

**BEREAVEMENT COUNSELLING IN NORTHERN IRELAND
AND UGANDA: A COMPARATIVE QUALITATIVE STUDY OF
PROFESSIONAL THERAPISTS' PERSPECTIVES**

Thesis submitted for the degree of
Doctor of Philosophy
at the University of Leicester

by

Lorna Montgomery MA
Vaughan Centre for Lifelong Learning
University of Leicester

2015

Abstract

Bereavement counselling in Northern Ireland and Uganda: a comparative qualitative study of professional therapists' perspectives

Lorna Montgomery

The conceptual analysis and empirical research presented in this thesis explores bereavement counselling in two settings. It compares the organisation, function, practices and belief systems characteristic of bereavement counselling in Northern Ireland, a province within the United Kingdom, and the Sub-Saharan African country of Uganda. In total, 41 qualitative interviews (38 informants) were conducted with bereavement counsellors across settings, exploring their perceptions and experiences. These were thematically analysed. The findings focused on four interweaving issues: the counselling context, the characteristics of counsellors, the characteristics of clients and counselling practices. Secondary data was gathered from desk research and participant observations.

The conceptual framework for this comparison combined a psychological and sociological approach, derived from a comparative analysis of the theories of Sigmund Freud and Norbert Elias. Although Freud has generated the fundamental theoretical assumptions that continue to guide bereavement counselling, Elias's figurational framework ultimately presented a stronger explanation for, and understanding of, the contrasting characteristics of bereavement counselling in the two societies, avoiding the reified and static notions often embedded in so-called 'cross-cultural' research.

An analysis of the findings has provided insights into the chosen theories and into bereavement counselling practices in each setting. In Uganda, Western models of counselling proved to be ethnocentric, because they are based fundamentally on working with Western notions of the presence of an individualised ego. Key features of these models appeared to require adaptation to non-Western settings. In Northern Ireland, counsellors were found to acknowledge the importance of interpersonal factors in bereavement reactions whilst working, almost exclusively, with intrapsychic processes. The levels of complexity of interdependency networks in the two settings appeared to influence counselling processes in substantially different ways.

Acknowledgements

Firstly, I would like to express my gratitude to my two supervisors, Dr Valerie Owen-Pugh and Mr Nick Jewson, for their patience, support, clarity of thought and intellectual insight in steering me through this research. I am grateful also to the Northern Health and Social Care Trust, and Queen's University Belfast, both of whom, as my employers, have supported me to complete this research.

I would also like to acknowledge the 38 informants in Uganda and Northern Ireland who have taken the time to share with me their experiences of supporting others through the loss of a loved one. The richness of those interactions has been the highlight of this study.

I wish also to express my thanks to my husband Gareth and our children Callum, Ellen, Simon and Tara; their patience, love and support have made this research project possible.

Table of Contents

Acknowledgements	ii
List of Tables.....	ix
Abbreviations	x
Chapter 1 The Research Question	1
1.1 Introduction	1
1.2 Arriving at the Research Question: A Personal Journey.....	2
1.3 Defining Key Terms.....	4
1.4 Specifying the Research Question	6
1.5 Northern Ireland and Uganda.....	8
1.6 Outline of the Thesis	12
Chapter 2 Death, Bereavement and Bereavement Counselling in the United Kingdom.....	14
2.1 Introduction	14
2.2 Development of the Literature	14
2.3 Death, Bereavement and Modernity	15
2.4 Bereavement Counselling in the UK.....	20
2.5 The Organisational Context of Bereavement Counselling	23
2.6 Bereavement Counselling: Best Practice Guidelines.....	24
2.7 Death and Bereavement Counselling in Northern Ireland.	28
2.8 Comparative studies of Death and Bereavement Counselling.....	32
2.9 Conclusion	34
Chapter 3 Death, Bereavement and Bereavement Counselling in Uganda	36
3.1 Introduction	36
3.2 Death and Bereavement in Sub-Saharan Africa.....	36
3.3 Bereavement Counselling in Uganda.....	41
3.4 Key Constructs in Attitudes to Death and Bereavement.....	46

3.5	Conclusion	50
Chapter 4	The Conceptual Foundations of Bereavement Counselling: The Legacy of Freud.....	52
4.1	Introduction	52
4.2	Freud's Theory of Mourning and Grief	53
4.3	The Capacity of Freudian Theory to Inform Comparative Societal Analysis.....	57
4.4	A review of Post-Freudian Theories	61
4.4.1	Lindemann and Gorer	61
4.4.2	Bowlby: Attachment theory	63
4.4.3	Parkes: Psychosocial transitions	64
4.4.4	Rubin and Malkinson Two-track model	64
4.4.5	Hagman: Developments in psychotherapy.....	65
4.4.6	Klass: Continuing bonds	66
4.4.7	Neimeyer: Meaning making.....	67
4.4.8	Prigerson and Jacobs, and Holloway: Traumatic grief and Special deaths.....	69
4.4.9	Doka: Disenfranchised grief	70
4.5	Freud's Enduring Legacy: Grief-Work Models.....	71
4.6	Freud's Enduring Legacy: Bereavement Counselling Practice	74
4.7	Conclusion	76
Chapter 5	Sociological Conceptions of Grief: Elias and Figurational Analysis	79
5.1	Introduction	79
5.2	The Sociological Analysis of Grief.....	79
5.3	Figurational Analysis	82
5.4	Sociogenesis and Psychogenesis: Transcending Dichotomies'?	83
5.5	The Figurational Analysis of Social Control	85

5.6	Structural Differentiation and Figural Theory	89
5.7	Critiques of the Civilising Process	92
5.8	Figural Analysis: Emotions, Death and Bereavement	95
5.9	Figural Analysis: Bereavement Counselling.....	97
5.10	The Interpretive Value of Eliasian and Freudian Theory.....	100
5.11	Conclusion	104
Chapter 6	Research Design and Methodology	105
6.1	Research Questions	105
6.2	Research Design: Issues and Debates	105
6.3	Rationale for the theoretical framework	110
6.4	Methodology	111
6.5	Desk Research.....	115
6.6	Participant Observation.....	116
6.7	Semi-structured Interviews: Sample Selection	117
6.8	Pilot Study.....	120
6.9	Interviews.....	121
6.10	Interpretation of the Data	123
6.11	Ethical Considerations	127
6.12	Reflexivity.....	128
6.13	Conclusion	132
Chapter 7	Findings: Counselling Context.....	133
7.1	The Wider Societal Context of Counselling in Uganda and NI.....	133
7.2	The Local Societal Context of Counselling in Uganda and NI.....	139
7.2.1	The Role Played by Local Communities	139
7.2.2	The Decline of the Community.....	147
7.3	Reflective summary: Counselling context.	151
7.4	Conclusion	152
Chapter 8	Findings: The Characteristics of Counsellors	155

8.1	Demographic Characteristics	155
8.2	Motivations for Becoming a Counsellor	157
8.3	Counsellor Goals	158
8.4	Personal Impact	161
8.5	Models of Intervention	166
8.6	Reflective summary: Counsellor characteristics	167
8.7	Conclusion	169
Chapter 9	Findings: Characteristics of Bereaved Clients	171
9.1	Informant Perceptions: Demographic Characteristics of Clients	171
9.2	Informant Perceptions: Referral Careers of Clients	173
9.3	Informant Perceptions: Reasons for Bereaved Clients to Seek Help	175
9.4	Reflective summary: Client characteristics	188
9.5	Conclusion	189
Chapter 10	Findings: Counselling Practice	191
10.1	Counselling Routines	191
10.2	Counselling Practice: Presenting Problems and Counsellor Interventions	197
10.2.1	Financial Issues	198
10.2.2	Behavioural Issues	198
10.2.3	Physical Symptoms	199
10.2.4	Relational Issues	199
10.2.5	Emotional Issues	199
10.2.6	Spiritual Issues; Making Sense of the Loss	206
10.3	Counselling Dynamics	210
10.4	Reflective summary: Bereavement Counselling	217
10.5	Conclusion	219
Chapter 11	Discussion and Conclusions	222
11.1	The Research Questions	222

11.2	The Context of Bereavement Counselling: An Overview of Findings	223
11.3	Characteristics of Bereavement Counsellors: An Overview of Findings	224
11.4	Characteristics of Clients: An Overview of Findings	225
11.5	The Practice of Bereavement Counselling: An Overview of Findings	226
11.6	Application of Findings: Comparative Dimensions of Death and Dying	228
11.7	The Heuristic Value of Freudian and Post-Freudian Theory	232
11.8	The Heuristic Value of Eliasian Theory.....	236
11.9	Contribution to Bereavement Counselling: Uganda	241
11.10	Contribution to Bereavement Counselling: Northern Ireland.....	244
11.11	Impact of Armed Political Conflict.....	246
11.12	Contribution to Bereavement Counselling in Pluralistic Societies	248
11.13	Limitations and Further Areas for Research	251
11.14	Conclusion and Personal Statement	253
	Glossary	255
	Appendix A: Interview Questions for Ugandan Counsellors	260
	Appendix B: Interview Questions for NI Counsellors	266
	Appendix C: Desk Research, Uganda	270
	Appendix D: Desk Research, NI.....	272
	Appendix E: Participant Observation Record	277
	Appendix F: Journal Extracts, Uganda	278
	Appendix G: Journal Extracts, NI.....	284
	Appendix H: Informant Biographies	285
	Appendix I: Research Ethics Approval Form: University of Leicester	295
	Appendix J: Research Ethical Approval Letter: NHS Northern Ireland	296

Appendix K: Research Information and Consent Forms: Northern Ireland	297
Appendix L: Research Information and Consent Forms: Uganda	300
Bibliography	302

List of Tables

Table 1: Contrasting perspectives in the management of death and bereavement	46
Table 2: The application of Freudian theory to Ideal Type Dimensions in the Management of Death and Bereavement	59
Table 3: Evaluation of Eliasian and Freudian theories of death and bereavement ..	101
Table 4: Demographic characteristics of informants	119
Table 5: The wider societal context of counselling	134
Table 6: Informant perceptions: the local societal context of counselling.....	139
Table 7: Informant characteristics.....	156
Table 8: Informant perceptions: demographic characteristics of clients	171
Table 9: Informant perceptions: referral careers of bereaved clients.....	174
Table 10: Informant perceptions: why bereaved individuals seek counselling	176
Table 11: Informant perceptions: counselling routines.....	192
Table 12: Informant perceptions: presenting problems brought by clients.....	197
Table 13: Informant perceptions: dynamics of the counselling relationship	210

Abbreviations

AIDS: Acquired Immunodeficiency Syndrome

ART: Antiretroviral Therapy

BACP: British Association for Counselling and Psychotherapy

CBT: Cognitive Behavioural Therapy

CVS: Commissioner for Victims and Survivors

DGH: District General Hospital

DHSSPS: Department of Health, Social Services and Public Safety

DHSS: Department of Health and Social Services

DoH: Department of Health

DPM: Dual Process Model

GDP: Gross Domestic Product

GP: General Practitioner

HIV: Human Immunodeficiency Virus

LRA: Lord's Resistance Army

NGO: Non-Government Organisation

NI: Northern Ireland

PIRA: Provisional Irish Republican Army

SIL: Summer Institute of Linguistics

SW: Social Work

UCA: Uganda Counselling Association

UK: United Kingdom

Chapter 1 The Research Question

1.1 Introduction

The inevitability of death lends universal relevance to understanding the process of grieving, a process much investigated across various disciplines in both science and the arts. Although death is an undeniable universal reality, responses to it are always culturally determined. *'There are no pan-human categories for understanding death; how people think about death is everywhere culturally embedded'* (Parkes et al., 1997: 31).

There is a growing body of research into how individuals in a Western context manage their grief (Stroebe et al., 2001). Here, grief is described essentially as an emotional reaction, which incorporates diverse psychological, behavioural and physiological symptoms (Stroebe et al., 2001). Most people respond to their grief adaptively and with resilience (Bonanno, 2001), coping in much the same way as they manage other losses (Fraley & Shaver, 1999). The goal in dealing with the loss of a loved one is for the individual who is bereaved to make the necessary psychological, behavioural and social adjustments to this loss. Increasingly, people are seeking professional help in this process (Raphael et al., 2001).

Whilst there is broad agreement within the counselling literature over normative manifestations of grief, there is also an acknowledgement, by some theorists, that these are Western-derived phenomena based on a Western bereavement discourse (Foucault, 1980; Stroebe & Schut, 1998). Despite the development of Western models of bereavement and a growing body of Western research in this field, there is a dearth of theorising around bereavement practices in other settings (Holloway, 2007; McLeod, 2009), and an acknowledgement that further research is needed in this area (Arulmani, 2007; Parkes et al., 1997; West, 2007).

The conceptual analysis and empirical research presented in this thesis seeks to explore bereavement counselling in two contrasting social settings. A comparison is made of the organisation, function, practices and belief systems characteristic of bereavement counselling in: Northern Ireland (NI), a province within the United Kingdom (UK), and the Sub-Saharan African country of Uganda.

This comparative study was initiated by my experience as a bereavement counsellor in these two settings. Comparative studies can provide greater awareness, and a deeper understanding, of social reality in each context (Ægisdóttir et al., 2009). Potential insights into grief reactions are limited if an ethnocentric analysis is adopted (Stroebe & Schut, 1998). This study sought to explore counsellors' perception of their practice with regard to four interrelated aspects of bereavement counselling, namely: the counselling context, the individuals who provide counselling, the individuals who seek counselling and the counselling practice. A theoretical framework was developed in which to understand and explain the similarities and differences observed.

In this chapter, an outline of the background to the research will be followed by a definition of key terms and a discussion of the purpose of the study. The research questions will then be presented, with comment on their scope and boundaries. This will be followed by an introduction to the research settings. Finally, an outline of this thesis is provided.

1.2 Arriving at the Research Question: A Personal Journey

My interest in this research was stimulated in 2003 when I transitioned from my home in NI to live and work in Uganda, East Africa, for a five-year period. At this time, I joined an international non-governmental-organisation (NGO) called the Summer Institute of Linguistics (SIL). SIL is a faith-based organisation which seeks to develop capacity for sustainable language development promoting linguistic research, literacy, translation and other education and research projects of practical, social and moral value (SIL, 2008). The organisation has a small subgroup of approximately 30 social workers, psychiatrists and psychologists, who are tasked with promoting good mental health among members and the wider indigenous communities in which they are based. I was one of two staff based on the continent of Africa providing generic counselling, mental health assessments and trauma counselling. Although based in Uganda, I had a wider remit, travelling to other African countries to provide psychological debriefing following traumatic incidents.

In the course of this work and in my observations and interactions within the Ugandan community, I became aware of the frequency with which people had to deal with the death of a loved one. One of the most striking aspects of Ugandan life was the

prevalence of premature death. The lives of many of the people I knew appeared to be dominated by intractable poverty, frequent sickness and vulnerability to violent crime. Additionally, the widespread impact of the acquired immunodeficiency syndrome (AIDS) influenced profoundly the structure and lifecycle of families I knew.

Furthermore, I observed that the most common presenting problem in my counselling practice with Ugandan clients was difficulty in coping with the death of a family member. This seemed to challenge the widely held view that, in African societies, the social network provides sufficient support following bereavement (Kilonzo & Hogan, 1999). I was interested in exploring why there was a need for professional psychological help following a death and how this fitted with pre-existing help-seeking practices.

An exploration of bereavement counselling in Uganda would have begun to address these issues. However, I had also practiced as a bereavement counsellor in NI and variations in counselling practices between the two settings were apparent, particularly around ways of making sense of the loss. The most striking of these, to my mind, was the contrast between the individualistic characteristics of NI and the more collectivist characteristics of Uganda. Societies characterised by predominately collective identities, or 'We-identities', referred to as collectivist societies in this thesis, are seen to manage grief in ways that are different from predominantly individualistic societies, characterised by 'I-identities'. In the latter, individual autonomy and self-actualisation is emphasised over identification with the group (Elias, 1978). However, it should be noted that the definitive, polarised characterisation of societies as either 'individualist' or 'collectivist', can be critiqued for disregarding their diverse and changing nature (Giddens, 1991). Nevertheless, within this thesis, these broad terms will be used loosely, in describing the two societies' contemporary dominant discourses (Howarth, 2007a).

In Uganda, and not in NI, people lived in households with large extended families and appeared to define themselves in relation to their role in society. I was interested in exploring how individualistic, Westernised models of counselling were utilised in such settings. Thus, the idea for a comparative study emerged, suggested because it would provide an opportunity to explore aspects of counselling practice in each context, and the influence of social context on counselling.

The comparative analysis of contrasting social settings is often referred to as ‘cross-cultural research’ (Denzin et al., 2008; Mabbett & Bolderson, 1999). This is a concept that will be extensively criticised below (for example, in Chapter 6). Nevertheless, comparative empirical research was acknowledged in the 1960s and 1970s as a valuable tool in countering Eurocentric counselling theories and practices (Ægisdóttir et al., 2009; Gerstein et al., 2009). Comparative studies highlight the local specificity of much mainstream research into counselling, in which findings are often inappropriately presented as universal (Bryman, 2004; Walter, 2012). Whilst there are a number of studies which compare how death is managed in different social contexts, these rarely include studies across different societies (Walter, 2012). This may be due, in part, to a concern that ‘cross-cultural research’ is particularly vulnerable to the influence of researcher bias, which can lead to a distortion of findings (Gerstein et al., 2009). In the present study, for example, as the researcher I was indigenous to one setting and not the other, raising the potential for personal bias. This potential problem will be explored as the thesis proceeds. As a starting point, I will share background information about myself in order to identify how these personal characteristics might influence research processes in either setting.

I am a white, middle-class woman and am currently living in NI, the country in which I was born. I have been brought up within the Protestant culture in NI; I am married and am mother to four children. In my professional life, I completed a primary social science degree, a master’s degree in psychoanalytical studies and a professional social work qualification. I have been employed for 20 years as a mental health social worker and a social work trainer within a Health and Social Care Trust. In November 2013, I changed my employment to that of a social work lecturer in a local university. I also volunteer as a counsellor within a charitable organisation, through which I offer bereavement counselling.

1.3 Defining Key Terms

Key bereavement terms can be ambiguous, since there is no universally agreed definition of bereavement or framework for intervention (Stroebe & Schut, 1998). Furthermore, it can be difficult to distinguish categorically between the terms, ‘bereavement’, ‘grief’ and ‘mourning’ (Stroebe et al., 2001). It is important to avoid colonising the practice of bereavement counselling by unconsciously exporting the

models and definitions of the West (Ægisdóttir et al., 2009). The following definitions are assumed in this thesis – they are designed to be inclusive of a broad range of professionals and activities, and to encompass aspects of death, bereavement and bereavement counselling across diverse settings.

- Bereavement: the objective situation of having lost a significant person through death (Hansson & Stroebe, 2007).
- Grief: the primarily affective and psychological reaction to the loss of a loved one.
- Grieving: the processes which the bereaved individual experiences and the psychological and emotional strategies which they utilise in this process (Holloway, 2007).
- Mourning: the social expression of grief, often presented through a set of rituals and shaped by the practices of a particular society or tradition (Hansson & Stroebe, 2007).
- Counsellor: the terms ‘counsellor’ and ‘therapist’ are used interchangeably in the literature (McLeod, 2009). They refer to an individual who has acquired specific life experiences and possess specific personal qualities such as emotional resilience, empathy and a capacity to accept others unconditionally. Through training, counsellors will have developed specific interpersonal communication skills which enable them to address psychological and social problems.
- Bereavement counselling: from a user-centred perspective, bereavement counselling refers to a private and purposeful conversation which arises from the intention of one person to work through issues associated with bereavement and the willingness of a trained professional counsellor to assist in this process (McLeod, 2009). The terms ‘bereavement counselling’ and ‘grief counselling’ are used interchangeably in the literature. Additionally, the term ‘bereavement care’ has also been used as an umbrella term for a range of counselling and support services (Walter, 1999). In this present study, whilst ‘bereavement counselling’ has been favoured, ‘grief counselling’ and ‘bereavement care’ have

been used where appropriate, according to their most common usage in either setting.

- Group counselling: the process of working with a small group of clients together, based on the assumption that people benefit from shared experiences (McLeod, 2009).

Definitions and explanations of other technical and counselling-related terms used in the thesis can be found in the Glossary of Terms, which is situated at the end of Chapter 11 and the list of commonly used Abbreviations, which is incorporated with the preliminary pages.

1.4 Specifying the Research Question

This research sought to explore counsellors' perceptions of the practice of bereavement counselling in NI and Uganda, and to elicit similarities and differences in this practice. The views of bereavement counsellors' were sought as this group of people are practical experts who deploy a body of theory and evidence in addressing pressing and difficult psychological and social problems. They apply knowledge in real-world situations. Diverse perceptions of these issues are likely because the personal, professional and historical experiences and relationships of bereavement counsellors in NI and Uganda are disparate. However, although bereavement counsellors in this study are at the forefront of the social construction of death in two very different settings, they both utilise concepts and discourses derived from one of these social contexts. Unlike those in NI, counsellors in Uganda apply bodies of theory and evidence generated in a different social setting to the one in which they and their clients are based. It was therefore anticipated that a comparison of the perceptions of bereavement counsellors in NI and Uganda would reveal interesting contrasts.

Thus, the overarching research question was: 'What are the similarities and differences in the practice of bereavement counselling in Northern Ireland and Uganda, as perceived by counsellors in both settings?'

In seeking to answer this question, data collection and analyses were designed to address four research sub-questions:

1. What are the similarities and differences in the context of bereavement counselling in NI and in Uganda?

2. What are the similarities and differences in the characteristics of counsellors as represented by the informants in both settings?
3. What are the similarities and differences in the bereaved individuals who seek counselling in NI and Uganda, as perceived by the informants in both settings?
4. What constitutes the practice of bereavement counselling in NI and Uganda, as perceived by the informants in both settings?

The counselling process is not just dependent on the interactions of individual counsellors and clients; rather it is embedded within the wider social context in which it occurs (McLeod, 2009). The term 'context' is used here to refer to a complex, multi-faceted set of social influences that are often not identified or acknowledged in counselling (McLeod, 2009). In this thesis, the historical, social policy and institutional context of both settings, including the professional organisation of bereavement counselling, are explored.

Attention is also paid to the personnel delivering bereavement counselling, some of whom are participants in this study. Specific characteristics of these counsellors and their practice are explored, including demographic information, their professional discourse and habitus. An overview of their professional training and qualifications is offered, along with the main theoretical frameworks utilised in these counsellors' professional practice and their perceived rationale for bereavement counselling.

Comparisons are also made of counsellors' perceptions of bereaved individuals who seek counselling, including demographic details, referral careers and reasons for seeking help.

Finally, aspects of bereavement counselling practice are compared, including the presenting problem brought by clients, and the ways in which clients appear to make sense of their loss and express their grief. Dynamic aspects of the counselling process, including the therapeutic relationship, are also examined.

This thesis adopts a broad investigative strategy since little prior research of this nature has been carried out. It will primarily focus on individual counselling as my prior observations in Uganda and NI identified that a form of individual counselling was most

often provided. However, where group counselling is referred to by informants, this will be discussed and compared.

