to evaluate the effectiveness of self help groups for bereaving individuals.

5. There should be further research to develop an instrument to measure specific problems related to bereavement. Such an instrument would assist the researcher-practitioner in determining with whom bereavement counselling should be utilized and when treatment should be terminated.

This study examined the effectiveness of bereavement counselling on the levels of stress, depression and attitudes toward family and peer relations of a grieving individual. The final chapter summarized the research, presented conclusions and provided recommendations.
Life Change Index Scale

by Thomas Holmes

Look over the events listed in the Life Change Index Scale. Place a check (✓) in the space next to a given event if it has happened to you within the last twelve months. Turn the page to find your score.

1. Death of spouse
2. Divorce
3. Marital separation from mate
4. Detention in jail or other institution
5. Death of a close family member
6. Major personal injury or illness
7. Marriage
8. Being fired at work
9. Marital reconciliation
10. Retirement from work
11. Major change in the health or behavior of a family member
12. Pregnancy
13. Sexual difficulties
14. Gaining a new family member (e.g., through birth, adoption, oldster moving in, etc.)
15. Major business readjustment (e.g., merger, reorganization, bankruptcy, etc.)
16. Major change in financial state (e.g., either a lot worse off or a lot better off than usual)
17. Death of a close friend
18. Changing to a different line of work
19. Major change in the number of arguments with spouse (e.g., either a lot more or a lot less than usual regarding child-rearing, personal habits, etc.)
20. Taking on a mortgage greater than $10,000 (e.g., purchasing a home, business, etc.)
21. Foreclosure on a mortgage or loan
22. Major change in responsibilities at work (e.g., promotion, demotion, lateral transfer)
23. Son or daughter leaving home (e.g., marriage, attending college, etc.)
24. In-law troubles
25. Outstanding personal achievement
26. Spouse beginning or ceasing work outside the home
27. Beginning or ceasing formal schooling
28. Major change in living conditions (e.g., building a new home, remodeling, deterioration of home or neighborhood)
29. Revision of personal habits (dress, manners, associations, etc.)
30. Troubles with the boss
31. Major change in working hours or conditions
32. Change in residence
33. Changing to a new school
34. Major change in usual type and/or amount of recreation
35. Major change in church activities (e.g., a lot more or a lot less than usual)
36. Major change in social activities (e.g., clubs, dancing, movies, visiting, etc.)
37. Taking on a mortgage or loan less than $10,000 (e.g., purchasing a car, TV, freezer, etc.)
38. Major change in sleeping habits (a lot more or a lot less sleep or change in time of day when asleep)
39. Major change in number of family get-togethers (e.g., a lot more or a lot less than usual)
40. Major change in eating habits (a lot more or a lot less food intake, or very different meal hours or surroundings)
41. Vacation
42. Christmas
43. Minor violations of the law (e.g., traffic tickets, jaywalking, disturbing the peace, etc.)

Index of Family Relations

by Walter W. Hudson

This questionnaire is designed to measure the way you feel about your family as a whole. It is not a test so there are no right or wrong answers. Answer each item as carefully and accurately as you can by placing a number beside each one as follows:

1 = Rarely or none of the time
2 = A little of the time
3 = Some of the time
4 = A good part of the time
5 = Most or all of the time

1. The members of my family really care about each other.
2. I think my family is terrific.
3. My family gets on my nerves.
4. I really enjoy my family.
5. I can really depend on my family.
6. I really do not care to be around my family.
7. I wish I was not part of this family.
8. I get along well with my family.
9. Members of my family argue too much.
10. There is no sense of closeness in my family.
11. I feel like a stranger in my family.
12. My family does not understand me.
13. There is too much hatred in my family.
14. Members of my family are really good to one another.
15. My family is well respected by those who know us.
16. There seems to be a lot of friction in my family.
17. There is a lot of love in my family.
18. Members of my family get along well together.
19. Life in my family is generally unpleasant.
20. My family is a great joy to me.
21. I feel proud of my family.
22. Other families seem to get along better than ours.
23. My family is a real source of comfort to me.
24. I feel left out of my family.
25. My family is an unhappy one.
Generalized Contentment Scale
by Walter W. Hudson