There are certain aspects of bereavement counselling which remained outside the remit of this thesis. Decisions around the criteria for exclusion were based both on limits of space and on the necessity of maintaining focus. Whilst an overview of counsellor qualifications and training is offered, an in-depth, detailed analysis of counsellor training *per se* is not the main theme of this analysis. The effectiveness of bereavement counselling is not a focus of the study. Neither is a first-hand account of the client's experience offered, as the chosen emphasis is counsellors' perceptions. This study focuses on counselling provided by individual counsellors offered for what, in the profession, is referred to as 'normal' grief; it will not specifically focus on differences between 'normal' or 'abnormal' grief (Worden, 1991), except where these issues are raised by informants. Defining what a normal or abnormal response to bereavement is can be problematic, because grief reflects individual circumstances and dispositions (Bonanno & Kaltman, 2001). Fundamentally, whilst symptoms may change in their intensity and impact, normal grief implies a gradual movement towards adaptive coping. In contrast, abnormal grief implies a deviation from the normal, culturally accepted course of bereavement, in terms of time, symptoms or intensity (Stroebe, M.S. & Schut, 2001a).

Consideration is also given to ways of theorising the similarities and differences identified between NI and Uganda, including the theorising of, on the one hand, the sociologist, Norbert Elias, and, on the other, the psychoanalyst, Sigmund Freud. Reference will also be made to structural differentiation theory (Durkheim, 1984 [1893]; Seidman & Alexander, 2008).

1.5 Northern Ireland and Uganda

The value of comparative studies depends in part on the commonality and contrasts offered by the selected social settings (van de Vijver & Leung, 1997). NI and Uganda were selected for study for practical convenience, since I had ready access to informants and research data in either setting. However, ease of access to research data does not, in itself, justify the value of research. As the demographic profile of any society is a determinant of how death is managed (Holloway, 2007), a brief overview of key

historical and demographic characteristics of NI and Uganda is offered. This will be followed by a discussion of the particular features of these two settings which suggest that a comparison would be of value.

NI is a province of the United Kingdom (UK) and shares a border with the Republic of Ireland. Its population of 1,828,600 (Northern Ireland Statistics and Research Agency [NISRA], 2011) is only 3% of the population of the UK. Relative to the rest of the UK, the population of NI is young with 19.6% 14 years or under, 65.8% between the ages of 15 and 64 years, and 14.6% 65 years or over. The next youngest constituent country is England which has 17.7% of its population 14 years or under and 16.3% 65 years or over (Office of National Statistics, [ONS], 2013). In NI, life expectancy for a man is 76 years and for a woman 80 years; infant mortality is 4.9 deaths per 1000 live births. NI is an ethnically homogenous society; over 99% of the population is white with the next largest ethnic group (Chinese) numbering only 0.25% (NISRA, 2011). The prevalence of the Human Immunodeficiency Virus (HIV) is 0.024%, with 522 people living with HIV in NI (Public Health Agency [PHA], 2012).

NI is one of the most commonly studied countries in the world. However it has been suggested that important sociological issues have been overlooked because of a predominate focus amongst researchers on its history of conflict (Brewer, 2001). It is difficult to access any information on NI which is not provided relative to this conflict (Conflict Archive on the Internet [CAIN], 2012).

The history of 30 years of civil conflict is well documented. In 1922, following a resurgence of Irish Nationalism, the 32 counties which made up the island of Ireland divided: six counties in the North separated from the 26 counties of the South, and became a semi-autonomous region of the UK known as NI. NI was ruled by a devolved government until 1972 when its government was dissolved and the province was placed under the direct rule of the UK parliament (CAIN, 2012). From 1969 to 1997 a paramilitary group, the 'Provisional Irish Republican Army' (PIRA), conducted a violent battle against the imposition of British Rule, as they saw it, campaigning for NI to be united with the Republic of Ireland (Hillyard et al., 2003). During this time, which is colloquially referred to as the 'Troubles', other paramilitary groups were formed and 3,254 people lost their lives (McKittrick et al., 1999).

Since 1998, when most of the paramilitary groups stopped their armed struggle, devolved government has been restored. However there remains a strong political divide between the Unionists, who are predominantly Protestant, and wish to retain the union with Britain, and the largely Catholic Nationalists who seek a united Ireland. Since the peace agreement of 1994, the intensity and character of sectarian conflict has changed. Sectarian murder is now rare but sectarian violence continues.

Economically, NI has a Gross Domestic Product (GDP) of £14,471 per-capita (CAIN, 2011) and, as part of the UK, is one of the three richest commonwealth countries in the world. However, economic, health and social issues have surfaced following almost 30 years of civil conflict. The economy has been deeply affected, leading to a high level of unemployment. A consequence of this increased unemployment has been the demise of the manufacturing industry and a huge growth in government and security service jobs (HM Treasury, 2011). Approximately two thirds of the population live in urban areas, with a third more sparsely distributed in rural communities. Agriculture represents an important industry in NI (CAIN, 2013).

In contrast, Uganda, a landlocked country in East Africa, is considered one of the world's poorest, with a GDP per-capita of \$1000 (International Monetary Fund [IMF], 2000). Most (85%) of the population of 33.4 million live in rural communities, surviving predominantly on subsistence farming (U.S. Department of State [USDS], 2007). Coffee remains its major export.

Despite recent economic growth, the majority of its population still live in poverty (IMF, 2000). The country's economy is highly dependent on aid from foreign countries and international agencies, with the UK, its fourth largest donor, pledging £700 million in aid in 2007 to be disseminated over a ten-year period. This aid has resulted in a huge increase in NGOs, which have expanded in number from 160 in 1986 to 3,500 in 2000 (Kelly & Ford, 2009).

In Uganda, infant mortality and life expectancy are considerably lower than in NI. Ugandan's young population has a median age of 15.1 years and an infant mortality rate of 86 per 1000. Life expectancy is 52 years for a male and 54 years for a female. In Uganda, 49.1% of the population are 14 years or under, and only 2.1% are 65 years or over. Whilst in the UK, 30% of deaths are of people aged 80 and over, in Africa this figure is only 4% (Holloway, 2009). Uganda has a diverse culture, with 17 ethnic tribes,

most of whom have their own mother tongue; English remains the official language (SIL, 2008). Christians represent 85% of Uganda's population, Muslims 12%, and traditional religions and other faiths 3% (Ugandan Bureau of Statistics [UBS], 2002).

Uganda has undergone a number of very significant changes since 1894 when a Protectorate British Government was established, ruling over what was then the Kingdom of Buganda. Since independence in 1962, there have been two decades of wars, civil unrest, economic decline and social breakdown (Seeley et al., 1991). During this time (1971-1979), Uganda became infamous for the military dictatorship of Idi Amin, in which thousands of Ugandans were murdered. However, the country has enjoyed relative stability under the current presidency of Yoweri Museveni, who has been in power since 1986 (Oloka-Onyango, 2004).

There are currently two major influences on life expectancy in Uganda. The first is the AIDS pandemic. In the early 1990s, HIV had a prevalence rate of 18.5%. However, as a result of comprehensive government policies to lower HIV, this figure has officially reduced to 7%. It is estimated that 1,500,000 people are living with AIDS in Uganda, alongside one million AIDS orphans, and 63,000 AIDS related deaths (United Nations AIDS [UNAIDS]), 2012). Ugandan women, who have an evident lower social status and are also more likely to be illiterate, have a disproportionately high risk of HIV infection (UNAIDS, 2010).

The second influence is the on-going rebel activity in northern Uganda. For the past 30 years an internal war has raged between the Ugandan government and the rebel group, the 'Lord's Resistance Army' (LRA), led by the self-appointed General Kony. There have been an estimated 1.8 million deaths and abductions as a result of this conflict (Oloka-Onyango, 2004). As a consequence, Uganda is home to 2 million internally displaced persons (IDP) and approximately 403,910 refugees (United Nations high Commissioner for Refugees [UNHCR] 2014).

This brief overview of key historical and demographic characteristics of NI and Uganda illustrates in part why a comparison between these two settings would be of interest. However, whilst differences in the collectivist and individualistic characteristics are apparent, it must be noted that these two settings are not simply at the extreme ends of a developmental continuum, and in fact may be said to share some characteristics. NI is often thought of as the most conservative, religious, sectarian and communal part of the

UK. Uganda is a nation state with some urban development and some national organisations. The comparison is not between the high point of modernity and village tribal society, and yet, it will be interesting to see whether conventional distinctions between ‘developed’ and ‘underdeveloped’ hold up. Moreover, the two societies have some striking similarities in their histories. Both have been subject to British colonial rule. Both contain deep ethnic and religious divisions and tensions (Brewer, 2001; Hodge, 2010). Both have experienced the long-term impact of terrorist activity (Coulter, 1999; Middleton, 1987 [1966]), activity that, in each setting, is justified through religious rhetoric (O’Callaghan et al., 2012; McMullen et al., 2012). It is anticipated that these violent conflicts will have considerable impact on the mental health of the populations involved (Cohen, 2001), influencing the presenting problems of counselling clients. It should also be informative to explore the extent to which these historical similarities and differences shape the experience of death and bereavement. Finally, comparative studies often downplay the detailed characteristics of the societies they study, and, as a result, the nuances and specific features of each setting are underrepresented. In the case of NI and Uganda, these nuances will be noted and explored. This chapter will now conclude with an outline of the thesis.

1.6 Outline of the Thesis

In Chapter 2, Westernised perceptions of death and bereavement are explored. Changing attitudes to death are traced and current views of death and bereavement identified. An overview of the structure and practice of Westernised bereavement counselling is then provided. This chapter concludes with an exploration of the practice of bereavement counselling in NI and consideration of how representative NI is of wider Western bereavement customs and counselling practices.

In Chapter 3, African perspectives on death and bereavement are examined. Bereavement counselling in Sub-Saharan Africa is discussed, with a particular focus on Uganda. The anthropological and sociological literature is reviewed and seven key constructs differentiating perceptions of death and bereavement in NI and Uganda identified.

In Chapter 4, the work of Sigmund Freud will be presented as instrumental in shaping Western attitudes to mourning and bereavement. A critique of Freudian theory and post-

Freudian theory is offered, out of which specific models and methods of intervention have evolved. This chapter concludes by evaluating the usefulness of Freudian theory to the present comparative study, and the need for a broader conceptual framework is identified.

Chapter 5 considers the role sociological approaches to conceptualising grief. The work of Norbert Elias is introduced and presented as a key theory for analysing and understanding grief processes and bereavement counselling practices across diverse settings.

In Chapter 6, a discussion of the issues and debates associated with ‘cross-cultural research’ is offered, before the chosen methodology is outlined and justified. The process of conducting the research is described, followed by an account of data analysis procedures. Finally, research ethics and the concept of reflexivity are explored.

The study’s findings are presented in Chapters 7, 8, 9 and 10, each chapter addressing one of the four interweaving research sub-questions outlined above.

In Chapter 7, findings relating to the counselling context are presented, with consideration of societal, professional and local community contexts. Chapter 8 considers the characteristics of counsellors, represented by 18 informants in Uganda and 20 informants in NI. Chapter 9 focuses on the characteristics of bereaved clients as perceived by informants in either setting. Chapter 10 explores counsellors’ perceptions of bereavement counselling practices.

Finally, Chapter 11 offers some reflections on the thesis as a whole. A summary of findings is presented. These are discussed in relation to the four research sub-questions posed at the outset of this project, and the seven key constructs relating to death and bereavement introduced in Chapter 3. Reflections are then offered on how these findings, and their interpretation, contribute to an understanding of Freudian and Eliasian theory and to our knowledge of bereavement counselling in Uganda and NI. The chapter concludes with a discussion of the limitations of the study and suggestions for further research.

Chapter 2 Death, Bereavement and Bereavement Counselling in the United Kingdom

2.1 Introduction

This chapter will consider perceptions of death, bereavement and bereavement counselling in the UK, with some comment on broader Western perceptions. An overview of changing attitudes to death and bereavement in Western societies is followed by a discussion of bereavement counselling practices, the organisational context of practice and a review of best-practice guidelines. The focus will then be placed specifically on bereavement counselling within NI, with a final discussion of how representative NI is of wider Western societies. To contextualise these discussions, the chapter commences with a brief overview of the historical development of Western literature on bereavement.

2.2 Development of the Literature

The field of bereavement research in Western contexts is robust (Raphael et al., 2001), with a series of distinct research topics having been developed over the last fifty years (Stroebe et al., 2001). These began with a methodical mapping of the manifestations and timing of grief. This intrapersonal focus was then widened to examine interpersonal issues including risk factors. The research focus then moved to consider the spectrum of available grief interventions and their effectiveness. More recently, complex phenomena associated with the biological, psychological and social levels of bereavement have been the subject of investigation, with a view to developing relevant theoretical frameworks.

Past research into bereavement interventions includes numerous small-scale cross-sectional studies, a number of large-scale longitudinal studies and several systematic reviews and meta-analyses (Currier et al., 2007; Currier et al., 2008; Forte et al., 2004; Schut, 2010; Wimpenny et al., 2006). However, Forte et al. (2004) ask why, given the prevalence of bereavement and the volume of research, bereavement intervention still lacks a formidable evidence base. They suggest that consistent flaws are present in the design and analysis of much of this research. Identified methodological problems include significant variation across studies in types of intervention studied, client

populations, and research methods. Inadequate reporting of interventions, with few published studies replicating previous research, compounds this problem. There has also been an absence of control groups in most quantitative studies, together with small sample sizes and possible bias in sampling due to difficulties in recruitment (Forte et al., 2004; Stroebe et al., 2003; Wimpenny et al., 2006).

Notwithstanding these issues, an overview of the available descriptive, theoretical and empirical literature will provide an informative starting point to this comparative study. This will commence with a discussion of changing attitudes to death and bereavement in the UK, and lead to a review of the current debate around the contemporary image of death.

2.3 Death, Bereavement and Modernity

Individuals' responses to death are constituted within the nexus of beliefs, values, norms and practices embedded within networks of social relationships of which they are a part (Holloway, 2007; Shapiro, 2001). Thus, individuals' experiences of dying and bereavement vary in different historical eras and in different locations (Elias, 2001[1982]; Holloway, 2007; Howarth, 2011). The pivotal works of Geoffrey Gorer (1965) and Philippe Ariès (1962, 1974, 1983), spanning three decades, convey the changing nature of Western attitudes to death. Ariès showed that many taken-for-granted contemporary attitudes to death are, in historical terms, relatively new. Looking back over one thousand years, Ariès suggests that the manner in which people died and mourned in the past was fundamentally different from that of today. He suggests that, in earlier epochs, death and mourning were ritualised, grief was overtly-expressed but short-lasting, and bereaved individuals quickly re-engaged with their responsibilities and with new relationships.

With a growing emphasis on individual autonomy came an increasing intolerance of separation from loved ones, and mourning began to be processed as an internal, psychological event (Hagman, 1995). In the course of this process, death became less integrated into the collective life of family, kinship and small groups; the hallmark of modern death is said to be banishment to the margins of life (Jalland, 2013). The denial of death is a clear theme in much of the current literature around Western death and

bereavement (Seale, 1998). It has been attributed to processes of secularisation, medicalisation, and individualisation.

Parkes (1996) suggests that attitudes to death in the West are profoundly influenced by secular assumptions, which are essentially rationalistic, characterised by a distrust of strong emotions. Thus, people in Western societies ignore or deny death because they no longer have a system of beliefs to make sense of it.

'Death is so alarming in contemporary societies because modernity has deprived increasing numbers of people with a means of containing it in an overarching, existentially meaningful, ritual structure' (Mellor & Shilling, 1993: 427).

Through the medicalisation process, death is no longer seen as an act of God but is deconstructed into discrete, identifiable diseases (Bauman, 1992). Most people die in hospital, surrounded by professionals, within a bureaucratic and impersonal environment in which *'dying has become the business of professional services'* (Holloway, 2007: 21). With advances in medicine, people have an expectation of longevity (Howarth, 2011). Death is generally not experienced in the midst of life (Walter, 2007). In many ways it is viewed as a medical failure (Jalland, 2013), promoting an illusion of immortality (Howarth, 2007a). Furthermore, a widespread assumption among contemporary Western people is that self-identity has to be individually constructed (Dalal, 1998). Thus the dying process and the meaning associated with it have become individualised. *'The quintessence of modern mourning culture is its individualization'* (Winkel, 2001: 65).

Whilst the death-denying paradigm is often deemed to represent the dominant discourse in contemporary Western societies, this is subject to debate. Kellehear (1984) argues that the theoretical basis for death-denial is weak, fragmented and unconvincing. A number of different theoretical positions have been adopted in relation to the visibility, individualism and secularisation of death.

According to Parkes (1984, 1996), we now have less need to deny death because death is less visible. Elias (2001[1982]) concurs, suggesting that the extent to which dying is removed from other spheres of social life in contemporary Western society is greater than at any previous time in history. However, conversely, death is also said to be more

visible, through well-publicised deaths and disasters across the world and voyeuristic opportunities provided through social media sites (Walter, 2007). Holloway (2007) identifies a paradox in which death associated with private family life remains taboo and hidden whilst murder, suicide and celebrity deaths have become very visible. Giddens (1991) argues that these 'mediated experiences' further sequester death through a confirmation of its separation from day-to-day life. Walter (1999) also identifies a paradox in the visibility of grief, in which emotional expression is required to be both expressed privately and restrained publicly, with the overt expression of emotion at funerals discouraged (Lovell, et al., 1993; Rosenblatt, 1997). Consequently, it is suggested that *'Death is both absent and present in contemporary society'* (Holloway, 2007: 20).

The individualism which is said to be characteristic of the management of death in Western societies is also subject to different interpretations. Walter (1994) discusses individualistic responses to death. He disputes the denial of death, suggesting that with advancements in medical and palliative care, people in the West are living longer and taking longer to die. This has led to a revival of death, based, not on tradition, but on the individualisation of the dying process.

'The revival of death takes individualism to its logical conclusion and asserts the authority of the individual over not only religion but also over medicine; only individuals can determine how they want to die or grieve' (Walter, 1994: 185).

However, Stanley and Wise (2011), challenge this view. Writing from an Eliasian perspective, they identify the continued significance of relationship networks in shaping bereaved individuals' responses to death. In particular, they emphasise the importance of domestic figurations; that is, a network of familiar and everyday relationships which connect large-scale social structures and interpersonal processes. They caution against a binary differentiation between the public and private sequestration of death, arguing that, whilst sequestration is associated with the regulation of death, the role of domestic figurations is still significant. Howarth (2007a) also suggests that choices associated with death are not necessarily made individually, but are influenced by social customs. A disparate range of possible meanings and rituals associated with death can be embraced which *'effectively super-imposes new frameworks of meaning onto pre-*

existing structures and rituals' (Howarth, 2007a: 263). Thus, new, diverse groups and communities of the dying and bereaved have emerged. Individuals become part of these communities and their self-identity is shaped accordingly. As established mourning rituals have disappeared, these are being replaced by new rituals, which are more individualised and personal. Holloway identifies a flux of beliefs and practices surrounding death. There is a move away from predetermined funerals to personally chosen forms of commemoration which seek '*enduring symbolic value*' (Holloway, 2007: 163). Wouters (2002) suggests that bereaved individuals have demanded public recognition of these rituals in a bid to claim membership of a virtual or imagined community. Wouters attributes these changes to differences in the balance of psychological and social mourning functions. Thus, vicissitudes in emphasis between an individualised 'I-identity', and the sense of belonging inherent in a collective 'We-identity', have been observed over time, with a current trend towards the latter (Wouters, 2002: 2).

More nuanced observations of Western secularism have also been offered. Whilst the absence of an overarching belief system is acknowledged, the need to make sense of death remains strong (Draper et al., 2013). Although religious practice has become a personal choice, within the culturally pluralistic UK society, a range of complex, nuanced and changing spiritual beliefs have been identified (Holloway, 2006; Draper et al., 2013).

Vicissitudes in the perception of death and bereavement can also be seen in the shifting ways in which death has been classified. Death can be viewed as good and bad, social and physical, and natural and unnatural (Prior, 1989, 2000). A 'good death' is managed according to socially-agreed rules (Howarth, 2011). Historically, in Western societies, it was seen as a tame death, with the individual dying at home surrounded by family and clergy (Ariès, 1983). In contemporary society, a good death is associated with symptom management and dying with dignity (Howarth, 2007a). Some argue that euthanasia represents a good death, although this is contentious. In contrast to a good death, a 'bad death' is often seen as one which is violent and for which there is no preparation. 'Social death' is deemed to occur when there is a physical or mental degeneration which leads to the perception of a separation between the body and self, as perceived, for example, in some individuals suffering from advanced dementia (Howarth, 2007a). As most people who die in the UK do so at aged 75 and over, death is often preceded by a

‘liminal phase’ characterised by frailty, debility and illness (Holloway, 2009). The term ‘special deaths’, refers to specific features and circumstances of death which complicate the grief reaction. It is the death itself which impacts grief, regardless of the characteristics of the bereaved person or their relationship with the deceased. In some circumstances, such as the prevalence of war or AIDS, ‘special deaths’ may represent the norm (Holloway, 2007).

In summary, an awareness of the disparate views identified here indicates that the unqualified characterisation of Western societies as, for example, death-denying, individualistic or secular, disregards the diverse and changing nature of the management of death within different settings. However, whilst it is apparent that attempts to locate varying attitudes to death within specific historical periods are simplistic (Walter, 1994), a historical shift in attitudes towards death and bereavement can perhaps be observed. Walter (2007) describes this trend as preceding from ‘traditional societies’, characterised by solidarity and collective support, through ‘modern societies’ characterised by individualism and fragmented networks, to ‘post-modern societies’, symbolising a global community in which individuals are bound, not by pre-existing social relationships, but by shared experiences.

Thus, as responses to death within societies are dynamic and varied (Howarth, 2011; Walter, 2010), individuals in contemporary Western societies will conceive of death, mourn for their dead, and overcome their loss, in ways which are both similar to and different from each other. Bereavement counsellors are at the epicentre of these trends in death and bereavement. They are at the forefront of changing attitudes and responses to grief and mourning practices. It is anticipated that the present study will inform the debate around the social construction of death in the West through an analysis of the bereavement counsellor’s perceptions of these issues.

A discussion of bereavement counselling practices in the UK will now follow. This will commence with an introduction to the concept of counselling, followed by an exploration of the different practices which constitute bereavement counselling. The literature outlining counsellor and client perspectives will also be presented.

2.4 Bereavement Counselling in the UK

The rise of bereavement counselling is linked to overall trends in the social construction of death in Western societies. It is associated with the decline in traditional mourning customs and with increased individualisation and secularisation (Walter, 1999). The role of therapy arguably substitutes for many of the former functions of religion and ritual, promoting a focus on the individual and his or her psychological well-being. In this process, science effectively replaced religion as the dominant explanatory framework for psychological illness, promoting the rise of the discipline of psychiatry, out of which psychotherapy and counselling emerged (McLeod, 2009). Counselling and psychotherapy have developed into highly differentiated specialisms, one of which is the counselling offered to bereaved individuals (McLeod, 2009). Although there is a powerful social movement promoting bereavement counselling (Raphael et al., 2001), there are few ethnographic studies of its practice, with Árnason (2001) providing a notable exception.

There is debate around the role that counselling plays in contemporary Western society. Counselling has been portrayed as repressive, promoting and reinforcing state domination (Masson, 1989); *'psychotherapy is government at a distance'* (Árnason, 2001: 302). Rose (1989) suggests that counselling seeks to produce subjectivity rather than repressing it, promoting people who govern themselves, arguably leading to the translation of political, economic and social goals into individual choices. Walter (1999) offers a different view, suggesting that bereavement counselling is part of a wider movement to help individuals become more autonomous, perhaps providing space where grief is not policed to the same extent as in wider society. Seale (1998) conceives of counselling as a *'resurrection practice'* (Seale, 1998: 1) through which people claim membership of imagined communities.

Whilst acknowledging that counselling is politically charged, Árnason (2001), based on his participant observations of bereavement counsellor training, addresses these disparate views. He suggests that counselling is a co-operative project between counsellor and client, created through *'the interactive and shifting relationship between subjectivity and subjection, authority, expertise and experience'* (Árnason, 2001: 311).

As definitions of counselling vary, one way to understand what happens in this process is through considering core assumptions of what constitutes counselling practice

(McLeod, 2009). From a user-centred perspective, bereavement counselling refers to a private and purposeful conversation which arises from the intention of one person to work through issues associated with bereavement and the willingness of a trained professional counsellor to assist this process (McLeod, 2009). In addition to individual counselling, group counselling represents an important form of practice, theory and research, with both the group process and group context being implicated in client change (Corey, 2008; McLeod, 2009). Bereavement counselling might be offered by a range of differently qualified professionals (Machin, 1998), including social workers, teachers, nurses, ministers of religion, and also lay members of religious communities or other groups (O’Kane & Millar, 2001). This present study will focus on the counselling offered by professionally qualified counsellors.

Clients can gain access to bereavement counselling either through self-referral or referral from other professionals such as General Practitioners (GPs). Counselling is usually conducted on a one-to-one basis, in a private room. Sessions normally last about 50-60 minutes and tend to be offered weekly; counselling contact may last for just one session or continue for several weeks or months. Counselling provided within the statutory or voluntary sector is often free of charge. However, counsellors working privately in the independent sector are more likely to charge a fee, which is usually in the region of £60 per session.

A range of counselling interventions may be offered following bereavement (Forte et al., 2004). Worden’s (1991) classic textbook differentiates between ‘grief therapy’ and ‘grief counselling’. Grief counselling is offered for uncomplicated mourning and provided by a range of professionals or volunteers on an individual or group basis. Here, the bereaved client is helped to work through the tasks of grief by talking through their loss. In contrast, grief therapy seeks to resolve what Worden designates as ‘pathological grief’, addressing inner psychological conflicts which have arisen from the separation. This therapy is generally provided by mental health professionals. Whilst Worden’s theorising is said to be the most influential in bereavement counselling (Wortman & Silver, 2001), the type of intervention used depends in large part on the theoretical orientation of the counsellor (Schut et al., 2001).

Forte et al. (2004) undertook a systematic review of bereavement care interventions. They identified diverse treatment modalities including support groups and

psychotherapy-based interventions. Walter (1999) notes that most bereavement counsellors base their practice on a psychodynamic or a person-centred model, other possible approaches include cognitive-behaviour therapy (CBT) and eclectic methods. Further details of these various approaches can be found in the Glossary of Terms and in Chapter 4.

Payne et al. (2002) explored the provision of bereavement counselling in primary-care settings; their findings suggest that bereavement counsellors located their interventions within a broader arena of work around loss and managing relationships. Eclectic approaches were used, along with specific strategies such as enabling clients to tell their stories, allowing people to talk, actively listening, developing supportive therapeutic relationships and enabling bereaved individuals to deal with unfinished business and say goodbye. These eclectic methods represent a pragmatic approach to counselling, the counsellor adopting what is considered to be the most effective combination of therapeutic procedures without necessarily working within an overarching theoretical framework (McLeod, 2009). Furthermore, the most helpful components of bereavement interventions are considered to be information-giving and normalisation of the grieving process (Vlasto, 2010). Studies of client experiences in general counselling reveal two aspects of counselling that clients consistently view as important (Elliot & James, 1989): firstly, the qualities of the counsellor, in particular, his or her capacity to be empathic, non-judgmental and genuine; and secondly, the quality of the therapeutic alliance. Similar factors have been identified in studies of bereavement support (Beresford et al., 2008; Gallagher et al., 2005; Lloyd, 1997; McLaren, 1998; Partridge, 2005).

Literature addressing the bereavement counsellor's experience is limited, and tends to focus on burnout and the emotional impact of this work (Puterbaugh, 2008). However, consideration of the counsellor's professional perceptions and development is essential in understanding the dynamics of change in counselling (Rønnestad & Skovholt, 2003, 2012). Puterbaugh (2008), in her phenomenological study of 10 bereavement counsellors, found that each had developed a work role which was highly congruent with their personal and professional selves, and focused on an integration of loss. Congruence within the counselling process required high levels of self-awareness and observation.

The need for self-care was also emphasised. Worden (1991) suggests that, given its high emotional intensity, bereavement counsellors are inevitably affected by their clients' losses, with implications for the psychological process of transference. In some studies, counsellors were found to experience personal bereavement following their clients' deaths. Notably, they were also drawn to their work following a personal loss (Garfield & Jenkins, 1981). In one study, counsellors reported a significant personal loss experience as centrally important to decisions around their career choice, with similarities between earlier resolutions of personal loss and their preferred intervention style (Dunphy & Schniering, 2009).

To summarise, whilst the counselling model outlined by Worden (1991) is widely used, bereavement counsellors often develop eclectic approaches which are influenced by their own experiences of loss (Dunphy & Schniering, 2009). Counsellor qualities, and the nature of the therapeutic relationship, are the most significant factors contributing to client satisfaction (Beresford et al., 2008). The experienced practitioner's skilled use of self incorporates integration of their own losses into the development of empathy for their clients.

2.5 The Organisational Context of Bereavement Counselling

Parkes (2001) outlines the history of professional therapeutic services intended specifically for bereaved individuals in Britain, the USA and Australia. In each country, large national organisations were established, such as the National Association for Loss and Grief (NALAG) in Australia, or Cruse Bereavement Care in Britain, initiating and supporting the development of therapeutic interventions.

Currently, the UK has an extensive counselling industry (Bond, 1998), with some 300,000 volunteer and 8,000 paid counsellors (Árnason, 2001). Within this industry, the emergence of bereavement counselling has been *ad hoc*, and associated with four main provider contexts, namely, the specialist voluntary organisation *Cruse Bereavement Care*, the hospice movement, local bereavement projects, and religious settings (Árnason, 2001; Dush, 1998). Whilst bereavement counselling is provided within the statutory, voluntary, faith and independent sectors (Stephen, et al., 2009), the majority of provision comes from voluntary agencies (Árnason, 2001). One study suggests that the voluntary sector provides 80% of bereavement counselling services in the UK

(London Bereavement Network, 2001), with Cruse Bereavement Care alone seeing upwards of 18,000 people annually (Marshall, 2007).

Within the statutory sector, there has been a recent emphasis on bereavement provision (Department of Health, Social Services and Public Safety [DHSSPS], 2009a; DHSSPS, 2009b; Department of Health [DoH], 2005; Wimpenny et al., 2006). In 2006, 54% of complaints to the Health Services Commission in England were related to death, dying and bereavement (Healthcare Commission, 2007). Of particular concern was the O'Hara Inquiry (DoH, 2002), which focused on the retention of human organs following post-mortem examination, without consent of family members. Recommendations arising out of this enquiry led to the introduction of statutory regional bereavement strategies throughout the UK.

Bereavement counselling is increasingly offered in primary care settings. Wiles et al. (2002) conducted qualitative interviews with 50 GPs to map their decision-making process when referring patients for bereavement counselling. They found that GPs were failing to use risk assessment procedures and overlooked certain groups such as older people.

The provision of bereavement services within the acute hospital sector is not well researched, and appears to be inconsistent (Field et al., 2007; Healthcare Commission, 2007; Walsh et al., 2008). In palliative care and hospice settings, there is more comprehensive bereavement care provision and a stronger research agenda (Field et al., 2004).

Thus, in the UK, the majority of bereavement services are provided by the voluntary sector. A somewhat *ad hoc* picture has emerged around provision in other sectors, with debate around what services should be offered and by whom (Stephen, et al., 2009).

2.6 Bereavement Counselling: Best Practice Guidelines

This present study does not seek to compare the efficacy of professional interventions within or across settings. However, a major theme in the bereavement literature concerns to whom, at what time, and with what interventions, the optimum benefit of bereavement counselling is achieved (Allumbaugh & Hoyt, 1999; Currier et al., 2008; Hoyt & Larson, 2010; Jordan & Neimeyer, 2003; Larson & Holt, 2007; Marshall, 2007; Neimeyer & Currier, 2009; Schut, 2010). In recognition of this literature, this section

offers a brief overview of best practice guidelines and the evidence base for bereavement counselling interventions.

There is a strong ethical and moral aspect to the practice of counselling since it is offered to people who are deemed vulnerable, and those who may be seeking guidance in making difficult moral decisions (McLeod, 2009). Professional counselling associations, which seek to uphold ethical standards, have increasingly sought to regulate counselling practice. Whilst a review of the various codes of ethics in counselling organisations in Western societies reveals a lack of consistency, and elements of ambiguity, there are many points of consensus (McLeod, 2009).

The ethical framework of the BACP (2013) identifies three elements to ethical practice. These are: the fundamental values on which counselling is based, including respect for human rights and personal dignity; a set of six ethical principles, in which the value-base is defined more precisely, including the principle of promoting client autonomy, and ensuring fair, impartial treatment; and the promotion of moral qualities of the counsellor, including humility and integrity.

In seeking to determine the most efficient form of bereavement intervention, several narrative reviews and meta-analyses of controlled peer-reviewed studies have reached very similar conclusions, namely, that universally-applied bereavement counselling achieves no measurable benefits (Currier et al., 2007; Currier et al., 2008; Schut & Stroebe, 2005). Although there are many positive accounts of the efficacy of interventions (Hoyt & Larson, 2010), there is still little evidence in general of the ability of any intervention to ameliorate the distress of bereavement, or to reduce the time of a normal grieving process (Geneviro et al., 2004). Rather, the available evidence suggests that it is not helpful to offer unsolicited bereavement interventions to people just because they have experienced a loss (Schut, 2010).

*‘There can be **no justification for routine intervention** for bereaved persons in terms of therapeutic modalities – either psychotherapeutic or pharmacological – because grief is not a disease’ (Raphael et al., 2001: 587) (emphasis in the original).*

It appears that the individuals who are most in need of, and benefit most from, bereavement interventions are those lacking social support. The availability and quality

of family support is a critical factor influencing help-seeking behaviour (Traylor et al., 2003; Wimpenny et al., 2006). In their literature review of bereavement and family support, Wimpenny et al. (2007) noted that dimensions of family conflict, expressiveness and cohesiveness appeared to predict family coping. That is to say, supportive families, and those whose members are emotionally self-aware, are less likely to need professional intervention following a death.

Jordan and Neimeyer (2003) highlight the potential for harm of routine intervention, although Hoyt and Larson (2010) suggest caution in making sweeping statements. There appears to be greater consensus around the view that treatments targeting more symptomatic individuals are more effective (Currier et al., 2008). Consequently, it is now generally considered that bereavement interventions should only be targeted at specific, individually-assessed clients (Agnew et al., 2009).

However, there is some ambiguity around what exactly constitutes high risk (Parkes, 2006). Risk factors can be categorised into those associated with the bereavement situation, such as sudden death, factors associated with the bereaved person, such as gender or personality traits, and factors associated with the interpersonal context including level of family support. Stroebe and Schut (2001) advise the use of an integrative risk model considering, not only risk factors, but also coping styles; positive coping styles include problem-focused coping, whilst maladaptive styles include avoidant behaviours.

Defining a normal or healthy response to bereavement can be problematic because grief reflects individual circumstances and personal characteristics (Bonanno & Kaltman, 2001). Fundamentally, whilst symptoms may change in their intensity and impact, normal grief implies a gradual movement towards adaptive coping. Thus, most people will experience significant negative consequences, resulting in changes in affect, cognitive disturbance, behavioural changes and physiological symptoms. Manifestations of affect include symptoms of depression, despair, anxiety, guilt, anger and loneliness. Behavioural consequences include agitation, fatigue, and social withdrawal. Cognitive manifestations include low self-esteem, self-reproach, thoughts of helplessness and hopelessness. Somatic symptoms such as poor appetite, sleep disturbance and energy loss are also common (Hansson & Stroebe, 2007). However, positive aspects of bereavement have also been identified (Howarth, 2007a), such as families becoming

closer or the enhancement of emotional strength and capacity for resilience (Hansson & Stroebe, 2007).

For a minority of bereaved individuals, (5-10 %) the effects of grieving can be difficult and are labelled by counsellors or medical practitioners variously as ‘pathological’, ‘abnormal’, ‘complicated’ or ‘traumatic’ (Hansson & Stroebe, 2007). In particular, exposure to armed political conflict is associated with risks for complicated grief reactions and long-term mental health problems (Campbell, 2007). While the potential for more complicated reactions to grief is well researched, these definitions lack consensus. They are generally understood to mean a deviation from the normal, culturally-accepted course of bereavement, in terms of duration, symptoms or intensity (Hansson & Stroebe, 2007). For example, a grief reaction may be one *‘that is excessive in duration and never comes to a satisfactory conclusion’* (Worden, 1991: 71). Grief may also be delayed, inhibited or postponed, or the symptoms of grief may be so intense and disabling that the bereaved individual develops a psychiatric illness such as a depressive or anxiety disorder.

The timing of any intervention is also seen to be important, with help offered too soon after a loss being considered potentially harmful, as it may interfere with an individual’s normal coping mechanism (Worden, 1991). The National Institute For Clinical Excellence (NICE), a UK public authority tasked with providing evidence-based guidance and advice within the health and social care sector, suggests that bereaved people should not be proactively engaged in counselling until eight weeks after their loss (NICE, 2004).

Finally, there is an increasing global impetus for evidence-based practice in the fields of health and social-care (Green, 2000). The World Health Organisation (WHO) has exhorted its member states to adopt an evidence-based approach to health promotion, policy and practice in all its forms (WHO, 1998). Within the UK, therapeutic interventions are considered appropriate for use if they have been shown to be effective in empirical studies (McLeod, 2009). However, debate continues over how effectiveness can be assessed within counselling (Cooper, 2011).

NICE (2004) recommends evidence-based guidelines for the care and treatment of adults with cancer, proposing a three-stage, ‘stepped-care’ model of bereavement

intervention. These guidelines have also been promoted for individuals who have been bereaved in circumstances other than cancer (DHSSPS, 2009a):

Level 1: Since grief is considered normal after bereavement, most people are assumed to cope without professional intervention. Consequently, NICE advises that all bereaved individuals should be offered information on grieving processes and how to access support.

Level 2: Some people may need a formal opportunity to process their grief. NICE advises that this can be provided through volunteer bereavement support, either on an individual or group basis. A referral system is required to be in place for referring individuals with the most complex problems to health and social-care specialists.

Level 3: A minority of bereaved people display complex problems and require special interventions. NICE requires that these are provided through specialist mental health services, counselling services or palliative care services.

To summarise, available research evidence suggests that bereaved individuals should not routinely be offered professional interventions and, in fact, may be hindered in their grieving process by so doing (Raphael et al., 2001). Additionally, those with family or other support are less likely to need professional help (Wimpenny et al., 2007). However, despite an increasing governance agenda, there is a rather *ad hoc* provision of bereavement counselling (Wimpenny et al., 2006), with many similar services offered in both the voluntary and statutory sector (Stephen et al., 2009).

2.7 Death and Bereavement Counselling in Northern Ireland.

In NI, bereavement counselling must be understood from the perspective of this province's specific history (McNally, 2007, 2011; Prior, 1989). In the 30 years of armed conflict in NI, over 3,200 people have been killed, and it is estimated that tens of thousands of people have experienced physical and psychological trauma (Fay et al., 1999). These are high levels of violence in the context of a population of 1.8 million people. Whilst the armed conflict has stopped, sectarianism remains an issue. It functions at many levels in NI with its insidious effects often reflected in everyday thoughts and action, creating the potential for distrust and fear.

'Sectarianism is maintained and reproduced, not just through the explicit use of violence and physical and social separation, but also by negative and discriminatory representations of the "other"' (Campbell, 2007, no page numbers).

Prior (1989), in his comprehensive quantitative survey of deaths and death notices in the city of Belfast, has also shown that sectarianism impacts both life and death in NI. He suggests that, the public organisation of death has become medicalised; it has been reduced to its physiological features and dominated by bureaucracy. Prior found that 58% of his surveyed individuals died in hospital (figures for other institutional settings are not provided). It is interesting to note the similarity of this finding to that of an audit conducted 24 years later. In 2005, an audit was taken of the 35 hospitals and five hospices in NI in order to map service provision and identify the profile of dying and bereaved individuals. It found that, of the 14,000-15,000 people who die each year in NI, over half (57%) die in hospitals, with a further 16% dying in nursing homes and other institutional settings (DHSSPS, 2009b). Similarly, 60% of the half a million people who die annually in Britain as a whole do so in hospital, although the majority of people want to die at home (National Audit Office, 2008). Within the Republic of Ireland, this figure is higher, with 66% of the 30,000 people who die each year dying in hospital (Walsh et al., 2008).

Prior (1989) also showed that the private organisation of death is regarded as the prerogative of the immediate family. Typically, in NI, and unlike the rest of the UK, a wake occurs in the family home, where the body of the deceased is present and viewed by relatives and friends; the funeral is typically held on the third day after the death. However, Prior noted differences in these customs along social-economic lines; for example, non-manual groups sought more privacy around death in comparison to manual groups who more readily welcomed extended family and friends to offer sympathy, visit the 'wake house', and attend the funeral. Additionally, Christian belief continues to impinge significantly on the death process but with marked differences between Catholic and Protestant attitudes towards death. This is seen, for example, in differences in eschatology, in which Catholics are more likely to continue to pray for their dead, whilst Protestants believe that the destiny of their deceased loved one can no longer be influenced by the living.

The segregation of Catholics and Protestants is seen to invade all aspects of life in NI and '*is of one of the most fundamental of all factors to affect the social organisation of death in Belfast*' (Prior, 1989: 114). Denominational differences exist in burial rites, there are separate Catholic and Protestant graveyards and death announcements are made in separate Catholic and Protestant newspapers.

In NI, 'special deaths' lack any clear defining characteristics, given the absence of legislative or statutory guidance. Prior (1989) noted inconsistencies in how coroners defined unnatural deaths with regard to cases of suicide and some, although not all, violent deaths.

Turning now to counselling in NI, the most comprehensive account is presented in a Department of Health, Social Services and Public Safety governmental review (DHSSPS, 2002), which surveyed counselling organisations, training organisations and service users. This review coincided with a national drive towards statutory regulation of counselling services. Its recommendations supported the introduction of statutory regulation, advocated improvements in training and emphasised the need for evidence-based practice. This survey indicated that more women than men sought counselling and that 52% of clients were between the ages of 12 and 18 years. Of the 111 counselling provider organisations identified in NI, the range of problems dealt with were categorised as follows: family difficulties (dealt with by 91%); relationship difficulties (89%); mental health (89%); bereavement (86%) and trauma (82%) (DHSSPS, 2002: 46). Whilst the large majority (86%) of counselling agencies in NI dealt with bereavement issues, only eight percent claimed to specialise in bereavement. However 72% of agencies reported working with Troubles-related problems. Clients' perceptions that they were being treated with respect and dignity in a reliable and confidential manner were found to be central in their overall satisfaction with services (DHSSPS, 2002).

The majority of bereavement counselling organisations in NI are based within the voluntary sector, with bereavement support also found in local community support groups, often located within churches. Cruse, established in 1984, was the first agency to offer services in NI (Gallagher et al., 2005). Since then, a range of specialist counselling organisations have been established, including those dealing with infant death, suicide or the impact of trauma. Many religious groups, representing both

sectors, have also been established to support bereaved individuals (Gibson & Iwaniec, 2003; Hendron et al., 2012; O'Kane & Millar, 2001). Gallagher et al. (2005) utilised a postal survey to access ex-clients' perceptions of bereavement counselling provided through a voluntary agency. They found that clients had very positive perceptions of the counselling they received, with counsellor qualities being central to measures of client satisfaction. Within the statutory sector in NI, each Health and Social Care Trust (HSCT) is required to: *'promote an integrated, consistent approach to all aspects of care ... in supporting individuals and families who have been bereaved'* (DHSSPS, 2009a: 4).

Whilst this account of counselling in NI bears many similarities to counselling practice throughout the UK, the distinctive sectarian dynamics of NI impact all aspects of life, including counselling provision (Bloomfield, 1998; DHSS, 1997).

During the Troubles, there was a dearth of research into the impact of violence; the little that was undertaken suggested that people responded to it with resilience (Cairns & Wilson, 1993). Moreover, there are still limited references to sectarian issues in many counselling studies. For example, Baginsky (2004), reviewing school counselling in NI, and O'Kane and Millar (2001), exploring the counselling-type work conducted by Catholic priests in NI, make surprisingly limited references to the exceptional nature of NI society. More specific research however has highlighted the long-term effect of the Troubles on bereavement reactions (Dillenberger et al., 2008; McNally, 2011), with a growth in counselling organisations established for those individuals most affected by the conflict (Bloomfield, 1998; DHSSPS, 2002). McNally (2011) suggests that the provision of bereavement support in NI requires sensitivity to issues of social justice by addressing the social and political context of the loss. Moreover, sensitivity to sectarianism is identified as a dynamic of the counselling process.

'In the context of local sectarian divisions, many individuals have high levels of anxiety about who can be trusted, making the task of seeking and securing safe and appropriate help more difficult' (DHSSPS, 2002: 6).

Acknowledging the exceptional nature of some aspects of life in NI raises the question of how representative NI is of the management of death, and the practice of bereavement counselling, in all Western settings. Consequently, this issue will now be addressed.

2.8 Comparative studies of Death and Bereavement Counselling

Identifying similarities and differences in death and bereavement practices can be problematic as, in many studies, the context in which death and bereavement are explored is implicitly assumed and infrequently analysed (Walter, 2012). Walter contends that it is difficult to see which ideas and theories relating to death and bereavement apply to nation states and which reflect global or universal processes.

Differences in the management and experience of death across diverse settings have been well documented (Irish et al., 1993; Morgan et al., 2009; Parkes et al., 1997) with differences between the UK and other countries also identified (Laungani, 1996; Valentine, 2009). Walter (2007) compares mourning practices in England, Ireland and Japan, concluding that English practices tend to be private and thus more individualistic, whilst practices in Ireland and Japan are more public.

Differences in religious beliefs and attitudes to an afterlife have also been shown to be associated with the management and experience of death (Rosenblatt, 1997; Stroebe, 2004). Death in Hindu (Laungani, 1997), Buddhist (Gielen, 1997), Islamic (Jonker, 1997) and Jewish cultures (Levine, 1997) have all been explored.

Often white Western attitudes and experiences of death are assumed to uniformly apply within and between societies; many researchers fail to identify subgroups or to acknowledge the diversity of most Western societies (Howarth, 2007a; Walter, 1999). Walter (1999) offers one of the few explorations of grief experiences outside ‘*mainline white culture*’ (Walter, 1999: xiv), in the USA and Britain. He highlights variations in the integration of the dead and their bereaved loved ones into societies, and in the regulation of emotions associated with grief. Variations in the experience of bereaved individuals, in the rituals associated with death, and in the services available to them, have also been identified within the UK (Brewer & Sparkes, 2011; Howarth, 1996; Saunders, 2012; Stephen et al., 2009). Variations in the management of death have also been noted across UK ethnic and religious sub-groups (Firth, 2000; Gardner, 1998), with variations also associated with social classes (Prior, 1989).

Exploring the uniqueness of bereavement counselling practices in NI is problematic as few studies, to date, have compared indigenous counselling practices across settings. Exceptions to this include the work of Gerstein et al. (2009) who presents indigenous accounts of counselling in nine regional areas of the world. Additionally, Tseng (1999)

reviews literature which focuses on the practice of psychotherapy in different societies. He identified differences in clients' belief and value systems, philosophical attitudes, and their orientation towards, and expectations of, psychotherapy.