This questionnaire is designed to measure the degree of contentment that you feel about your life and surroundings. It is not a test, so there are no right or wrong answers. Answer each item as carefully and accurately as you can by placing a number beside each one as follows:

1 = Rarely or none of the time
2 = A little of the time
3 = Some of the time
4 = A good part of the time
5 = Most or all of the time

1. I feel powerless to do anything about my life.
2. I feel blue.
3. I am restless and can't keep still.
4. I have crying spells.
5. It is easy for me to relax.
6. I have a hard time getting started on things that I need to do.
7. I do not sleep well at night.
8. When things get tough, I feel there is always someone I can turn to.
9. I feel that the future looks bright for me.
10. I feel downhearted.
11. I feel that I am needed.
12. I feel that I am appreciated by others.
13. I enjoy being active and busy.
14. I feel that others would be better off without me.
15. I enjoy being with other people.
16. I feel it is easy for me to make decisions.
17. I feel downtrodden.
18. I am irritable.
19. I get upset easily.
20. I feel that I don't deserve to have a good time.
21. I have a full life.
22. I feel that people really care about me.
23. I have a great deal of fun.
24. I feel great in the morning.
25. I feel that my situation is hopeless.

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Index of Peer Relations
by Walter W. Hudson

This questionnaire is designed to measure the way you feel about the people you work, play, or associate with most of the time, your peer group. It is not a test so there are no right or wrong answers. Answer each item below as carefully and as accurately as you can by placing a number beside each one as follows:

1 = Rarely or none of the time
2 = A little of the time
3 = Some of the time
4 = A good part of the time
5 = Most or all of the time

1. I get along very well with my peers.
2. My peers act like they don’t care about me.
3. My peers treat me badly.
4. My peers really seem to respect me.
5. I don’t feel like I am “part of the group.”
6. My peers are a bunch of snobs.
7. My peers really understand me.
8. My peers seem to like me very much.
9. I really feel “left out” of my peer group.
10. I hate my present peer group.
11. My peers seem to like having me around.
12. I really like my present peer group.
13. I really feel like I am disliked by my peers.
14. I wish I had a different peer group.
15. My peers are very nice to me.
16. My peers seem to look up to me.
17. My peers think I am important to them.
18. My peers are a real source of pleasure to me.
19. My peers don’t seem to even notice me.
20. I wish I were not part of this peer group.
21. My peers regard my ideas and opinions very highly.
22. I feel like I am an important member of my peer group.
23. I can’t stand to be around my peer group.
24. My peers seem to look down on me.
25. My peers really do not interest me.

SELF ANCHORED SCALE OF
FEELINGS RELATED TO BEREAVEMENT

WEEK # ______ DATE: __________

Feelings of Helplessness and Panic -- H
Depression/Sadness -- D
Feelings of Guilt -- G

RATING: 1 -- rarely if ever
2 -- very infrequently
3 -- infrequently
4 -- neutral
5 -- frequently
6 -- very frequently
7 -- all the time

INTENSITY

7
6
5
4
3
2
1

DAY 1 2 3 4 5 6 7
## SELF ANCHORED SCALE OF
## BEHAVIOURS AND PHYSICAL RESPONSES
## RELATED TO BEREAVEMENT

<table>
<thead>
<tr>
<th>DAY</th>
<th>ONE</th>
<th>TWO</th>
<th>THREE</th>
<th>FOUR</th>
<th>FIVE</th>
<th>SIX</th>
<th>SEVEN</th>
</tr>
</thead>
</table>

### EMOTIONAL RELEASE
- Crying
- Screaming
- Wailing
- Other (specify)
- Other (specify)

### PHYSICAL DISTRESS
- Tightness in chest
- Shortness of breath
- Sighing
- Empty feelings in stomach
- Lethargy
- Upset stomach
- Other (specify)
- Other (specify)

### ILLUSIONS
- Visual
- Auditory
- Dreams
- Other (specify)
- Other (specify)
BIBLIOGRAPHY