O'Leary and O'Shea (2009) highlight cultural influences on counselling in Ireland, including the illegal status of abortion in that country and major health issues associated with alcohol abuse. In another study, Goldstein (2009) identifies cultural influences on counselling in the UK, including clients' increasing willingness to accept psychological help, and changes in the attitudes to marriage and divorce. Comparative studies of counselling between the UK and other nation states (Rowling, 2000; Young, 2009) have researched diverse aspects of counselling but no common themes have emerged. Thus, counselling practices in NI may share many similarities to those in other Westernised societies, but variations within and between countries is also to be expected.

To summarise, a review of this literature has identified variations in the management of death, and in bereavement counselling practices, within and across Western societies. Bereavement counselling in NI is clearly not representative of all Western societies; however, neither do the distinctive characteristics of NI render it totally unique. Walter (2012) identifies globalising trends in Western cultures in respect of the psychologising of grief and the medicalisation of mourning. Moreover, in the present study, a broad underlying trajectory of development common to Western societies will be proposed, that effectively distinguishes them from other societies. In Chapter 5, a classification of societal types will be offered, drawing on structural differentiation theory (Durkheim, (1984[1893])). Here, NI will be presented as sharing the characteristics of structurally relatively complex societies, enabling comparison with structurally relatively simple African societies, such as Uganda. This conceptual framework will facilitate comparison of bereavement practices across these two settings.

Despite differences across societies, the literature suggests that, globally, professional counselling services are generally based on concepts derived from Western- philosophy and psychology, which are considered normative for all cultures (Tseng, 1999). Gerstein et al. (2009) assert that the USA took a historical lead in the development of counselling practices, and consequently dominates worldwide. It is argued that an individualised Western counselling framework has been imposed on the collectivist traditions of other cultures (Arulmani, 2007; Rosenblatt, 1993; Tseng, 1999).

Historically, psychology has sought to distinguish itself from theology by adopting an inductive approach of scientific reasoning, based on objective verification of facts, thereby separating itself from preoccupation with the soul, while privileging the study of behaviour (Arulmani, 2007). However, the Western emphasis on talk, intellectual insight, and developing a personal relationship between counsellor and client, are seen to be narrow, restrictive and ethnocentric from a comparative perspective across societies (Tseng, 1999; Arulmani, 2007)

2.9 Conclusion

This chapter has explored a range of factors which contribute to perceptions of death, bereavement and bereavement counselling in Western settings, and more specifically, within the UK and NI. A historical shift in attitudes to death and mourning has been identified. Since industrialisation, death has become less directly visible in day-to-day lives (Walter, 1999), although different theoretical positions around the contemporary social image of death have been identified (Howarth, 2011). Moreover, as societies have become more structurally differentiated, as a result of industrialisation and urbanisation, experiences of death and bereavement have become less homogeneous within social formations. Death has become more diverse as societies have become more complex.

The organisational context of bereavement counselling, and best practice guidance, was also explored. Whilst bereavement is seen to be an inevitable life-event in which individuals do not routinely need professional interventions (Raphael et al., 2001), professional support following a death is widely available in the UK (Wimpenny et al., 2006). The absence of family or other social support appears to be a significant determinant of the need for professional intervention. UK Government guidelines stipulate the circumstances in which bereaved individuals should be offered professional help (NICE, 2004). However, despite an increasing governance agenda, there is a rather *ad hoc* provision of bereavement counselling (Wimpenny et al., 2006), with many similar services offered in both the voluntary and statutory sectors (Stephen et al., 2009). Within NI, bereavement counselling is offered by professional counsellors and mental health professionals (DHSSPS, 2002), in addition to volunteers and clergy (Hendron et al., 2014; O’Kane & Millar, 2001). However, the focus of this study is on counselling offered by professionally-trained counsellors across different settings, as this has been identified as a major gap in the literature (Gerstein et al., 2009).

It can be concluded that changing attitudes to death in Western settings will be reflected in the experiences and expectations of bereaved individuals and those who work with them. Bereavement counsellors are at the heart of the interconnected trends in death and bereavement highlighted in this chapter. Perceptions of this professional group can provide a microcosm of much deeper and longer trends. The following chapter will seek to offer a comparable account of the Ugandan perspective on death and bereavement. This will conclude with a review of how the issues and debates highlighted in these chapters can inform the development of the present research questions.

Chapter 3 Death, Bereavement and Bereavement Counselling in Uganda

3.1 Introduction

The literature on death and dying offers limited insight into African perspectives on grief and bereavement, a notable exception being anthropological studies of mourning rituals (Parkes et al., 1997). Knowledge of African bereavement practices has come largely from observational studies or anecdotal accounts (Maasdorp & Martin, 2009) and there is an identified need for research in this area (Klass, 2008).

In this chapter, an initial discussion of death and bereavement practices in Sub-Saharan Africa will be followed by a focus on bereavement counselling in Uganda. This will include an overview of the introduction of counselling into Uganda, and how this relates to pre-existing support mechanisms. This will be followed by a review of the current knowledge of counselling practices in this setting. The chapter will conclude with a summary of the apparent contrasts in death and bereavement practices between African and Western settings.

3.2 Death and Bereavement in Sub-Saharan Africa

A core issue in any comparative study of bereavement is the degree to which grief and mourning can be seen as universal human responses to loss (Eisenbruch, 1984a; Stroebe & Schut, 1998). Archer (2001) argues that grief is universal, on the grounds that it is documented in diverse settings and evidenced in the natural world. Rosenblatt (2001) questions the extent of commonality of grieving experiences. Adopting a social constructionist view, he suggests that grieving is malleable and there is not a simple developmental or biological process which controls how people grieve. Although mourning and grief appear to be common phenomena, associated ritual, cognition, expression and practice differ widely (Mantala-Bozos, 2003; Parkes et al., 1997).

It is therefore important to consider how representative Uganda is of sub-Saharan African countries in terms of bereavement practices. There are contrasting views. Ugwuegbulam et al. (2009) suggest that pan-African generalisations can obscure societal differences, with anthropological studies clearly identifying different mourning practises across ethnic groups in Africa (Douglas, 1963, 1966). In contrast, Withell

(2009) indicates that studies across sub-Saharan Africa demonstrate remarkable similarities in many aspects of bereavement. This chapter will privilege research literature on Uganda. However, as this is not extensive, literature relating to other sub-Saharan African countries will also be presented, with differences and similarities acknowledged.

Maasdorp and Martin (2009) identify four challenges to bereaved individuals in what they term the ‘developing’ world: political challenges; economic challenges; social, cultural and spiritual challenges; and finally, specific challenges. These will now be considered in relation to Uganda.

Maasdorp and Martin (2009) contend that political instability in many countries has led to death becoming politicised. During times of conflict, deaths may not be policed appropriately, limiting communities’ opportunities to bury their dead and mourn according to prescribed customs. Within Uganda, it is estimated that, in the 1970s, 300,000 people were murdered by Amin’s military regime (Oloka-Onyango, 2004). Whilst the country now enjoys relative stability, the US Department of State (USDS) has highlighted human rights violations:

‘Serious human rights problems in the country included arbitrary killings; vigilante killings; mob and ethnic violence; torture and abuse of suspects and detainees; harsh prison conditions; official impunity; arbitrary and politically motivated arrest and detention’ (USDS Bureau of Africa Affairs, 2013).

Furthermore, the internal war between the Ugandan government and the rebel group, the Lord’s Resistance Army (LRA), continues, resulting to date in over 1.8 million deaths and abductions (Kiboneka, et al., 2009). Roberts et al. (2008) explored the impact of this trauma on individuals living within an International Displaced Persons (IDP) camp in northern Uganda, finding that 54% of respondents suffered from post-traumatic stress disorder (PTSD) and 67% met the criteria for depression. Three quarters of respondents had witnessed or experienced the murder of a family member or friend. These levels of PTSD and depression are among the highest recorded globally using similar methods.

With regard to economic challenges, factors such as unemployment and low wages shape the ability of individuals to respond to grief (Maasdorp & Martin, 2009). The

provision of hospitals or welfare support is often inadequate and neglect individuals' emotional needs. People may have little choice but to take risks in meeting their basic daily needs, particularly during natural disasters (Howarth, 2007a).

Empirical evidence suggests that, in Uganda, the practical and economic costs of bereavement place a significant burden on individuals. A study of palliative care services in Uganda, Kenya and Malawi identified that already poor patients were struggling to deal with the costs of illness and their futile attempts to gain a cure (Grant et al., 2011). Other Ugandan studies have suggested that bereavement is often associated with a loss of income, which may have serious consequences for survival, especially if the death is that of the bread-winner. Many bereaved individuals define their loss in terms of the input of the deceased into the household, suggesting a correlation between the economic and emotional aspects of loss (Kaleeba et al., 1997; Kikule, 2003; Mpolo, 1985; Withell, 2009).

The spiritual aspects of life in African societies, and the consequent need to make sense of death, are common themes in the literature. Death is widely considered to be a transition to another spiritual state (Douglas, 1966). Hertz (1960[1907]) and van Gennep (1960[1909]) both describe the place of ritual in managing life's major transitions, in particular, death. Here, the passing from life to death is seen in three stages: separation, a subsequent liminal stage, and finally entry to the new status that death brings. Death practices promote the cohesion of the extended family, including continuity with ancestors, with a series of rituals developed to maintain the relationship of the living with the dead. *'Clearly prescribed and strict rituals exist in every tribe, determining for everyone the appropriate behaviour in the face of death'* (Kilonzo & Hogan, 1999: 260). These rituals are typically brief, intensive and collective.

In Uganda, the work of two anthropologists has identified mourning rituals for particular ethnic groups. John Middleton (1987[1966]) conducted fieldwork among a prominent ethnic group, the 'Lugbara', suggesting that the role of religious practice is to try to contain a world which is otherwise uncontrollable. Central to these beliefs is the management of *'the cult of the dead'* (Middleton, 1987[1966]: 25) in which ritual seeks to maintain a permanent relationship between the living and their dead relatives. A second British anthropologist, Colin Turnbull, conducted ethnographic research whilst living within the communities of the nomadic people-group, the 'Ik'. His major work,

The Mountain People (1972), identified a system of collective death rituals which seek to appease the ancestral spirits, ensuring the spirits of the deceased do not return to haunt the living.

Other Ugandan studies highlight that death is often explained as the fault of another person, associated with human malice, either from within the family through ancestral displeasure, or as a result of witchcraft (Seeley & Kajura, 1995). This is accompanied by a strong spiritual component in the coping mechanisms of bereaved individuals, frequently embedded within syncretistic belief systems (Grant et al., 2011; Hodge, 2010). In particular, as AIDS has become more widespread, AIDS deaths are explained in terms of both witchcraft and medical science; while it may be understood that AIDS can be ‘caught’ through a sexual act, vulnerability may still be attributed to witchcraft (Hooper, 1987).

A number of Ugandan studies indicated that the expression of grief is strictly controlled by collectively-enforced social norms. Several have focused on the experience of orphans (Atwine et al., 2005; Fjermestad et al., 2008; Oleke et al., 2007; Sharpe, 1999; Withell, 2009). They emphasise the embargo on children expressing grief outside the mandatory grieving period; the expression of grief is short, intensive and prescribed. Sharpe interviewed 48 orphans and their carers from a rural district in Uganda. Her findings suggest that it was not culturally acceptable for children to express their on-going grief, although anger was widely acknowledged.

‘Over 80% of the orphans ... spoke of being angry and irritable, “angry with my parent for dying”, “angry for being left poor, without anything, even land,” “angry for not having money for school fees”, “angry for being neglected”’
(Sharpe, 1999: 69).

Fjermestad et al. (2008) conducted semi-structured interviews with orphans and their guardians in a city slum in the capital, Kampala. They found that coping strategies revolved around attempts to ignore the loss. As one child poignantly put it: *‘It can save you if you just forget’* (Fjermestad et al., 2008: 445). The same picture of avoidance of grief, and normatively imposed silence, emerges in other studies; for example *‘When we cry nobody bothers’* (Oleke et al., 2007: 540). Another study found that children might be aware that their loved one is dying but pretend not to know in *‘the conspiracy of silence’* (Withell, 2009: 132).

Similar findings are presented in studies of adult grief in East Africa (Lie & Biswalo, 1994; Nordanger, 2007). Nordanger found that coping strategies largely revolved around avoidance and repression of emotions outside highly intensive short mourning periods. These strategies were reinforced through community-based and religious beliefs; *'sorrow brings sorrow'* (Nordanger, 2007).

'Avoidance stands out as the predominant coping norm among Tigrayan informants exposed to politically violent events. This norm is reaffirmed by cultural beliefs saying that grieving and crying would have negative impacts on people's health, households, as well as on their relation to God' (Nordanger, 2007: 557).

Maasdorp and Martin (2009) suggest that the structure and role of extended families impact on how bereavement is experienced. The role of the Ugandan family, village and community in supporting sick and bereaved individuals is discussed in a number of studies. Nwoye (2000) identifies a joint responsibility for the care of bereaved individuals on the part of professionals and the wider community. When someone dies, what is lost is a *'general asset'* to the whole community (Nwoye, 2000: 63); for example, the death of a young person represents the loss of a future asset. The collective message to the bereaved is that the burden of loss is not theirs alone. It is also a loss to the community and the community can replace that which was lost in the bereavement. Individuals offer support to others in large part as insurance against their own loss when it comes (Nwoye, 2000).

However, Seeley and Kajura (1995) suggest that family involvement may be easier in rural communities but is not always seen as helpful. The process of widowhood often means that women are disadvantaged. In many African settings, including many in Uganda, a leviratic inheritance system exists in which the bride and any children of the marriage are deemed to belong not just to her husband, but his lineage. Thus, on the death of a husband, the marriage may be continued through a second marriage, to a wife's, often polygamous, brother-in-law. In contemporary Africa, these arrangements are often fraught with difficulty, since urbanised women may demand choice, and geographical mobility may mean wives are strangers to their husbands' male relatives. Hence this system has been said to generate *'harrowing and sadistic experiences from*

the very social support network intended to cushion the traumatic impact of widowhood' (Kalu, 1989: 144).

The final category of challenges to the bereaved, suggested by Maasdorp and Martin (2009), is that of 'specific challenges' of which a central factor in Uganda is the AIDS pandemic. Although only 10% of the world's population live in Sub-Saharan Africa, it is home to 68% of adult sufferers and 90% of diagnosed children (Dixon, 2004). Throughout sub-Saharan Africa, the AIDS pandemic has altered formal and informal helping systems. The stigma of AIDS and the associated label of immorality can extend to bereaved family members. Ingrained traditional mourning rituals with '*deep mitigating psychological functions*' (Kilonzo & Hogan, 1999: 277) have been abridged or abandoned as a result of the AIDS pandemic. The numbers of dead, and the consequent economic and time constraints, have rendered it impossible to maintain traditional rites around death and mourning (UNAIDS, 2010).

Uganda is heralded as a country which has subdued this pandemic (Dixon, 2004) and which promotes tolerance, acceptance and solidarity with AIDS sufferers (Maasdorp & Martin, 2009). Even so, the impact of AIDS on death and bereavement practices in Uganda is significant (Oleke et al., 2007; Seeley et al., 1991). There has been a shift in prevalence from younger to older individuals (UNAIDS, 2010). A large proportion of informal carers are HIV positive, compromising the sustainability of informal support networks, which have already been impacted by many years of war, civil unrest, and economic decline. Stigma associated with an AIDS death is also identified as a significant influence on the grieving process (Seeley & Kajura, 1995).

Maasdorp and Martin (2009) also consider special deaths. However, notably absent from the literature on death and bereavement in Uganda is any reference to special deaths. This may be due to the fact that multiple, premature and violent deaths in many African societies, have become regarded as normal (Kilonzo & Hogan, 1999).

3.3 Bereavement Counselling in Uganda

An analysis of bereavement counselling in Uganda must begin with some comment on the milieu in which counselling has developed.

'A study of African indigenous counselling reveals that from time immemorial, African societies have institutionalised psychological provision for the

maintenance of the well-being of all members of society' (Alao, 2004: 250, cited in Ugwuegbulam et al., 2009: 437).

It is unclear how Alao defined '*African indigenous counselling*', highlighting a lack of consistency in the use of this term. Lago (1996) suggests that familial relationships and traditional healers both provide a form of counselling.

The empirical and discursive evidence relating specifically to Uganda suggests that support and advice have typically been provided within family structures. Often, traditions of giving advice discriminate by age and gender (Seeley & Kajura, 1995), passed down through kinship groups and local communities (Senyonyi et al., 2012). Structured support and guidance is provided during significant life-events, such as pregnancy, birth, adolescence, marriage and death. For example, among the Buganda in Uganda, the maternal aunt has traditionally been the one to advise a bride on her role, accompanying her through the ceremonies and to her new home (Seeley & Kajura, 1995).

In addition, as part of this culturally sanctioned system, the majority of individuals in Africa – a figure given as 80 % by the WHO – have sought help and indeed continue to seek help from traditional healers (WHO, 2003). Although the WHO recognises the positive role played by indigenous healers, the efficacy of this practice is much in question (Tseng, 1999). The numbers of people accessing traditional healers may now be declining, a development attributed to the high costs of healing and lack of confidence in the healer (Kang'ethe, 2009). The Western practice of counselling has been introduced into these pre-existing structures and practices and co-exists with traditional methods of helping (Lie & Biswalo, 1994). Senyonyi et al. (2012) suggest that the development of counselling in Uganda has its roots in three areas: traditional guidance systems provided by families; school-based guidance and counselling; and counselling offered within the support structures of AIDS organisations. In other African countries, such as Nigeria (Ugwuegbulam et al., 2009) and Gambia (Pattison & Corr, 2009), counselling is still very much associated with school counselling. In Uganda, the introduction and increased take-up of counselling practice has been facilitated by the promotion of HIV counselling (Grinstead & van der Straten, 2000). This change has also been highlighted in a study in the neighbouring country of Tanzania:

'Today with a fragile defensive structure bereft of its traditional grieving devices, Tanzanian society has regulated its mourning task to mass-produced, briefly-trained counsellors and the availability of counselling services is expanding dramatically' (Kilonzo & Hogan, 1999: 275).

Whilst counselling was introduced into East Africa as recently as the early 1990s, by 2000 counselling was said to have already become established (Kilonzo & Hogan, 1999). It is difficult to know if individual professional counsellors existed prior to this time. Some studies suggest that the skills of counselling are not new to helping professionals in Uganda, but these professionals have not previously dealt with issues of loss, illness and sexuality (Karamagi, et al., 2004; Seeley & Kajura, 1995).

The most frequently cited problem associated with the introduction of counselling into Uganda concerns the introduction of a practice that is firmly rooted in Western values and beliefs. Counselling is said to be founded on Eurocentric values of independence, self-direction and assertiveness (Bracken, 2002; Lago, 1996). In contrast, African religions and belief systems require communal and family needs to take precedence over individual needs. *'The cultural importance of the larger group takes precedence over personal needs and results in a locus of control that is externally based'* (Ugwuegbulam et al., 2009: 436). A number of Uganda-based studies which have explored community attitudes to HIV counselling (Gusdal et al., 2011; Kairania, et al., 2010; Kipp et al., 2002) suggest the need to adapt Western counselling approaches to the Ugandan context. Madu et al. (1999) indicate that, in African help-seeking models, sickness is deemed to originate as a punishment from gods or ancestors, and therefore traditional healing methods are deemed necessary to end this punishment. In this process, traditional healers work with the family or community, not solely the individual. The need for professional counselling to take into account the principles of indigenous healing practices has also been identified in studies across a wide range of African countries, including Kenya (Ochieng, 2010; Trivasse & Trivasse, 2002), Nigeria (Oyewumi, 1986; Ugwuegbulam et al., 2009), Rwanda (Bagilishya, 2000), South Africa (Naidoo & Kagee, 2009) and Tanzania (Kilonzo & Hogan, 1999).

Difficulties arising from the individualised nature of much counselling have also been noted (Pattison & Corr, 2003; van Dyk & Nefale, 2005). There are conflicting arguments around the relative effectiveness of particular theoretical models across

different societal settings (Tseng, 1999; Dalal, 1997). Tseng (1999) suggests that, because of colonial dominance, there are few indigenously-trained mental health professionals in Africa. Most mental-health professionals and counsellors are trained in settings where Western counselling models are used. Counselling training courses in Africa often utilise Western models of counselling and assessment tools (Trivasse & Trivasse, 2002; van Dyk & Nefale, 2005; West, 2007) that '*are not contextualised to fit the different cultures of Africans*' (Senyonyi et al., 2012: 502).

Counselling practice in Africa is often seen as didactic, akin to the role of the village elder who disseminates wisdom and instruction (Ugwuegbulam et al., 2009). Several studies record expectations of a directive counselling approach (Nefale, 2004; Pattison & Corr, 2003), and note that African clients express problems somatically (Madu et al., 1997). Naidoo and Kagee (2009) found that counsellors in Tanzania became more directive in response to the expectations of their clients. Likewise, Oyewumi (1986), a Western-trained Nigerian psychotherapist, suggests that Nigerian patients expect authoritarian treatment and are confused by a model that leaves them to decide what to do next. Neki et al. (1985), in reviewing their clinical experiences with Tanzanians over many years, conclude that the core belief that 'talk is good for you' is a product of Western beliefs. However, some studies have found that indigenous African counsellors view the client-centred approach positively (McGuinness et al., 2001; West, 2007), a view also taken by at least one group of clients (Lie & Biswalo, 1994).

Seeley et al. (1991) found that local communities expected to be consulted and involved in the establishment of a counselling programme in their villages. In developing an HIV counselling service in three rural settings, village leaders had a pivotal role in deciding who should or should not be allowed to receive their HIV results. Evidence is also provided of leaders thwarting the counselling programme when it did not please them, or where the counsellor, in their view, was 'not doing it right'. More generally, HIV counselling needs to deal with a variety of issues including the impact of stigma, multiple losses, a reduced caring network and transference dynamics (Crowley, 1995; Lie & Biswalo, 1994; Martin & Dean, 1993; Nefale, 2004; Swartz, 2007; Yamba, 1999).

The dynamics of the counselling process, including transference and countertransference (see Chapter 4 and the Glossary for an explanation of these terms),

have also been highlighted in the literature. Countertransference has been associated, for example, with counsellor and client having a shared historical identity (Swartz, 2007), shared HIV status (Crowley, 1995; Nefale, 2004), and shared experience of violence (Ochieng, 2010). A longitudinal qualitative study, at Uganda's Mildmay HIV hospital, explored the experiences of staff who were themselves HIV-positive (O'Keefe & Frankham, 2002). Many acknowledged their own emotional distress, describing multiple losses due to the death of patients and family members. Other Ugandan studies suggested that a counsellor's capacity to listen is enabled by shared experience of pain, stigma, isolation and multiple losses (Kaleeba et al., 1997; O'Keefe & Frankham, 2002).

First-hand accounts of indigenous counselling practice from across sub-Saharan Africa provide useful insights. McGuinness et al. (2001) found that professional counsellors in Kenya emphasised the importance of building a therapeutic relationship based on respect. Counsellors in Uganda emphasised the need to maintain confidentiality and to be good role models within their community (Grinstead & van der Straten, 2000). Ochieng (2010), in her account of bereavement counselling with an orphaned girl in Kenya, describes a client-centred model, with the inclusion of a wide range of therapeutic strategies including writing exercises, physical education and drama. Pattison and Corr (2009), in their study of school counselling in Gambia, identify the lack of a confidential, quiet counselling environment, which was also noted as a problem by Ochieng (2010).

Pletzer (1999) presents an African counselling model, developed from his work with victims of violence living in refugee camps in Uganda and Malawi. This model emphasises the need to encourage bereaved individuals to think positively about their loss. For example, clients are encouraged to: compare themselves with those less fortunate; selectively focus on positive attributes of themselves in order to feel advantaged; and imagine a potentially worse situation whilst construing benefits that might derive from the victimisation experience.

From this discussion, it can be concluded that, in African settings such as Uganda, traditionally death and mourning are ritualised, the permitted expression of grief is brief and intense, and bereaved individuals are expected quickly to re-engage with their responsibilities (Sharpe, 1999). However, political, economic and other pressures from

within and outside Uganda may be introducing large-scale social change, and thus influencing the context and practice of bereavement counselling. While counselling training may follow Westernised models, counselling practice may adapt to local conditions.

3.4 Key Constructs in Attitudes to Death and Bereavement

This chapter will conclude by offering a set of seven broad dimensions that appear to differentiate attitudes to, and experiences of, death and bereavement in contemporary Western and African societies. The literature reviewed so far in this thesis has identified key differences in the manner in which death, grief and mourning are handled in different social contexts (McLeod, 2009; Stroebe & Schut, 1999; Valentine, 2009; Walter, 1999; Walter, 2012). These differences are presented in Table 1 in the form of ‘ideal types’ (Webber, 1949[1904]), as a convenient means of illustrating and summarising the themes emerging from the literature.

Table 1: Contrasting perspectives in the management of death and bereavement

Dimension	Dominant perspective in African societies	Dominant perspective in Western societies
Response to death	Collective	Individual
Negative impact of death	Economic	Emotional
Mourning duration and intensity	Short, intensive	Long, repressed
Belief system	Sacred, holistic	Secular, dualistic
Death narrative	Shared mythology	No agreed narrative
Concept of self	Directed	Autonomous
Grief sharing	Integrated, open	Sequestered, closed

These dimensions represent the dominant discourses, or salient narratives, within which death and bereavement are conceptualised, interpreted and experienced. Variations can be expected to exist within these polarised dimensions. For instance, within

Westernised, individualist settings, some collective elements can still be observed (Howarth, 2011) and contrasting sub-groups are evident (Walter, 1999). Identified variations in death and bereavement practices are often associated with a range of interdependent social, demographic and structural factors (Howarth, 2011). These include rural and urban contrasts (Rosenblatt, 1997), age and gender differences (Hansson & Stroebe, 2007; Stroebe et al., 2003), and influences due to ethnicity and religious belief (Parkes et al., 1997) as well as socio-economic status (Howarth, 2007b). However, ideal types are conceptual constructs not empirical generalizations or summaries. Their function is to pinpoint the key underlying features of social processes and relationships.

The dimensions listed in Table 1 should be considered as continua rather than discrete, opposed categories, such that individuals, groups and societies can be located at variable points on each continuum. Later in this thesis, the research findings will be considered in terms of how exemplify or diverge from these ideal types, and how these ideal types can be related to informants' perceptions of their counselling practice. The dimensions outlined in Table 1 will now be explained.

African societies can be broadly said to be highly collective in their response to death (Nefale, 2004). Individuals are expected to sacrifice their personal freedom for the good of the group. There is less emphasis on individual psychology, and causes of death are sought in malicious interpersonal relationships (Hodge, 2010). Mourning rituals reinforce cultural connectedness and continuity of relationship with the deceased (Kilonzo & Hogan, 1999). Community involvement with dying individuals and their bereaved families is widespread and assumed (Muhwezi et al., 2007). In contrast, Western societies emphasise individual autonomy. Westernised peoples tend to develop their understanding of self and others through independent reflective processes; death is therefore managed by individualistic rules (Winkel, 2001). In practical terms, family support for bereaved individuals is relatively attenuated as a consequence of enhanced geographical and marital mobility (Parkes, 1996).

In African societies, the negative impact of death is defined in terms of the household's socioeconomic situation (Nordanger, 2007); the death of an individual means a loss of the contribution of that individual to the functioning of the community (Nwoye, 2000). In contrast, within Western settings, the impact of death is predominantly understood in

emotional terms, with less account taken of the secondary adjustments that need to be made by bereaved individuals (Hansson & Stroebe, 2007; Stroebe & Schut, 1998, 1999).

Mourning duration and intensity also vary across settings. Social customs in African settings require emotional expression to be contained within certain strict boundaries (Middleton, 1987[1966]); an overt, intense but brief expression of grief is expected, followed by an embargo on subsequent emotional expression (Seeley et al., 1991). Thus, grieving is expected to be short and intense. In most non-Western settings, somatic grief symptoms predominate to a greater extent than within Western contexts (Stroebe & Schut, 1998). In contrast, the intense expression of emotion at funerals is said to be discouraged in Western societies (Lovell et al., 1993; Rosenblatt, 2001), where restraint is expected from bereaved individuals (Parkes et al., 1997). Boundaries around the timing of individualised mourning are unclear, but both families and professionals have expectations of a normal grieving period. An individual's grief can be classified as 'complicated' if it is prolonged (Holloway, 2007). Because individuals' ontological security is challenged by death, death is denied and sequestered from the public sphere, resulting in emotional grief reactions which are likely to be repressed and enduring (Elias, 2001[1982]; Seale, 1998).

In African societies, explanations for illness and death are often associated with a syncretistic worldview, incorporating magical and religious beliefs (Withell, 2009; Yamba, 1999). People view the world as a whole; spiritual, mental and physical dimensions are all seen as interconnected aspects of a single reality and death is considered a transition to some other spiritual state (Hertz, 1960 [1907]). In the increasingly secularised and humanised society of the West, bereavement is often understood according to a secular framework (Parkes et al., 1997). There is said to be a dualistic division between the mind and body, and an impenetrable boundary between the living and the dead (Howarth, 2000). However, it must be acknowledged that, within this broadly secularised society, a spiritual narrative is often employed in helping individuals to make sense of death and dying (Agnew et al., 2008; Howarth, 2007a; Kellehear, 2000; Walter, 1994).

Death narratives also vary across settings. In African contexts, culturally-sanctioned rituals around mourning and lamentation include a shared mythology for making sense

of loss (Elias, 2001[1982]). Mourning rituals focus on the cohesion of the extended family, including continuity with ancestors. There is a strong continuity between the past and present, which is passed down through an oral tradition of storytelling (Ugwuegbulam et al., 2009). In particular, it is assumed that death is the outcome of fault and is often associated with human malice (Seeley & Kajura, 1995). In contrast, in Western societies, there is said to be a limited shared system of beliefs (Parkes, 2001). Mourning rituals may be replaced by discourse in which individual reflection and psychologising are employed to make sense of a loss (Giddens, 1991).

Variations in the concept of self are also reflected in bereavement processes. In African settings, the self can be said to be defined by social norms and status, by authority structures and stabilising routines (Giddens, 1991; Grant et al., 2003; Nwoye, 2000). Appropriate behaviour following a death is prescribed by collectively enforced norms (Kilonzo & Hogan, 1999). In Western settings, people are more likely to be seen as autonomous, separate individuals. Constraints on personal choice are often seen as undesirable; a good choice is authenticated by the fact that it has been made by the individual without constraints of external authority (Walter, 1994).

There are also contrasts in grief sharing in African and Western settings. In African contexts, death is more integrated into the fabric of everyday life and is in essence a public affair (Middleton, 1987 [1966]; Ochieng, 2010). Consequently, death is less sequestered. In contrast, much of the literature on dying and bereavement describes Western societies as being in denial of death (Elias, 2001[1982]). The professional and medical management of death enables individuals to distance themselves from the dying, who have become sequestered from day-to-day life. Whilst the extent to which death is denied and sequestered is debated (Howarth, 2007a), death is more private and hidden in comparison with African societies.

In summary, these seven dimensions help to identify and clarify discernible dominant approaches to the management of death and bereavement within Western and African settings. The empirical findings reviewed in Chapters 2 and 3 suggest that NI and Uganda conform fairly closely to these ideal types, although variations are evident. Discussion of these ideal types will be continued in subsequent chapters and, in Chapter 11, the findings from this study will be discussed with reference to them.

3.5 Conclusion

This chapter provides insight into how death and bereavement are experienced in African settings such as Uganda. The development of ideal types highlights comparisons and contrasts with the management of death and bereavement in Western settings, such as NI.

A range of factors have contributed to the perception of death, bereavement and bereavement counselling in African cultures generally, and more specifically within Uganda. Challenges to bereaved individuals in Uganda include: political challenges; economic challenges, social, cultural and spiritual challenges; and specific challenges such as the AIDS pandemic. In Uganda, the customs surrounding death and mourning are ritualised, the expression of grief is brief and bereaved individuals are required to quickly re-engage with their responsibilities; help-seeking structures and belief systems are collective. Differences are evident between the philosophy and values of Western counselling models and Africa's religious and communally-based belief systems and practices.

The analysis of contrasting perceptions of death, bereavement and mourning in Western and African settings establishes an agenda of research themes and questions for this study. It highlights the influence of historical, social policy and institutional factors on bereavement counselling, including comparisons of organisational and governmental guidelines. Additionally, the differential histories of violence and division within NI and Uganda may influence the delivery of bereavement counselling (McNally, 2011; Seeley & Kajura, 1995).

In relation to characteristics of counsellors, Table 1 suggests that an exploration of the counsellor's rationale, goals and practices is a key task. It is anticipated that the nature of the bereavement experience of counsellors will vary across settings. Bereaved individuals and their counsellors in NI are likely to have a higher regard for individual autonomy; self-identity may be negotiated, and moral absolutes may be rejected. In Uganda, it is anticipated that identification with the group will be emphasised over self-actualisation, and a network of social relations and indigenous healing customs and traditions will influence bereavement responses. Counsellors' perceptions of how they negotiate an individual's response to loss should be explored in both settings. The personal impact of bereavement work on the counsellor should also be examined, along

with transference issues, reflecting shared experiences of loss between clients and counsellors.

In exploring counsellors' perceptions of clients, the relationship of the client to the wider community must be a central theme. The presence or absence of family support appears to be significant in NI. In Uganda, counsellors' perceptions of how counselling relates to traditional support mechanisms should be explored. Finally, in relation to the counselling practice, it is of interest to explore the methods and models used in bereavement counselling in NI and Uganda and the influence on practice of the individualistic or collectivist characteristics of each setting.

Before considering these research aims further, it is necessary to develop a suitable theoretical framework for this study. In so doing, the research questions will be guided by relevant theory, and the study move beyond a simple description of similarities and differences in bereavement counselling, to one which considers why and how these differences occur. In the following two chapters, the value of adopting a combined psychological and sociological framework will be explored.

Chapter 4 The Conceptual Foundations of Bereavement Counselling: The Legacy of Freud

4.1 Introduction

The goal of this and the following chapters is to establish a theoretical framework capable of explaining differences in patterns of bereavement counselling in the contrasting societal contexts of Uganda and NI. This chapter will discuss the psychological conceptions of grief that constitute the theoretical and conceptual foundations of bereavement counselling in both societies, with an emphasis on Freud and the post-Freudians. In the following chapter, sociological conceptions of grief will be considered, with an emphasis on Elias's figurational theory.

There are opposing opinions on the validity of Freudian theory (Hagman, 1995; Wortman & Silver, 2001). The reason for the inclusion of Freudian theory here is that Freud laid down the basic conceptual parameters of the theory and practice of bereavement counselling that continue to this day. Hence, an analysis of the influence of psychoanalytic theory on the contemporary understanding of mourning and on the practice of counselling is essential to an understanding of the professional practices of bereavement counsellors. This chapter will also evaluate the efficacy of Freudian theory in accounting for the subsequent findings of comparative studies of grief and bereavement in a range of different types of societies, described in Chapter 3. As a grand theorist, Freud, perhaps uniquely, offers a psychological theory which addresses both personal and interpersonal activities. It has the potential to conceptualise overarching macro-factors associated with counselling context, whilst linking these with a micro-level analysis of the characteristics of counsellors, clients and counselling practices. It is unlikely that a micro-level bereavement theory would have the explanatory potential to address issues relating to these broad research questions.

This chapter will begin with an overview of relevant Freudian theories and a discussion of their utility as an explanatory framework for this study. Secondly, key post-Freudian theories are reviewed in order to consider how they might address any identified limitations of Freud. This will begin with a review of Gorer, Lindemann, Bowlby and Parkes, with reflection on their potential influence on bereavement counsellors. This will be followed by a brief discussion of the work of Rubin and Malkinson, Hagman,

Klass and Neimeyer. Finally, the work of theorists whose focus is on the area of complicated grieving, namely Prigerson and Jacobs, Holloway and Doka, will be explored. This section will conclude with comment on the extent to which these post-Freudian theorists can establish a theoretical framework capable of explaining differences in bereavement and bereavement counselling between societies. In reviewing and evaluating these later contributions, the prevailing influence of Freud on bereavement theory and therapeutic interventions, will become apparent.

4.2 Freud's Theory of Mourning and Grief

Sigmund Freud (1856-1939), the founding father of psychoanalysis, sought to explain the '*entire gamut of personal and interpersonal activity*' (Frosh, 1987: 19). Bocock (1991) suggests that Freud has contributed to knowledge in three main ways: firstly, by presenting a theory of the mind; secondly, by developing a method of therapy based primarily on exploring the unconscious; and finally, by presenting a set of statements, sociological in nature, about societies and their major institutions.

In order to understand Freud's theory of mourning, it is necessary to understand his topographical model of the mind, and his theories of drive psychology and psychosexual development (Bradbury, 2001). However, it must be noted that Freud's ideas changed significantly throughout his life (Badcock, 1992; Bradbury, 2001), with many of his theories remaining complex and ambiguous (Laplanche & Pontalis, 1988) and given contradictory explanations in the literature (Dalal, 1998).

The most radical feature of Freudian theory is the distinction it makes between the conscious and unconscious mind, and the supposition of a spectrum of states of consciousness (Symington, 1986). In *The Ego and the Id* (1923), Freud introduced his structural model of the mind, comparing the id, ego and super-ego (Laplanche & Pontalis, 1988). The id is deemed to be present at birth and to provide all the energy to run the psyche. The ego is deemed to comprise the conscious sense of self, along with an unconscious force and a reservoir of libidinal energy; it is the primary agent of repression. The super-ego is deemed to represent the internalised value judgments of others; it is an umbrella term for the highest-level mechanisms that work to access the ego's ability to meet an imagined ideal (Carhart-Harris et al., 2008).

Freud postulated that drives provide the energy within this model; these are deemed to come from the body and produce mental events. These ideas were ultimately expressed in a dual instinct theory, presented in *Beyond the Pleasure Principle* (1920). Whilst his theorising of the nature of drives changed over time, drive theory '*remained one of the invariants in his evolving theoretical edifice*' (Dalal, 1998: 20).

Freud's theory of psychosexual development, presented in *Three Essays on the Theory of Sexuality* (1905), set out to explain how children grow into healthy adults, whose relationships are characterised by consenting, mutually satisfying, genital sexuality. This was deemed to entail the successful negotiation of psychosexual stages in early life in which id impulses are dominant; thus, an infant's development progresses through oral, anal, phallic and genital stages. Within the phallic stage, a child must resolve the Oedipal complex where he or she desires to sexually possess the parent of the opposite sex. The development of personality is deemed to relate to the manner in which a child negotiates these stages.

Within this structural model, Freud positioned his account of mourning (Freud, 1917). He compared the experience of mourning with the pathological state of depression. Mourning is seen as the forced, involuntary withdrawal of the cathexis of an object; that is, a loved one. In response, the ego protests, denies the loss and strives to replace it with a substitute object, either real or imagined. Recovery occurs when the energy ties are severed to the original object and displaced onto new objects (Carhart-Harris et al., 2008). Freud suggests that the mourner relinquishes the emotional ties to the lost object through a process of reality testing. Initially, the mourner adopts a state of 'hyper-remembering', obsessively recollecting the lost object, assessing the value of the relationship and comprehending the loss. By comparing memories of the loved one against reality, the bereaved individual comes to a determination that the object no longer exists. This 'grief-work' is assumed to be unavoidable, required if the loss is to be confronted and the initial denial of reality overcome. Should this not happen, pathological grief is to be expected. It is hypothesised that every bereaved person will experience depression or distress during this process, but recovery can always come with time. The work of mourning is complete when the ego '*becomes free and uninhibited again*' (Freud, 1917: 245) but completion does not take place if the ego refuses to give up its attachment.

Raphael et al. (2001) suggest that Freud's mourning theory represents the earliest attempt to separate the clinical presentation of grief from depression. Whilst this is often considered Freud's main account of grief, it has been developed and expanded in other works (Bradbury, 2001; Clewell, 2002). In *On Narcissism* (1914), Freud suggests that we love others less for who they are and more for their ability to reflect back that part of ourselves we have invested in them. The loss of a love object is therefore a temporary disruption of the mourner's narcissism. The mourner must debate whether to follow the dead object or to live, thereby abandoning the other. This represents the battle of life and death and is resolved when the mourner chooses the narcissistic value of being alive (Clewell, 2002). Severing one attachment and returning the emotional investment to the ego is a prelude to making another attachment. In this scenario, the loss is really '*an irrecoverable attribute of the self, necessary to the mourner's sense of coherent identity*' (Clewell, 2002: 47).

In *On Transience* (1916), Freud questions why detachment from objects is such a painful process, suggesting that severance and replacement may not be straightforward. However, it is not until *The Ego and the Id* (1923) that Freud presents the culmination of his thinking around grief (Clewell, 2002). Here, a framework is provided for thinking about how the lost other creates the character of the ego. Freud postulates that it is only by internalising the lost other through the work of bereavement identification that the mourner's own identity is developed; identification is deemed to be the only means by which the id can give up its object. The character of the ego develops, therefore, as a 'precipitate' of abandoned objects: '*an embodied history of lost attachments*' (Clewell, 2002: 56). Thus, grief-work does not end with the freeing of the libido but is in fact an interminable labour.

In explaining these theoretical developments, Gay (1989) suggests that the influence of Freud's own personal circumstances is perhaps under-acknowledged. It is enlightening to consider the extent to which Freud was influenced by his father's death, his daughter Sophie's death, and the death of her infant son (Dozois, 2000). His 1929 correspondence nine years after Sophie's death may illustrate his need to normalise interminable mourning:

'Although we know that after such a loss the acute state of mourning will subside, we also know we shall remain inconsolable and will never find a substitute. No

matter what may fill the gap, even if it be filled completely, it nevertheless remains something else. And actually that is how it should be. It is the only way of perpetuating that love which we do not want to relinquish' (Freud, cited in Clewell, 2002: 61).

Freud's theory has been criticised for offering explanation only for mourning processes following the death of an individual under ordinary conditions. However, Ornstein contends that it can be applied to loss under conditions of '*war, acts of terrorism, and natural disasters*' (Ornstein, 2010: 631). In applying Freudian theory in these circumstances, Ornstein argues that, in situations characterised by multiple deaths and an absence of prescribed rituals, mourning is frequently delayed. Within the dual task of seeking new relationships whilst consolidating the old, typical mourning processes are reversed. Normally, new objects can only be found when old ones have been decathected. However, because of the volume of loss, new objects are not available to facilitate recovery. Therefore, defence mechanisms of disavowal or numbing are activated. These protect the individual from intolerable pain until the availability and support of others enables the grief-work to begin.

Some theorists consider Freud's work to be essentially flawed and invalidated by a lack of empirical evidence (Bonanno, 2001). It is critiqued as being unfalsifiable in that concepts such as decathexis are simply not testable (Hornstein, 1992), and as being based on work with a small, unrepresentative clinical sample (Wollheim, 1991). Alternatively, others have accepted Freudian theory as a foundation for further development. Some theorists, familiar with its equivocal empirical support, suggest the need for shifting emphasis and theoretical additions (Stroebe, M.S. & Schut, 2001a). These theoretical additions have ranged from revisions to extensive and radical changes (Hansson & Stroebe, 2007; Klass et al., 1996; Klass & Walter, 2001; McLaren, 1998; Stroebe & Schut, 1999). Notwithstanding these criticisms and further developments, it is the contention of this chapter that Freud has set the essential underlying parameters of discourses surrounding bereavement, grief and grief counselling. Arguably, many criticisms have been empirically based and have not generated a radically new paradigm.

In summary, Freud's developed model of mourning is clearly complex. Many of those who are critical attack his early model, which is dominated by the process of decathexis

and detachment (Bradbury, 2001; Hagman, 2001). His later model, which stresses that internalisation and identification with the lost other is healthy and inevitable, is often overlooked (Hagman, 2001; Ornstein, 2010).

4.3 The Capacity of Freudian Theory to Inform Comparative Societal Analysis

In his major writings on society - *Totem and Taboo* (1912-13), *Group Psychology and the Analysis of the Ego* (1921), *The Future of an Illusion* (1927), *Civilisation and its Discontents* (1930) and *Moses and Monotheism* (1939) - Freud was essentially interested in discovering the social foundations of humankind, in the origins of religion, morality and social institutions, and to explore 'primitive' attitudes to death and mourning (Cavalletto, 2007; Wollheim, 1991).

In acknowledging the sociological leaning of these works, it has been suggested that, rather than being a theory of individual development, Freud's work is essentially a social theory: '*Freud's theory is not a theory of individual personality systems seen in abstraction from groups*' (Bocock, 1991:176). Of prime importance is the relationship between the individual and the social group. This is seen predominately in the development of the superego where there is a strong focus on the internalisation of values derived from membership of a society (Bocock, 1991). Freud's social theory, which makes connections between social, and psychological processes, is potentially valuable as a conceptual framework for cross-societal analysis. However, it is difficult to read Freud and not find a seeming contradiction between the emphasis he places on, firstly, an entirely internal, instinct-driven and therefore universal psyche, and secondly, one which is developed through external influences and is, at least in part, culturally-specific (Cavalletto, 2007; Dalal, 1998; Fromm, 1971[1935]; Hagman, 1995). Dalal (1998) argues that, while Freud's evolving theoretical journey continues to address the influence of the external on internal psychic processes, it nevertheless assumes that the social is the outcome of internal processes. '*The bottom line in Freud is that he gives ontological priority to the internal over the external, to the biological over the social, and to the individual over the group*' (Dalal, 1998: 32).

Whilst Freud's social theory has potential for conceptualising practices in different social settings, it is considered to be ambiguous, widely speculative and outmoded (Bocock, 1991; Wollheim, 1991). '*To try to find in Freud's writings an articulated or*

coherent social theory or ethic ... is a vain task' (Wollheim, 1991: 219). Therefore, the present discussion will be limited to Freud's enduring psychoanalytic and structural concepts.

Consideration will now be given to how Freudian theory addresses the seven comparative dimensions in the management of death and bereavement, outlined at the end of the previous chapter. The dominant discourses within Western and African societies were summarised in seven ideal type dimensions (see Table 1). The perspective of Freudian theory on each of these dimensions is outlined in Table 2. These include Freud's interpretation of responses to death, the impact of death on the bereaved, mourning processes, beliefs about mourning, death narratives, concepts of the self and opportunities for the sharing of grief. In addition, drawing on material discussed in Chapter 3, Table 2 also highlights key challenges to Freudian theory derived from anthropological, historical and sociological studies of bereavement and grief. Table 2 thus identifies both the main aspects of Freud's theoretical contribution to the understanding of bereavement and the major limitations of his analysis as a conceptual framework of a comparative study across contrasting societal contexts.

In explaining bereaved individuals' responses to death, Freud proposes an intra-psychic, as opposed to a social, mourning process which is standardised and regimented. He argues that grief-work processes are triggered by spontaneous painful and sad affects, which arise following a loss and are associated with the involuntary withdrawal of the ego from a loved one. This is deemed to explain the individualistic and emotional response to death characteristic of Western societies.

It can be argued that, ironically, Freudian theory is suited to Western societies because their grief cultures have been shaped by an individualised philosophy and psychology (Shapiro, 2001; Walter, 1999). In this view Freud's theory is ethnocentric.

'Freud's bereavement theory remains influential because an individualised model promising that emotional catharsis will be followed by detachment and a full recovery powerfully appeal to modern, Western cultural beliefs in the encapsulated, isolated self-controlling fate' (Shapiro, 2001: 304).

This lacks the capacity to explain differences in responses to death and the negative impact of death including the immense influence of secondary losses identified in anthropological studies.

Table 2: The application of Freudian theory to Ideal Type Dimensions in the Management of Death and Bereavement

Dimension	Application of Freudian theory
Response to death	<p>Healthy grieving is deemed to require every person to engage in grief-work. This is viewed as a solitary, individual and intra-psychic process.</p> <p>This theory cannot account for collective responses to loss or the influence of contextual factors.</p>
Negative impact of death	<p>Grief-work is deemed to require the involuntary withdrawal of ego from a loved one. This process inevitably causes distress and depression.</p> <p>This theory does not address secondary losses, including economic concerns arising from loss.</p>
Mourning duration and intensity	<p>The severance and replacement of emotional ties is not considered straightforward. Grief-work is viewed as an interminable labour which is long and repressed.</p> <p>This theory cannot account for variations in emotional expression of grief according to socially agreed rules; and in particular, for grief which is confined to brief but intense periods of mourning.</p>
Belief system	<p>Freud's mourning theory does not address the significance of religious belief. In his other theories (1927, 1930, 1939) religious belief is portrayed as a neurotic response to helplessness.</p> <p>These theories can only account for the greater propensity to sacred belief systems in African societies by portraying them as manifestations of a universal neurotic process.</p>
Death narrative	<p>Grief-work is deemed to be an individual narcissistic process, and therefore ahistorical, intrapersonally negotiated and decontextualised.</p> <p>This theory cannot account for variable systems of belief and behaviour in different social contexts</p>
Concept of self	<p>Grief-work is deemed to be instinct-driven, self-directed and autonomous.</p> <p>This theory does not account for grief reactions which are directed by, for and to others.</p>
Grief sharing	<p>Denial and repression are deemed to be inherent in the grief-work process. Therefore, death is deemed to be closed and hidden in order to maintain this denial.</p> <p>This theory cannot account for death responses shaped by social norms.</p>

In considering the duration and intensity of mourning, Freud's initial theory (1917) deems the completion of grief-work to lead to a full resolution, following a typical and time-limited course up to the point at which the attachment to the dead person is given up. However, in later refinements to this theory, the severance and replacement of emotional ties is considered less straightforward, and grief-work is reinterpreted as potentially an interminable labour, which is long and repressed. This helps to explain the repression observed in Western societies, but offers little explanation for grief that is confined to the brief but intense periods of mourning evident in many African societies. In examining the belief systems of bereaved individuals, Freud's mourning theory is not helpful as it privileges vicissitudes in psychic energy as opposed to core beliefs. In explaining the significance of religious belief in shaping the process and outcome of mourning, other Freudian theory should be considered (1927, 1930, 1939). Here, religious belief is portrayed as a neurotic response to helplessness and sacred belief systems are considered to be less necessary in Western cultures where there is greater control of one's environment. Effectively, then, Freud's theory of religion can acknowledge and explain the greater propensity to sacred belief systems in African societies, albeit by portraying them as manifestations of a universal neurotic process.

From Freud's perspective, the death narrative is negotiated by bereaved individuals in intra-psychic terms, leaving little room for discourses which are shared by social norms and belief systems. Furthermore, Freud's classic theory deems vicissitudes in psychic energy to represent the core processes of recovery (Hagman, 2001); this theory overlooks the social meanings associated with bereavement, portraying grief-work as an independent, narcissistic and decontextualised process. This perspective is compatible with a concept of the self as autonomous, and supports the individualised grief-work processes seemingly characteristic of Western contexts. However, it cannot acknowledge individual and sub-cultural variations within Western societies, or account for the prescriptive mourning processes and belief systems, that have been identified in anthropological studies of many African societies (Douglas, 1966).

Finally, in terms of grief sharing, Freud deemed denial and repression to be inherent aspects of grief-work, arguing that death needs to be closed and hidden in order to maintain this denial. Freudian theory is therefore unable to account for societies in which death and its aftermath are openly acknowledged and integrated into everyday life.

In conclusion, the capacity of Freudian theory to inform an analysis of bereavement in contrasting social settings is challenged by the findings of anthropological studies and other research into bereavement, mourning and grief. Freud's grief-work paradigm assumes a universally fixed and solitary mental process in which an individual psyche comes to terms with loss (Hagman, 1995). This ahistorical and ethnocentric model lacks the capacity to explain variation in Western and African death and bereavement practices. *'Psychological factors, as universals, cannot explain the particulars of cultural variation'* (Wallace, 1983: 182).

4.4 A review of Post-Freudian Theories

This section introduces and discusses a number of key contributions to the psychological understanding of grief and bereavement which have been made since Freud's death. These will be evaluated firstly, in terms of how they address some of the limitations of Freud's work, as outlined in Table 2 and, secondly, in order to highlight the ways in which Freud has continued to shape the conceptual underpinnings of bereavement counselling.

4.4.1 Lindemann and Gorer

It is not insignificant that Freud's influential text on mourning was written at the time of the First World War, with the next major theoretical advancement coinciding with the Second World War (Parkes, 2001). Erich Lindemann (1944) built on Freud's mourning theory through research he conducted with 101 patients who sought help following a fatal fire at the Coconut Grove nightclub in Boston, USA. Lindemann's publication *Symptomatology and the Management of Acute Grief* (1944) was pivotal in promoting grief as a psychological reaction (Granek, 2010). Parkes (2001) suggests that Lindemann's innovative descriptions of the somatic, cognitive and behavioural symptoms, and views of morbid grief, did much to create the current views of normal and abnormal grief.

At this time, when research into grief comprised largely of psychoanalytic studies, Gorer (1965), a British anthropologist, provided one of the first accounts of bereavement which acknowledged the importance of context. His aim was, *'To identify the sociological and cultural implications of a situation – bereavement – which is customarily treated as exclusively or predominantly private and psychological'* (Gorer,

1965: vii–viii). In his seminal text, *Death, Grief and Mourning in Contemporary Britain*, Gorer (1965) postulated a dysfunctional decline of mourning rituals in Britain within which, with few exceptions, ‘*the style of mourning in Britain is a matter of individual choice*’ (Gorer, 1965: 64).

Gorer (1965) suggested that mourning rituals had been initiated and sustained through religious belief, which was now in decline. Instead, individuals sought a full and busy life, characterised by a duty to enjoy oneself and appear to be well adjusted. The ‘right’ to be happy had turned into an obligation which had no tolerance for the slow process of mourning and the emotional intensity of grief (Granek, 2010).

Within this broadly sociological account, the influence of Freud on Gorer is evident, in that Gorer attempts to integrate psychoanalysis with his survey findings (Walter, 1999). This is seen most clearly in his notion of ‘time-limited mourning’ which, according to Walter, has become part of the perceived wisdom of bereavement care, and which ironically contributed to grief becoming even more psychologised.

‘Paradoxically Gorer, the anthropologist who wanted to highlight grief’s social context, has proved to be one of the chief promoters of this inherently context-free notion’ (Walter, 1999: 86).

Walter also argues that the theoretical bases on which Gorer makes his claims are limited. Gorer assumes the rituals of ‘traditional’ societies to be functional and the lack of ritual in contemporary British society to be dysfunctional. However, both adaptive and maladaptive ‘traditional’ rituals have been identified in anthropological studies (Hockey, 1990; Walter, 1998).

In seeking to explain and understand bereavement counselling practices in two different settings, the work of Gorer is relevant inasmuch as it has influenced the Western understanding of grief (Parkes, 2001). However, the nature of that influence is debateable. Whilst Gorer promoted the importance of context, highlighted the stigma associated with grief and explored the concept of death as taboo, he also presented grief as a time-limited process. This reinforced Freud’s intrapsychic grief work model, and arguably reinforced a psychological understanding of grief in Western settings (Walter, 1999).

4.4.2 Bowlby: Attachment theory

John Bowlby's attachment and loss theory (1969, 1973, 1980) originated within a psychoanalytic perspective. Bowlby saw serious flaws in drive theory and instead argued that attachment in and of itself was a core motivational system (Holmes, 1993). Bowlby offers an explanation both for the human tendency to make strong affectional bonds with others and the strong emotional reactions they experience when those bonds are threatened or broken. Bowlby suggests that attachments come from our need for security and safety; they represent normal infant behaviour and continue throughout life (Fraley & Shaver, 1999). Healthy mourning differs for individuals with different attachment styles. Although different theorists ascribe different labels to these, originally three (Ainsworth et al., 1978), and later, four, attachment styles were identified, categorised as secure, dismissing, preoccupied and disorganised (Stroebe et al., 2005). They are said to remain relatively stable throughout life (Fraley & Shaver, 1999). Empirical evidence highlights the importance of the relationship between attachment style and grief reactions, with early attachments influencing the intensity, course and nature of grief. Servaty-Seib (2004) suggests that therapeutic interventions for bereavement should acknowledge these different attachment styles.

However, like psychoanalysis, attachment theory has also been criticised for failing to pay attention to social context, and acknowledge variations in patterns of attachment between societies and different social settings (Holmes, 1993; Rando, 2008). Grounded in evolutionary biology, one of its core assumptions is the universal nature of infant-caregiver attachments. In their comparative study of attachments between Japan and the USA, Routhbam et al. (2000) argue that attachment theory is laden with Western values and meaning. As with the critique of Freudian theory, the universal and ahistorical nature of attachment theory limits its capacity to explain differences between societies in responses to death, and the negative impact of death including the influence of secondary losses.

Attachment theory does however remain relevant in this study inasmuch as Bowlby has proposed a set of four psychological processes or phases which follow a loss. This represents a widely accepted bereavement model, and one which forms the foundation for other models such as Dual Process Model (DPM) and Psychosocial Transitions (PST) (Parkes, 2001).

4.4.3 Parkes: Psychosocial transitions

Parkes, a British psychiatrist and protégé of Bowlby, was instrumental in establishing the first counselling service within the hospice movement and has had a long history of conducting empirical research into the clinical processes of grief. He continued to develop Freud's mourning theory along attachment lines, whilst incorporating the theorising of psychosocial transitions (PST). In *Bereavement, Studies of Grief in Adult Life* (1996), Parkes presents grief as a process, a core part of which is the need for bereaved individuals to manage their inward turmoil. He assumes that individuals have largely stable, and taken-for-granted ways of understanding their worlds. He suggests that people experience and interpret life through a set of 'assumptive models', constructed to address both internal, intra-psychic, and external, relational worlds. The loss of a loved one impacts both these internal and external models. PST represents the process through which people, through time, relinquish old models and create new ones to make sense of their loss, 'to give up one set of habits and to develop another' (Parkes, 1996: 90). This involves a period of disorganisation and reorganisation. The grieving process enables individuals to adjust their inner models, whilst social interaction facilitates the development of a new identity. Consequently, grieving is not only seen as an intra-psychic process, but one which is influenced by the responses of other people (Parkes, 1996).

Thus, bereavement can lead to a disruption of individuals' assumptive world views, affecting fundamental beliefs regarding fate, religion, the safety of the world, the meaning of life, and the degree to which people perceive that they can control their own destiny (Schwartzberg & Halgin, 1991). The nature of these belief systems is likely to differ between Western and non-Western settings (Janoff-Bulman, 1989). Consequently, unlike Freudian theory, PST allows for different death narratives and variable systems of belief and behaviour characteristic of different societies.

4.4.4 Rubin and Malkinson: Two-track model

Rubin and Malkinson (Rubin et al., 2012) propose a bifocal theory of bereavement, the 'two-track model'. The first strand, based on Freud's psychodynamic theory, considers separation from the lost loved one as the core response to loss, whilst acknowledging the ongoing struggle to fully separate from the deceased. The second strand, drawn from an empirically-orientated perspective, considers bereavement as a biological,

behavioural, emotional and cognitive process, which evokes responses similar to those following a traumatic incident or crisis situation. Accordingly, the response to loss must be understood '*as it relates to both the bereaved's functioning and the quality and nature of the continuing attachment to the deceased*' (Rubin, 1999: 685). Bereavement counselling, according to this model, requires consideration of the clients' responses across these two dimensions: how people are involved in maintaining and changing their relationships to the deceased, and how people's ability to function is impacted by the 'cataclysmic' life experience of bereavement.

Rubin and Malkinson conducted much of their empirical research in the context of war related death in Israel, identifying variations in the way social, professional and religious perspectives influence grief. Thus, moving beyond Freud's intrapsychic processes, the 'two-track model' considers the negative impact of death on wider functioning, and identifies the continuous interplay between individuals and their social context. The model arguably can account for differential responses to death, which can be individualistic or collectivist, and also variation in the negative impact of death including the influence of secondary losses.

4.4.5 Hagman: Developments in psychotherapy

Many classical psychoanalytic theorists continued to adhere to versions of Freud's grief-work model. In '*Psychoanalytic Terms and Concepts*', Moore and Fine (1990) offer a definition of mourning that is essentially unchanged from Freud's original theory. However, a recent sea-change in psychoanalytic theory and practice has been identified. Hagman argues that contemporary analysts have abandoned the standard model and moved to create a new psychoanalytic mourning theory. '*The notion that the mind is a private, closed system that primarily functions to regulate its own inner world of energies and defences is essentially defunct*' (Hagman, 2001: 21).

Hagman proposes a new psychoanalytic definition of mourning which recognises the profoundly relational nature of human psychological life, in which the work of mourning is rarely done in isolation from others. In this, the importance of meaning and the need to re-establish a sense of self, is acknowledged. Thus, in contrast to the individualistic and universalist stance taken by Freud, the process of mourning is deemed to be seen as more variable and shaped by its social context.

In acknowledging the relational component of psychic processes, such a model may account for differential responses to death which include collective responses to loss and the influence of contextual factors. Differences in death narratives and in the duration of mourning can also be understood within a relational psychotherapeutic framework.

Thus far, in the review of post-Freudian theorists, the influence of Freud has been apparent, the overarching ethos being one in which grief work is required to deal with the emotional catharsis of grief, followed by detachment and a full recovery. However, a number of other theorists have deviated significantly from Freud's grief work model, of these, the work of Klass (1996) and Niemeyer (2001) have arguably been most influential, and it is to these two theorists that we now turn.

4.4.6 Klass: Continuing bonds

In *Continuing Bonds: New Understandings of Grief*, Klass et al. (1996) challenged the dominant Freudian models of grief, suggesting that linear models, ending in a detachment from the deceased, essentially denied the reality of how many people grieve. They proposed a new paradigm in which,

'Many bonds between the living and the dead continue ... the purpose of grief is to construct a durable biography of both the survivor and the deceased' (Klass & Goss, 1999: 547).

Accordingly, the goal of grief work is to find ways to adjust and redefine the relationship with a lost loved one, allowing for a continued bond that will endure to varying degrees and in different ways throughout life. Continuing bonds theory is considered '*a reversal of the historical trend in bereavement theory*' (Lalande & Bonanno, 2006: 305). Arguably, Klass builds on Freud's (1923) later notion of grief-work, in which it is only by internalising the lost other, through the work of bereavement identification, that the mourner's own identity is developed. Klass's theory has been widely accepted and integrated into many subsequent bereavement theories such as the DPM (Stroebe & Schut, 1998), challenging former definitions of pathological grief in which an inability to sever ties was seen as maladaptive.

The potential for adaptive mourning to include ongoing links with the deceased arose from observational and anthropological accounts of bereavement practices in non-

Western settings (Klass, 2001). Klass has continued to explore how different societies manage their relationship with the dead, and, in particular, has examined how, in Japan, continuing relationships with deceased ancestors are maintained and endorsed (Klass, 1996; Klass, 2001). A number of other comparative studies have explored the concept of continuing bonds. Lalande and Bonanno (2006) highlighted the link between continuing bonds, adaption to the loss, and contrasting belief systems in China and the USA. Valentine (2009), in her comparative study of bereavement in England and Japan, found that the bereaved English individuals in her study described their dead loved ones as forming an integral and crucial component of their sense of self, and experienced an on-going sense of their continuous and tangible presence. Hagman supports this view; in his clinical practice he observed '*a heightened re-engagement with the dead person and eventually a transformation of memory into a permanent part of the patient's internal world*' (Hagman, 1995: 914).

By acknowledging the social meanings associated with bereavement, this theory can allow for differences in the death narrative and in belief systems identified in Western and Africa settings (Table 2). Accordingly, a variety of ways of experiencing and handling the thoughts and emotions with which bereaved individuals respond to death are found in different social contexts and societies. Often these differences are linked to religious belief and have socio-political functions (Klass, 2001; 1996: Klass & Goss, 1999). The communal mourning rituals in non-Western settings often act as a conduit to maintain a strong connection with the dead during the first months of bereavement, and represent an adaptive response to the loss (Lalande & Bonanno, 2006). In Western settings, however, whilst the dead remain in relationship with the living, their actions and messages seem restricted to the private sphere. Even in societies where death is hidden, individuals continue to maintain bonds and connections with their deceased loved ones (Klass & Goss, 1999).

4.4.7 Neimeyer: Meaning making

Neimeyer critiques Freud for construing bereavement in stages of emotional adjustment or psychiatric symptomatology, which do not grasp the subtleties of loss and transformation. Rather, all symptoms have significance, and are understood as an outward manifestation of the inward struggle to accommodate changed reality.

Neimeyer proposes that '*meaning reconstruction in response to a loss is the central process in grieving*' (Neimeyer, 1998, cited in Neimeyer, 2001: 4).

Neimeyer's framework for conceptualising the complexity of loss relies on a constructivist emphasis on the individuality of meaning-making, on the narrative construction of self, and on the linguistic negotiation of changed meanings. He accepts a position of '*epistemological humility*' (Neimeyer, 2001: 263), recognising that whatever the status of external reality, its meaning is determined by our constructs of its significance. Like Parkes (1996), Neimeyer describes the loss of assumptive worlds where bereavement assaults the belief that life is predictable or that the universe is benign. However, if the loss is consistent with existing worldviews then making sense of it does not appear to represent a significant coping issue.

Neimeyer (2001) reflects on the ways in which bereavement counselling might facilitate the process of meaning reconstruction, emphasising the subtle use of language and the extent to which an intimate sense of self is rooted in shifting relationships with others. Counselling becomes a safe place in which the client can tell their story and within which, the counsellor requires '*a deep engagement in the client's experiential world as a precondition to its reconstruction*' (Neimeyer, 2001: 261). The reconstruction of identity therefore requires a recursive tacking between the self and the social. In this process, counsellors become the audience that helps to validate a new version of self.

Neimeyer suggests that spirituality plays a significant part in the accommodation of loss for many grievers, and is generally an adaptive method of coping. However, bereaved individuals sometimes struggle spiritually, sensing God's punishment or abandonment (Neimeyer & Burke, 2011).

Of particular relevance to this study, Neimeyer highlights how narratives draw on a discursive framework based on pre-established and socially sanctioned meanings; such discourses vary across '*cultures, sub-cultures, communities and families*' (Neimeyer, 2001: 264). Loss is given significantly different meaning within different validated discursive frames of reference.

Thus, in addressing the limitations of Freudian theory (Table 2), Neimeyer suggests that there is no grand narrative of grief but an array of perspectives which are culturally

determined, within which different individuals are positioned. Again, this addresses the limitations of the intrapsychic, ahistorical theory and has the scope to explain differences in the mourning processes and belief systems shaped by social norms.

4.4.8 Prigerson and Jacobs, and Holloway: Traumatic grief and Special deaths

This current study focuses on counselling provided by individual counsellors offered for what, in the profession, is referred to as ‘normal’ grief (Worden, 1991), except where informants might discuss problematic grieving processes (see section 1.4 for a discussion of this exclusion). Whilst the focus here is largely on theories of ‘normal’ grieving processes, a substantial component of current bereavement research has focused on grief which is complicated (Holloway, 2006). The contribution of two key theorists in this area will now be considered.

Prigerson and Jacobs (2001) have sought to develop a consensus of diagnostic criteria around ‘pathological’, ‘traumatic’ and ‘complicated’ grief reactions (Stroebe et al., 2001). More recently, they have favoured the term, ‘traumatic grief’, considering other terminology, such as ‘complicated’, to be too vague and ‘abnormal’ and ‘pathological’ to have negative, derogatory associations (Prigerson et al., 2009). They suggest that traumatic grief is ‘*a distinct disorder worthy of diagnosis and treatment*’ (Prigerson & Jacobs, 2001: 615). Whilst encouraging the development of uniform diagnostic criteria, they acknowledge that such uniform criteria may promote a homogenised view and miss societal or individual differences in reactions to loss.

In its clinical description, symptoms of traumatic grief can be divided into two categories: separation distress, which includes preoccupation with thoughts of the deceased to the point of functional impairment, and traumatic distress, which includes feelings of disbelief about the death. Prigerson and Jacobs (2001), whilst acknowledging that many of these symptoms have been observed by Freud, appear to have revised Freud’s mourning theory by attributing to traumatic grief some symptoms, such as a reduced sense of self-worth, which Freud attributed to melancholia (Jacobsen et al., 2010).

Whilst ‘traumatic grief’ is concerned with grief reactions, the focus of ‘special deaths’ (Holloway, 2007) is on the specific features and circumstances of death from which a complicated grief reaction might emerge, regardless of the characteristics of the bereaved person or their relationship with the deceased. The term has been applied to

bereaved children, bereaved parents and individuals bereaved through suicide. Such deaths are characterised by a problematic social context, which evokes media interest and in which there is dissonance between the public representation and the private story. Special deaths may also elicit a threat to the ontological security of the bereaved individual and society. Late modernity is said to have been characterised by an escalation in special deaths with socio-political complications, for example, death through terrorist activity.

Whilst ‘traumatic grief’ and ‘special deaths’ are not the main focus of this study, the potential for each has been identified in NI and Uganda. For example, in Uganda, high levels of PTSD and depression have been found among individuals living in IDP camps (Roberts et al., 2008). Similarly, in NI, high levels of depression and traumatic grief have been associated with Troubles-related bereavement (Dillenberger et al., 2008), which may also be delayed or postponed (Manktelow, 2007). Thus, it is anticipated that these issues might be identified by counsellors in this study. Where relevant, the work of Prigerson and Jacobs, and Holloway will be applied to explore similarities and differences in the characterisation and management of special deaths and traumatic grief.

4.4.9 Doka: Disenfranchised grief

In his book, *Disenfranchised Grief: Recognizing Hidden Sorrow*, Doka (1989) introduced the concept of disenfranchised grief, defined as: ‘*the grief experienced by those who incur a loss that is not, or cannot be, openly acknowledged, publicly mourned or socially supported*’ (Doka, 1999: 37).

Every society has socially validated norms around acceptable behaviour following the death of a loved one, which govern who can legitimately grieve for the loss, and the level of support offered (Parkes et al., 1997). In certain circumstances, however, the bereaved may be denied the right to publically acknowledge grief and the grieving role.

Doka (1999) identifies five categories of ‘disenfranchised grief’. Firstly, the relationship of the griever is not recognised. In Western societies, kin-based relationships are considered to be the most important; consequently non-kin based deaths may be disenfranchised. Secondly, the loss is not recognised; many relationships may not be publically acknowledged, such as extra-marital affairs, or may have existed primarily in the past. Doka also records the attachments and subsequent loss characterising

individuals' relationships to celebrities. Thirdly, the griever is not recognised; unrecognised loss may include abortion or miscarriage. Fourthly, the loss itself may not be recognised, such as loss resulting from AIDS. Finally, the manner in which an individual grieves is not validated, such as gendered expectations around grieving.

These grieving rules do not necessarily follow the nature of attachments; disenfranchised grief may create problems for bereaved individuals who often remain isolated, without support and with complicated grief reactions. Kauffman (2002) suggests that individuals internalise these rules, and may believe that their own grief is inappropriate, leading to feelings of guilt or shame. Alternatively, Machin (2009) suggests that bereaved individuals, marginalised through lack of social and professional recognition, may seek self-empowerment through establishing self-help groups.

The value of Doka's approach for this study is that he focuses attention on the social rules of grief and bereavement, and thus highlights variations within and between social settings. In so doing, he develops Freud's intrapsychic, ahistoric account of mourning to include interpersonal factors. Whilst Doka tends to discuss disenfranchised grief within Western contexts, the application of his theory may be relevant in other settings. For example, Maasdorp and Martin (2009) highlight the potential for difficult political situations in 'third world countries' to lead to disenfranchised grief. It will be informative in this study to observe bereavement counsellor's perceptions of their clients' experiences of disenfranchised grief, and to explore differences in the ways counsellors in NI and Uganda might conceptualise these experiences.

4.5 Freud's Enduring Legacy: Grief-Work Models

A review of these post-Freudian theories suggests that Freud's conceptualisation of grieving as withdrawal of psychic energy from the deceased has undergone transformative change. A core feature of almost all recent critiques of Freud's classical model has been the failure of his intra-psychic focus to acknowledge the role of other individuals in the grieving process. There is a '*growing acceptance that psychological life is fundamentally embedded in relationships and interpersonally orientated meaning*' (Hagman, 2001: 19). Thus, many of the post-Freudian theorists here reviewed recognised societal differences in the meaning and experience of bereavement and grief. Nevertheless, these theorists continue to work with a conception of self which is deeply

rooted in Western notions of individualisation and reflexive introspection. While challenging Freudian theory with the results of more recent anthropological and sociological studies of death, they have not substantially altered Freud's theoretical inheritance. They continue to conceptualise bereavement in terms of the need for individualised reflexive processes required to accommodate the lost other. The pervasive influence of Freudian concepts on the development of models of grief and on bereavement counselling practice, is also evident.

Several writers have developed models or frameworks for understanding the process of grieving. These often describe a linear process (Holloway, 2007) and seek to distinguish between adaptive and maladaptive ways of grieving (Stroebe, M.S. & Schut, 2001a). Many of these contemporary models are essentially based on the Freudian premise that grief-work is necessary to successfully negotiate loss (Hansson & Stroebe, 2007). Perhaps the best-known staged model of grief is that of Elizabeth Kubler-Ross (1969), who conceptualises the grieving process in a five-stage cycle of denial, anger, bargaining, depression and acceptance. Bowlby (1980) suggests four consecutive stages or phases of grieving: numbing, yearning and anger, despair, and reorganisation. Worden (1991) proposes four tasks of grieving: accepting the reality of the loss; experiencing the pain of the grief; adjusting to the environment; and emotionally relocating the deceased in a way that maintains connection (Worden, 1991). However, the staged approaches have been criticised for negating the individuality of mourning (Howarth, 2007a; Payne et al., 2002). These models have arisen from the psychodynamic conception of grief-work as a standardised process. Freud has institutionalised a belief that a healthy bereavement is dependent on successful progression through specific stages (Hagman, 2001).

Shaver and Tancready (2001) have criticised the proliferation of grief models, suggesting that new models and theories often emerge as a reaction to those that have gone before and that, in the process, they have become fragmented and isolated. They argue that a more useful way forward is to encourage an integration of theoretical insights and empirical findings, as in the case of the DPM, which is said to have superseded stage models (Valentine, 2006). Whilst the DPM is rooted in cognitive stress theory, it also incorporates a form of attachment theory and acknowledges the Freudian approach to grief-work; it is now summarised here.

In acknowledging the impact of multiple stressors on the bereaved individual, Stroebe and Schut (1999) argue that the death of a loved one leads to the accumulation of loss-orientated stressors that include the loss of a physical relationship, support and future plans. Loss-orientated behaviours resemble grief-work, occurring early in the grief process (Richardson, 2007). In contrast, restoration-orientated stressors relate to secondary losses of bereavement, such as loss of money or status. These two forms of stressor are deemed to be both problem-orientated and emotion-orientated. This model emphasises the dynamic nature of coping with bereavement, and implies that the bereaved person will oscillate between loss-orientated and restoration-orientated behaviours (Hansson & Stroebe, 2007). In effect, a bereaved individual will, at times, focus on issues other than their loss; these issues will take their attention away from their intense grief and enable them to preserve their mental and physical health (Stroebe, M.S. & Schut, 2001b; Stroebe & Schut, 2010).

Stroebe and Schut (1998) suggest that the DPM was developed, in part, through a scrutiny of variations between social contexts. They observed that the phased theoretical approaches, based on the grief-work concept, were not universally applicable, arguing that such phases cannot be identified universally and that there is no universal evidence of grief-work. Rather, in some societies, the processes of regulation and avoidance are prevalent. *'If one looks beyond Western culture, it becomes evident that other prescriptions exist which lead to good adjustment'* (Stroebe & Schut, 1998: 9). Thus, both the patterns of adjustment, and the extent of changed life circumstances, vary across social settings; for example, the balance between loss-orientated and restoration-orientated behaviours will vary according to cultural demands (Maasdorp & Martin, 2009).

Arguably, the DPM has redressed some of the more obvious criticisms of other models by accommodating previously contrasting theoretical concepts. It combines two aspects of mourning which have hitherto been difficult to reconcile, by integrating Freud's notion of decathexis with continuing bonds (DeSpelder & Strickland, 2002). It acknowledges the importance of interpersonal processes, allows for different grieving profiles in different settings, different genders and different subgroups of societies, and has been supported by a body of empirical data (Hansson & Stroebe, 2007). In so doing, it addresses some of the criticisms of Freud listed in Table 2, and has the scope to

acknowledge mourning duration and intensity, belief systems, death narrative and grief sharing between Western and African societies.

4.6 Freud's Enduring Legacy: Bereavement Counselling Practice

Freud's psychoanalytic and mourning theories have also strongly influenced the origins and practice of therapeutic interventions following a loss (Labi, 1999). Freud's influence on counselling theory and practice can be traced through the emergence and development of the bereavement counselling industry. In Western societies, the development of counselling has been well documented, from the treatment of people with a mental illness in the eighteenth century to the widely accepted practice of counselling and psychotherapy in the later part of the twentieth century and beyond (McLeod, 2009; Walter, 1996). In the UK, the practice of psychotherapy emerged from the scientific discipline of psychiatry (McLeod, 2009). Freud, the key figure in this transition, crucially presented psychotherapy as relevant to everyone, not just those with an identified mental illness (McLeod, 2009).

The practice of counselling emerged from psychotherapy, in large part through the influence of Carl Rogers (1957), who objected to the notion that only medically-trained individuals could practice psychotherapy. Counselling and psychotherapy have developed into highly differentiated specialisms, one of which is the counselling offered to bereaved individuals (McLeod, 2009).

There is however no single dominant theoretical paradigm or bereavement counselling model, with a range of counselling modalities utilised in bereavement counselling (Servaty-Seib, 2004). The three principal contemporary counselling approaches are identified as person-centred, cognitive-behavioural and psychodynamic (McLeod, 2009). Person-centred theory is radically critical of Freud (Rogers, 1957), cognitive-behavioural theory, in seeking to enable clients to identify and work through their own problems (Barbato & Irwin, 1992), is often viewed as a reaction against Freud's interpretive model (Meichenbaum, 1977), whilst psychodynamic counselling builds on Freudian theory. However, despite their differences, all three theories adapt core Freudian concepts, premised on Freud's topographic model of the mind, acknowledging the importance of the therapeutic alliance and the dynamic features of counselling.

Of particular relevance here is Freud's psychodynamic approach which privileges the exploration of unconscious processes and the client's past life. In so doing, bereaved individuals can attribute the unfinished business of mourning to their therapists, who become temporary substitutes for the ambivalent feelings that are preventing resolution (Parkes, 1996; Sanders & Wills, 2005). Moreover, psychodynamic counsellors purposefully adopt an active, authoritative role in which they impart knowledge to the client (McLeod & Wheeler, 1995). However, it has been argued that psychodynamic interventions lack empirical support and that scientific evidence favours other forms of treatment (Roth & Fonagy, 2005). The embattled position of psychodynamic counselling is evidenced, for example, in NICE guidance regarding the use of psychological therapies and in recent management strategies for developing clinical services in the statutory sector (NICE, 2006; 2009a; 2009b; 2011), which tend to favour CBT. Whilst the efficacy of psychodynamic approaches has been questioned, psychodynamic theory offers useful concepts in understanding therapeutic relationships (Sandler et al., 1992). For example, Freud argued that successful therapy requires the development of a strong therapeutic alliance, which enables the client to maintain a positive attitude towards therapy. There are similarities here with Erikson's (1950) notion of basic trust. The building of a positive therapeutic alliance is widely accepted as a critical condition for effective counselling amongst practitioners of all forms of therapy, despite variations across modalities in the power balance between counsellor and client (McLeod, 2009). A strong positive correlation has been observed between the quality of the therapeutic relationship and good outcomes for the client (Cooper, 2008; Gallagher et al., 2005).

Freudian theory also introduced the pivotal concept of a transference relationship existing between counsellor and client (Freeman, 1994). *'A whole series of psychological experiences are revived, not as belonging to the past, but as applying to the person of the physician at the present moment'* (Freud, 1905: 116). In its broadest definition, transference can be understood as a ubiquitous feature of all therapeutic relationships. Transference is deemed by psychodynamic therapists to develop through a process in which the client's past psychological experiences are revived and then relived in relation to the therapist (Freud, 1905). For example, it would be anticipated that a client's anger towards a parent might be revealed through expression of hostility towards the therapist – once it has been revealed, it can be openly worked on by

counsellor and client. Transference can occur in both directions; that is to say, counsellors can also experience transference towards their clients. The emotional response that arises in the psychodynamic therapist's unconscious, in response to a client, is termed 'counter-transference', and post-Freudian theorists have tended to broaden this concept to include *'the totality of the analyst attitudes and behaviour towards his patient'* (Sandler et al., 1992: 85). However, usage of the terms, 'transference' and 'counter-transference' is not unique to psychodynamic therapy; for example, while their usage is debated, reference has also been made to these terms by some writers on CBT (Gilbert, 2008; Gilbert & Leahy, 2007; Wills & Sanders, 1997).

Freudian theory offers an enduring legacy which has underpinned many subsequent bereavement counselling theories and models of intervention. It has been suggested that Freud's influences have so institutionalised psychological discourse around grief that, by the 1980s, *'grief theory had become decontextualized from experience and had been psychologized completely. The focus was entirely on symptoms, and the ability to measure, diagnose, and manage grief'* (Granek, 2010: 64).

4.7 Conclusion

The application of Freudian theory has both strengths and limitations in providing an overarching conceptual framework and informing the research questions in this study with references to counselling practice, counselling context and counsellor and client characteristics. Three aspects of Freud's theory are particularly worth noting. Firstly, Freud's topographical model of the mind has provided a broad framework within which the interpretation of human psychology, and mourning in particular, has developed. It offers a vision of three interwoven elements of self: the instinctual drives and forces routed in the body (the id); constraints placed on these drives from the pressures of standards and rules in society (the superego); and the mediating function of individual discernment and choices (the ego). Conceptualising the development of the human personality in terms of links between psychological, social and biological processes was an important advancement from previous, philosophical accounts of the development of human personality. Secondly, Freud is recognised as providing foundational understanding of the psychological processes of mourning and loss (Bocock, 1991). He introduced the concept of grief-work, a concept which has underpinned many subsequent bereavement theories and practices, and in this study may also help to

explain the bereavement counselling practices utilised by the NI and Ugandan informants. Thirdly, Freud's theories have shaped key aspects of the practice of therapeutic interventions in mental health. His conceptualisation of the role of talk within the therapist-client dyad, the transference dynamic and the dynamics of the therapeutic relationship are fundamental to bereavement counselling (Sandler et al., 1992).

Freud clearly made huge strides in enhancing our understanding of human consciousness and behaviour, and some of this study's findings will be open to explanation in Freudian terms. Freud has had a profound influence in shaping the underlying assumptions and deep-rooted professional paradigms – the discourse – of bereavement counselling. This legacy can be summarised as: a conceptualisation of the self in terms of intra-psychic forces; a perception that the task of the bereaved is to undergo a journey of adjustment or reformulation of the self; and a belief in the therapeutic value of the alliance between counsellor and client. Chapters 7 to 10 report on the extent to which bereavement counsellors in NI and Uganda both identify and utilise these Freudian theories in their practice.

However, as a conceptual framework for the present study, the usefulness of Freudian theory is ultimately limited. Freud's social theory sought to make connections between social and psychological processes, and was thus potentially valuable as a conceptual framework for cross-societal analysis. However, these theories are considered to be ambiguous, speculative and outmoded (Bocock, 1991; Wollheim, 1991). The present study therefore focused on Freud's psychological theories; a key limitation of which was the inability to acknowledge variation in bereavement and grief across social settings. These theories did not sufficiently acknowledge the influence of differences rooted in social practices and relationships.

The limitations of Freudian theory have been considered by post-Freudian theorists, such as Gorer, Lindemann, Bowlby, Parkes, Rubin and Malkinson, Hagman, Klass, Neimeyer, Prigerson and Jacobs, Holloway and Doka. Some of these theorists have devised ways of acknowledging differences across social contexts in the resolution of bereavement. In particular, Klass's (2001) continuing bonds theory addresses the bereaved persons' relationship to the inner representation of the deceased and acknowledges that this relationship will vary across social settings (Lalande &

Bonanno, 2006). Neimeyer's (2001) meaning-making model focuses directly on the ways in which pre-established, socially-sanctioned meanings vary across settings. Doka's (1999) theory of disenfranchised grief focuses on the social rules of grief and bereavement, highlighting variations within and between social settings. Parkes's PST model also acknowledges variation in belief systems across settings. However, empirical findings of core differences in the meaning, experience and conceptualisation of loss, evident in anthropological studies (Rosenblatt, 2001), are not adequately accommodated in these theories. There is a mismatch between these theories, which are still largely premised on a Western model of an autonomous, individualistic and reflexive version self, and empirical findings. Post-Freudian writers acknowledge empirical variations in bereavement practices between social contexts but do not adjust their theoretical and conceptual assumptions to explain why there are such variations and why such variations follow a consistent pattern between African and Western societies.

Arguably, neither Freudian nor post-Freudian theory is sufficiently robust to act as an overarching framework for this present study. An alternative theoretical paradigm is needed for this purpose. The following chapter will consider a theoretical framework which may have the capacity to encompass differences in bereavement experiences and bereavement counselling between NI and Uganda.

Chapter 5 Sociological Conceptions of Grief: Elias and Figurational Analysis

5.1 Introduction

In this chapter the main sociological perspectives on grief and mourning will be briefly outlined, followed by an account of the principal concepts underpinning the sociology of Norbert Elias and, more specifically, his figurational analysis of social change. The next section outlines the arguments presented by critics and defenders of his approach. The application of Elias's concepts to understanding death, bereavement and bereavement counselling occupy the following two sections. The chapter ends with a critical comparison of the capacity of Freudian and Eliasian theory to understand death and bereavement practices.

5.2 The Sociological Analysis of Grief

The social construction of grief was discussed by Hertz (1960[1907]), and was also an important theme in the work of Durkheim (2006[1897]). Durkheim argued that biology should be viewed as a background to social life rather than its determining factor (Prior, 2000); from this perspective, mourning is understood as a socially controlled activity. A number of contemporary theorists have also sought to conceptualise grief predominantly in social terms (Exley, 2004). For example, Leming and Dickinson (1994) contend that every act of dying is a social event and can be understood as a social symbolic process. From this perspective, the key factor that unites individuals is shared meaning, reflected in the use of symbols. Death, therefore, is '*shared, symbolized and situated*' (Leming & Dickinson, 1994: 48).

Leming and Dickinson differentiate between two contrasting sociological approaches to the conceptualisation of death, the 'social factist' paradigm and the 'social definitionist' paradigm. The former applies a structural functionalist theory to understanding death; the latter takes a symbolic interactionist perspective.

The 'social factist' paradigm is primarily concerned with social structures and group actions, and privileges the direct observation of social facts. Structural functionalists view society as a social system of symbiotically interacting parts. They highlight the ways in which death-related meaning systems contribute to and are shaped by larger

social systems. Functionalism focuses on the intended and unintended consequences of social relationships; for example, Malinowski (1948[1925]) adopts a functionalist perspective in suggesting that the ritual processes which surround a death function to create equilibrium, and to restore the social order following its disruption by the death.

In contrast, the 'social definitionist' paradigm is concerned with the subjective character of social interaction. Social relations are seen as emerging from the subjective meanings attributed by actors to their interactions with others. Reality is socially constructed, often through the process of everyday conversation. *'Individual-level behaviour is in response to Symbols, relative to the Audience, and relative to the Situation'* (Leming & Dickinson, 1994: 67). Within this paradigm, symbols and words are the medium through which individuals adjust to their environment and interpret experience. In conceptualising reactions to death, Berger & Luckman (1966) suggest that death requires intense reality maintenance. The death-related behaviour of the dying individual, and their loved ones, occurs in response to the meanings attributed to the death, to the interaction with an 'audience' such as the family, and to the situation in which the death occurs. The anthropologist, Rosenblatt (1993), uses this model to argue that the dying and bereaved can be viewed as autonomous individuals who interpret the dynamic death-related symbols in their environment through communicating and consulting with others around them. In applying a social constructionist perspective to bereavement in conflict zones, Rosenblatt (2001) suggests that bereaved individuals may be required to hide or deny their feelings of grief because of oppressive political regimes. In such circumstances, bereaved individuals may adopt multiple social constructions of death, in which public and private expressions may differ.

Currently, the most utilised sociological theories of bereavement appear to be those provided by social constructionist theorists such as Neimeyer (2001). These theories have emerged from interactionist and family systems models and assume that grief is socially patterned (Hansson & Stroebe, 2007). As noted in Chapter 4, Neimeyer presents a model in which the principal task of grieving is that of meaning reconstruction. It is deemed that narratives are constructed by the living to enable them to integrate the dead into their lives, a process that requires them to both redefine themselves and rework how to engage with the world.

In a different vein, Foucault's theorising of social discourse is also relevant to this study (Foucault, 1994[1966]). He argues that, at different times in history, different discourses linked to power relationships have dominated societies. Therefore, the '*effects of truth are produced within discourses that in themselves are neither true nor false*' (Foucault, 1994[1966]: 9). It would follow that dominant discourses will exert significant influences on the bereavement counselling process and on the theorising of death and bereavement (Walter, 1994). The relevance of discourse analysis to a comparative study is evident; it is easy to appreciate that the dominant discourse in an African context will differ from that of a Western context (Nordanger, 2007).

Nevertheless, it appears that the social theorising of bereavement is much less developed than corresponding psychological theory (Stroebe M.S. & Schut, 2001a). Functionalist theories have been heavily criticised, in general, for failing adequately to explain social conflict and social change. Social interactionist theories predominantly address micro-level social encounters and have little to say about systemic differences between societies. Shapiro (2001) has suggested that the interpersonal focus of social theories lacks systematic conceptualisation. There is a problematic absence of theory on the boundary between sociology and psychology. Whilst a number of theorists have sought to make links between the two disciplines, notably members of the Frankfurt school, Freud has essentially remained peripheral to conventional sociology (Bocock, 1991).

It is in the light of these observations that the work of Norbert Elias (1897-1990) is salient for this study. Perhaps uniquely among sociologists, Elias has identified and developed links between biological, psychological and social processes, providing '*a synthesis of insights from Freudian psychoanalysis with a historical sociology of long-term processes of development*' (Loyal & Quilley, 2004: 6). His life-work revolved, to a large extent, around the development of a comprehensive theory of human society; essentially he offers a '*central theory*' in sociology (Quilley & Loyal, 2005: 808). Elias was critical of isolated, short-range sociological models, noting that '*A peculiar distortion has followed from this foreshortening of the sociologists' field of vision*' (Elias, 1974: xvi). In his two-volume account of the 'civilising process', Elias established a sociological paradigm that essentially differed from much of conventional sociology (Pinker, 2011). He argued that human beings are inherently social animals

and are embedded throughout their lives in networks of interdependent relationships which he called figurations.

'Since people are more or less dependent on each other, first by nature and then through social learning, through education, socialization, and socially generated reciprocal needs, they exist, one might venture to say, only as pluralities, only in figurations' (Elias, 1994a [1939]: 213).

Elias's 'figural' theory offers a distinctive sociological framework for the present study that addresses similarities and differences in both the social context and psychological experience of death, bereavement and bereavement counselling. In this perspective, figural interdependencies are implicated in shaping individuals' responses to bereavement, and also the therapeutic practices that they may subsequently seek.

5.3 Figural Analysis

Elias suggested that an analysis of how figurations are formed and reformed is the central question of sociology. His theory became known as 'figural theory' or 'figural sociology', although he later expressed a personal preference for 'process sociology'.

Elias viewed individuals as possessing an 'open-personality' as opposed to existing in a self-contained private world. Individuals are deemed to begin life in a complexity of symbols and language; in acquiring language, each person also acquires intergenerational and interactional experiences, which bind them into interdependent networks of bonds and ties (Elias, 1991b [1989]). Individuals can therefore be understood in terms of their networks of relationships. These relationships are shaped by participants' power to constrain and to facilitate one another's actions. Power is conceptualised, not as a thing to possess, but as a reciprocal dynamic of all relationships. When one party in a relationship has value for another, then he or she is not without power (Elias, 1974). Individuals are deemed to strive, in as far as they can, to reduce their obligations to others and to minimise the extent to which their own actions are constrained. Consequently, their relationships are characterised by unstable and shifting power dynamics. These dynamic tensions shape the development of

figurations and the life trajectories of individual people both at micro and macro levels (Loyal & Quilley, 2004).

The core tenet of Elias's figurational paradigm is based, then, on the relational nature of social life and its processual character (van Krieken, 1998). Dunning and Hughes emphasise the absolute centrality of these concepts; '*it is **radically** processual and **radically** relational in character*' (Dunning & Hughes, 2013: 50) (emphasis in the original). Figurations of interdependent individuals must be understood as existing over time and as undergoing continual transformation.

'The proper object of investigation for sociologists should always be interdependent groups of individuals and the long-term transformation of the figurations that they form with each other' (Quilley & Loyal, 2005: 813).

Applying Eliasian theory to the present questions requires an analysis of the figurational characteristics of either setting. It directs the focus of study upon the processual characteristics of the figurations that bind together bereavement counsellors and bereaved clients, through the practice of bereavement counselling.

5.4 Sociogenesis and Psychogenesis: Transcending Dichotomies'?

According to Elias, sociological questions should not focus on individuals in isolation from others; it is in exploring the network of relations between people (their sociogenesis) that the emerging character of individuals (their psychogenesis) might be understood. Elias refers to the psychological make-up of individuals which is shared with fellow members of the same group as a shared 'social habitus'. This '*constitutes the collective basis of individual human conduct*' (van Krieken, 1998: 59); an example of this would be 'national character'. Crucially, the formation of habitus is deemed to be a continuous process.

'The structures of the human psyche, the structures of human society and the structures of human history are indissolubly complementary, and can only be studied in conjunction with each other' (Elias, 1991a [1987]: 36).

Elias disputes Freud's ahistorical conception of the psyche (Mennell, 1989), suggesting that, whilst the raw material of drives, the id, may have changed little throughout history, the drive controls, through which the drives must pass, have changed. It is the

relationship between drives and drive controls within which self-constraint develops. This presupposes a reciprocal relationship between psychogenesis and sociogenesis, suggesting that, habitus is not only generated within figurations, but shapes these figurations and the dynamics of power within them. These reciprocal processes do not follow a planned trajectory; from *'the interweaving of countless individual interests and intentions ... something comes into being that was planned and intended by none of these individuals'* (Elias, 1994a [1939]: 160).

As well as avoiding the psychological determinism of some interpretations of Freudian theory, Elias also avoids the sociological determinism associated with some theories of cultural socialisation. Figurations emerge from the clash of intentions of their members, locked in unequal power relations. Habituses are products of the active, creative actions of people engaged in social relationships, even though their outcomes typically entail unintended consequences. Thus, Elias's theory does not portray people as deluded, passively socialised into conformity with social norms. The concept of habitus avoids the reification, homogenisation and simplification often characteristic of explanations of human behaviour which invoke 'culture' as an explanatory variable. This point is discussed further in Chapter 6.

Elias challenged any interpretation of his theory which suggested a continuous process of increasing and strengthening self-restraint, contrasting 'tribal' with 'developed' societies. Such a model, he argued, offered a 'vulgarised' representation of the civilising process (Mennell, 1989). Rather, the character of self-restraint is often irregular; in 'tribal societies', under certain conditions self-restraint may far exceed the level required in developed societies, whilst at other times, in the same societies, there can be *'an unbridled liberation of affects'* (Elias, 1984: xxxv).

Thus, Elias sought to transcend arguments around the priority of structure versus agency, and 'social factist' versus 'social definitionist' paradigms, challenging the reification of what he considered to be dynamic social processes. Individuals are not seen as living within societies; from Elias's perspective, individuals are societies and societies are composed of individuals. His notion of figuration and habitus transcend the dichotomy between the individual and social. He belies the conventional view of societies as structures external to and separate from individuals (Dunning & Hughes, 2013). Dalal (1998) suggests that Elias presents a theory that unifies the internal with

the external, and the individual with the social. However, van Krieken (1998) argues that Elias's theory does incorporate some inconsistencies. In particular, he notes, Elias is ambiguous in his presentation of desires, locating them both within the individual, as an instinct in psychoanalytical terms, and as a product of society in behavioural terms. This ultimately leaves Elias's analyses of European history '*with a Hobbesian opposition between nature and society*' (van Krieken, 1998: 129).

In spite of these potential inconsistencies, this central tenet of Elias's theory remains unchanged. As applied to the present study, the twin concepts of habitus and figuration enable an understanding of the emotional and intellectual dispositions of bereavement counsellors and clients to be rooted in an analysis of their relational networks of interdependence. Thus, in this present study, differences in the management of emotions, and the implications for this in counselling practice and in the management and use of self for the counsellor, will be discussed, not in relation to the potentially reified concept of culture, but in terms of the differing habitus of counsellors.

5.5 The Figural Analysis of Social Control

Elias's theory of 'civilising processes' is presented largely through three core texts, *The Court Society* (2006 [1933]), *The Civilising Process* (1994a [1939] i & ii), which has recently been re-entitled *On the Process of Civilisation* (2012), and *The Germans* (1997 [1989]). Whilst most of his major texts elaborate on the concepts outlined in *The Civilising Process*, Elias's ideas have evolved over time.

Elias (2006 [1933]) initially studied the royal and aristocratic courts of Europe. In tracing the key role played by the royal courts in the emergence of capitalist societies, he identified central processes which continue to shape contemporary societies; namely, court rationality, the dynamics of power and processes of social differentiation. These ideas are elaborated in *The Civilising Process* (1994a [1939] i & ii) where Elias examines micro- and macro-social processes in Europe since the Middle Ages:

'Elias's intention is to show by the examination of empirical evidence how, factually, standards of behaviour and psychological make-up have changed in European society since the Middle-Ages, and then to explain why this has happened' (Mennell, 1992: 30).

In the first volume, he explores the psychological consequences of changing social structures. He suggests that modes of acceptable behaviour are socially defined and that this pattern of behaviour was less controlled in the medieval period, compared to later times. Thus, medieval society is characterised by '*a lesser degree of social control and constraint of instinctual life*' (Elias, 1994a [1939]: 159). However, people of higher rank gradually imposed greater standards of self-control, which resulted in the regulation of bodily functions and emotional expression. Thus, in the course of the sixteenth century, a more rigid social hierarchy began to emerge, in which people of higher rank moderated their behaviour in increasingly subtle ways, differentiating themselves from others. Since the pursuit of personal desires could jeopardise their 'power opportunities', individuals increasingly regulated their conduct with reference to each other. Restraint was therefore imposed by the requirements of increasingly complex and differentiated figural networks, motivated through individuals' need to secure advantage over one another. Elias defines this self-restraint in similar terms to the Freudian super-ego. In this way, increasing aspects of human behaviour were considered distasteful and were conducted behind closed doors, promoting a uniform standard of good social behaviour, the institutionalisation of more controlled forms of behaviour and the development of a new 'habitus'.

In the second volume of *The Civilising Process*, Elias (1994a [1939] ii) explores corresponding systemic processes of change in European social structures (Mennell, 1992). Here, he argues that, in the process of state formation, society becomes more centralised and, through time, social networks become more complex, structures and institutions become more differentiated, and chains of interdependence become longer and denser. In this process, the formation of state monopolies of violence and taxation were the principal means of regulation (Dunning & Hughes, 2013).

'The web of actions grows so complex and extensive, the effort required to behave correctly within it becomes so great, that beside the individual's conscious self-control an automatic, blindly functioning apparatus of self-control is firmly established' (Elias, 1994a [1939]: 445).

The Civilising Process was completed in 1939 and, whilst his fundamental ideas did not change substantially, Elias presents a more nuanced picture of these processes in his later publication, *The Germans*. The four major themes in this volume each develop his

earlier ideas (van Krieken, 1998). Firstly, Elias acknowledges the importance of national identity and an awareness of processes of civilisation and de-civilisation. Secondly, he acknowledges the potential for civilising processes to have a 'dark side', as in the case of civilised barbarism. Thirdly, processes of informalisation, in which increased restraint allows for a relaxation in cultural norms, are accommodated within a figurational framework. As part of the latter discussion, Elias revisits the relationship between external social constraints and individual self-constraints to suggest that, in structurally simpler societies, *'The pressure can come from other people, such as a chief, or from imaginary figures such as ancestors, ghosts or deities'* (Elias, 1997[1989]: 33). Thus, considerable external pressure is necessary to strengthen the *'framework of people's self-constraint'* (Elias, 1997[1989]: 33). Fourthly, and finally, he examines the distribution of opportunities and power across generations.

The argument emerging from this figurational perspective is that the complexity of networked interdependencies, and therefore, we can reasonably assume, the degree of structural differentiation, in societies at any point in time, can provide a yardstick of comparison by which differences between them can be understood. Elias considered that these societal differences would include the differential development of self-control. This requires the development of foresight, and Elias describes three processes which enable foresight to develop: firstly, psychologisation and mutual identification; secondly, rationalisation; and thirdly, the advance of thresholds of shame and embarrassment. These key concepts might help to explain how the civilising processes of different societies differentially influence reactions to loss and engagement in bereavement counselling practices.

Psychologisation refers to individuals' ability to objectively observe one another and interpret others' motives and nuances of behaviour, instead of reacting to them in an impulsive and openly emotional manner. Thus, a reaction originally dominated by anger or fear is replaced by an ability to stand back, observe and understand the behaviour of others. As such, psychologisation encourages a process of mutual identification and a reflective appreciation of how one's behaviour impacts, and is interpreted by, others.

In the rationalisation process, attitudes to religion, science and the economy become more detached. Elias argues that rationality results from a developing self-consciousness, which becomes less permeated by impulses. Here, whilst Elias does not

explicitly use the terms, he arguably alludes to Freud's notion of the Reality Principle that comes to overrule the Pleasure Principle (Mennell, 1992). Increasing rationalisation is the ability to delay immediate gratification, to avoid explanations which are linked with the magical and supernatural, and instead to stand back and analyse a situation. For Elias, this process was inevitably bound up with figurational movement. Consequently, rational behaviour may look different within different figurational structures, *'revolved around the growing reflexive understanding of our own actions, those of others, their interrelationships and their consequences'* (van Krieken, 1998: 105).

The reduction of thresholds of shame and embarrassment correspond with advancing 'civilising' processes. Shame represents the internal anxiety that is aroused when individuals have violated an external rule. Embarrassment results when the rule is internalised and the observed transgression is that of another person and not oneself. Like rationalisation, shame and embarrassment are deemed to result from changes in the way individuals' consciousness is permeated by impulses; from a Freudian perspective, this would arguably correspond to changes in drives and drive controls. To avoid situations which feel shameful, individuals have to anticipate social prohibitions (which vary across social formations), and regulate drive controls so that prohibitions are not violated. Whilst Elias utilises these Freudian terms, he does so with caution, emphasising that these are not static processes but are embedded in interdependent networks (Mennell, 1992).

Perhaps the most far-reaching implication of Elias's theory is that the changes in behaviour resulting from long-term figurational movement do not merely represent changes in individuals' conscious self-regulation, but much deeper psychological changes; that is to say, externally-imposed controls become self-imposed restraints. *'The social standard to which the individual was first made to conform by external restraint is finally reproduced more or less smoothly within him'* (Elias, 1994a [1939]: 128).

Using the conceptual framework of psychoanalysis, the inevitable implication of this argument is that the repression of drives is a product of long-term figurational change in the direction of higher levels of complexity. Hence, drives become more controlled in Western societies. In accordance with this theory, Elias asserts that European people in the sixteenth century were psychologically different from their ancestors, and also from

their descendants. *'The civilising process does involve sequential changes in a consistent direction over the long term in the psychological make-up of European people'* (Mennell, 1992: 49). Social habitus is reshaped as social figurations change. It is now necessary to examine a related sociological concept that was briefly alluded to earlier, namely, structural differentiation, and consider its relationship to Elias's ideas.

5.6 Structural Differentiation and Figural Theory

Structural differentiation theory has developed from the long tradition of thinking about social development in terms of the changing form of social relationships. It focuses on societal systems as a whole and how they operate and change, analysing societies' potential to accommodate greater social complexity (Luke, 1990). It is particularly associated with classical sociological thinkers such as Durkheim (1984[1893]).

Durkheim, in his *Division of Labour* (1984[1893]), explores how societies maintain their integrity and stability in the change process (Lukes, 1973). He conceptualises the process of differentiation in terms of the division of labour, highlighting changes from structures with a low division of labour, characterised by strong kinship ties and collective identities, to societies with a high division of labour where shared religious beliefs and ethnic background can no longer be assumed. He suggests that the former are characterised by 'mechanical solidarity', where social order is maintained because people tend to act and think alike, possessing a shared 'conscience collective'. This forms the moral basis of social relations, ensuring that questions of identity, individual thought and behaviour are determined collectively by the community (Nisbit, 1979). In contrast, in advanced, industrial capitalist societies, an increase in population density has led to a need for people to develop specialisms of function, with a corresponding need to be more interdependent and integrated. Within this 'organic solidarity', social order is maintained through mutual interdependence.

A key feature of Durkheim's theorising is that modern organic solidarity, characterised by a decline in the collective moral order, and the rise of individualism, is held together by a division of labour, *'Heterogeneity and individualism will replace homogeneity and communalism, and division of labour will provide all that is necessary to unity and order'* (Nisbit, 1979: 85). However Durkheim later adjusted this view, concluding that

the division of labour did not ultimately provide a substitute for the power of religion. Consequently, a moral crisis was identified in modern cultures.

Elias's version of structural differentiation theory initially focused on the societal differentiation that resulted from lengthening chains of interdependencies. These ideas were developed in several texts, two of which are particularly relevant to this study. In *Towards a Theory of Communities*, the foreword to Bell and Newby's *The Sociology of Community* (1974), Elias seeks to '*transform the historical into a sociological mode of perception*' (Elias, 1974: xxiii). Here, he presents the distinguishing characteristics of communities as characteristics of differential developmental stages. Within early forms of community, interdependencies are deemed to be all-embracing; individuals are closely bonded to each other and chains of interdependencies are undifferentiated, short and small in number. The overarching goal of each member of society is to secure communal survival. Most functions of daily-living – economic and food production, education, religion, and leisure – are performed at the community level. However '*as the bonds between first producers and last consumers become longer and more differentiated*' (Elias, 1974: xxvii), decision-making processes become more removed from community life, private and public aspects of life become increasingly segregated and societies become more differentiated. Elias describes two forms of differentiation: differentiation of function, and the development of specialisms or hierarchies within these functions. Furthermore, Elias identifies de-differentiation processes that co-exist with differentiation processes, and are evident of counter-trends within cultures.

In *What is Sociology?*, Elias (1978[1970]) further conceptualises the processual character of interdependent relationships, using the analogy of a series of games. In this game model, he presents a succession of teams characterised by increasing complexity. Additionally, the changing power dynamic is explored as a central feature of the competitive environment, with the stability, fluidity and proportion of power relations analysed. For example, simple 'two-player' games could be said to represent traditional communities, being differentiated horizontally on one level. In contrast, games with multiple players in different locations could be said to be differentiated horizontally and vertically. Elias argued that, as the teams become more complex, the mind-sets of players would change. This is analogous to the ways in which individuals within a community moderate their actions in response to increasing numbers of people, as a

consequence of which the habitus and psychological make-up of the community changes.

Compared to Durkheim, Elias presents a fuller picture of differentiation processes and thus of the different ways in which people are interdependent (Dunning & Hughes, 2013). He acknowledges personal interdependencies which develop through emotional bonds, and the interaction of economic with political bonds. He is critical of Durkheim's conceptualisation of structural differentiation, suggesting that it: is limited in its sole focus on impersonal economic interdependencies; blurs the distinction between voluntary and involuntary bonding processes; and presents static polarities, which leave little room for acknowledging the continuous course of social development. In contrast, Elias's version of structural differentiation suggests a plurality of interweaving processes. Transformations of relationships are deemed to be interwoven with many other processes of change including economic, psychological, geographical and political change (van Krieken, 1998).

Viewed through the lens of these concepts, Uganda is a structurally simple, relatively undifferentiated society; chains of interdependencies are short; there are fewer institutions than in NI and these have more broadly defined functions. Kinship, clan, and village play significant roles in what is a collective way of life (Kikule, 2003). In contrast, NI would be defined as a structurally complex, relatively highly differentiated society; it has been described as a capitalist society but with an '*intricate sequence of hierarchies that oversee the allocation of material and figurative resources*' (Coulter, 1999: 5). The interplay of these hierarchies, and their association with class, religion and ethnicity, determine how life in NI is ordered. Within NI, chains of interdependencies are long, and there is an extensive range of differentiated, interdependent semi-autonomous institutions. Services are provided by the public, private and voluntary sectors, covering education, health, politics, welfare and the economy (Prior, 1989).

As these two societies differ in the level of complexity of their figurational interdependencies, Eliasian theory would suggest that people in each, experience death and bereavement differently. For example, varying degrees of figurational complexity might be associated with varying degrees of foresight, differentially influencing individuals' ability to rationalise death, to reflect on their own and others' behaviours

around death, and also to experience shame associated with death. Consequently, in contrast to NI, one could anticipate that in Uganda the dominant sense of identity is found in collective relationships with others, and that there is a less rational and psychological understanding of events, co-existing with an increase in beliefs in ritual and magic. It might also be expected that shame would be a more common emotion than embarrassment, due to the high value placed on the external collective control of behavioural standards. In comparison, bereaved individuals in NI might experience greater subjective individuality and a greater capacity for rationalisation. Embarrassment and guilt would be more likely than in Uganda, as internalised and individual moral codes will have been violated. People may behave with less impulsivity, with a greater display of self-regulation, and with longer-term deferment of goals. The practice of bereavement counselling in either setting would therefore be influenced by their differing figural characteristics, with consequent differences in the habitus and psychological make-up of bereaved individuals. However, before reflecting further on the usefulness of these concepts, a critique of Elias's theory will be offered.

5.7 Critiques of the Civilising Process

Elias's theorising has had mixed academic reviews. Like Freud, he offers a theory with wide-ranging application and implications. However, unlike Freud, who had an immense influence on twentieth century thought, culture and psychology (Bocock, 1991), Elias is said to be *'the most important thinker you have never heard of'* (Pinker, 2011: 59).

Elias's proponents have described him as unique among sociological theorists in his attempts to offer a far-reaching analysis of the historical roots and development of modern society, encompassing both sociological and psychological paradigms (Goudsblom, 1987; Mennell, 1992; Pinker, 2011; van Krieken, 1998). His critics argue that his work lacks coherent logical analysis and a strong theoretical base. He is accused of arrogance, for confidence in his own position and for not referring to other theorists to back up his argument. He is also accused of being racist, ethnocentric and Eurocentric (Blok, 1982; Duerr, 1988; Goody, 2002), in the sense that his figural framework is said to legitimise the dominance of the 'civilised' over the 'primitive'.

Mennell (1992) discusses the main criticisms of Elias's work, two of which are particularly relevant here. The argument from cultural relativism cites individuals' ability to view the beliefs and customs of another culture from within the context of that culture rather than their own; this is seen as more ethical than postulating an evolutionary progression of cultures from 'primitive' to 'advanced'. Any distinction between more civilised and less civilised societies, where the former is presented as superior to the latter, is subject to criticism (Blok, 1982; Goody, 2002). This is often presented as 'a unilineal evolution' in which European Christians are seen as the pinnacle of human evolution (Goody, 2002). As such, Elias is said to expound a linear progression in one path of development, from less civilised societies, with few chains of interdependence, to more civilised societies with more interdependence and a consequent refinement of personality and self-control.

In addressing these criticisms, Dunning and Hughes (2013) suggest that Elias sought to contribute to the question of how and why changes within the West happened, but he did not claim to offer the definitive answer. Thus, his theory is Eurocentric, but only in terms of being focused on Europe; it is not an example of Western or European triumphalism. Mennell and Goudsblom contend that whilst contemporary social scientists usually refer to terms such as 'socialisation,' 'en-culturation,' or 'personality formation', rather than 'civilisation', long-term societal changes are not disputed, *'At least since Freud, Piaget and Kohlberg it has not been seriously disputed that this process does indeed occur nor that it has a sequential structure'* (Mennell & Goudsblom, 1997: 730).

Mennell (1992) further suggests that the difference between unilinear and multilinear accounts of development reflect differences in the level of abstraction, and also that Elias adopts a middle course in which he studies progressions and regressions within societies.

Elias himself argued that he did not postulate an original state of nature; *'There is no zero point in the historicity of human development'* (Elias, 1994a [1939]: 131). There is no specific beginning to the civilising process and there is no ending, no optimum state of civilisation. *'There are progressions, but no progress'* (Elias, cited in Liston & Mennell, 2009: 53). Whilst it is deemed that individuals always have the ability to control immediate impulses to achieve longer-term results, the direction, pattern and

degree of control may vary in different social groups and at different historical stages. As such, Elias's theory presents a variety of figurational change processes that can be considered value-neutral. '*Elias recognised there are ways of 'being civilised' other than the Western one*' (Dunning & Hughes, 2013: 78). The balance between external controls and self-constraints is overseen by the social standards inherent in each society and will differ from one society to another. Thus, the direction of civilising processes varies from '*tribe to tribe, nation to nation*' (Elias, 1986, cited in Mennell, 1992: 207).

The second criticism, the argument from stateless society, has been made by some theorists, most notably Duerr (1988), who deny the correlation between standards of behaviour and levels of social complexity. They suggest that high levels of civilisation can be found in societies that have no state structures, citing anthropological findings which reveal high levels of self-constraint and foresight in stateless, isolated societies (Théoden van Velzen, 1982; van Krieken, 1998). In response, Mennell argues that, although the strength of external constraints may vary between societies, the shifting balance of controls, which are theorised to lead to increased self-control and foresight, can arise from '*functional alternatives to state formation*' (Mennell, 1992: 241). Elias himself addresses this point in *The Germans*, where he notes that behaviour may be constrained by not only powerful external individuals, but also powerful imagined figures such as ancestors.

While Quilley and Loyal (2005) commend the broad applicability of figurational theory, they note that *The Civilising Process* focuses on particular European societies during a specific time-frame, and therefore does not necessarily have universal validity. However, they suggest that the underpinning concepts permit a more '*general understanding of the social processes qua figurations*' (Quilley & Loyal, 2005: 819). Elias has also suggested that figurational theory might be applied to contemporary societies with variable degrees of differentiation, including African societies (Elias, 1994b [1987]).

Duerr (1988) also notes that the nature of social restraint may not only change in form, (i.e. from externally- to internally-derived), but also in effectiveness, in that self-restraint appears, in Elias's account, to be more successful. Van Krieken (2005) acknowledges that the core of Duerr's arguments needs to be taken seriously, and notes that Elias appears to blur the distinction between the form and effectiveness of social

restraint. He also highlights inconsistency in Elias's theory around the durability of habitus in relation to social conditions, but notes '*the often contradictory character of social and psychic life*' (van Krieken, 1998: 132).

Although some reconstruction and refinement of Elias's theory may be required, it arguably provides a powerful line of explanation relevant to the present study. A further advantage of employing figurational theory here is that Elias has explicitly explored both individuals' expression of emotion, and their social practices, in relation to death. This aspect of Elias's theory will now be addressed.

5.8 Figurational Analysis: Emotions, Death and Bereavement

In *On Human Beings and Their Emotions* (1987b), Elias explores societal control of the expression of emotions, a key component of managing loss. He suggests that individuals' control over drives and emotion is not simply genetically determined but needs to be learned early in life. '*No emotion of a grown up human person is ever an entirely unlearned, genetically fixated reaction pattern*' (Elias, 1987b: 352). Elias's theory addresses the ways in which emotions are shaped by the necessities of social interdependence; it is deemed that people in different figurations will experience different balances between emotional expression and emotional control. This phenomenon is widely acknowledged in anthropological studies of bereavement: '*I know of no society in which the emotions of bereavement are not shaped and controlled, for the sake of the deceased, the bereaved person or others*' (Rosenblatt, 1997: 36).

In his work on *Involvement and Detachment* (Elias, 1987a), the development of knowledge is understood in terms of the changing balance between subjective experiences of the world or 'involvement' and an attempt to overcome these experiences through 'detachment'. Here, Elias suggests the long-term development from magical-mythical ideas dominated by 'involved' needs and emotions, to situations which attain more detachment from direct emotional responses (van Krieken, 1998). Thus, in structurally simple settings, it can be anticipated that the self may be characterised by strong instinctual passions, and strong collective restraints. In Uganda, bereaved individuals would be expected to experience, on the one hand, highly involved unrepressed emotion but, on the other, strong external control of emotional expression.

Conversely in a structurally complex society, like NI, self-imposed and detached emotional control may be relatively strong and internalised.

In the *Loneliness of the Dying* (2001[1982]), Elias presents a theoretical account of death in Western societies. He discusses changing attitudes to death and bereavement, noting that there has been a general historical shift from societies where death was a visible and integrated part of life, to societies which are said to be in denial of death (Gorer, 1965; Mellor & Shilling, 1993; Walter, 1996). Elias offers an explanation for these changing attitudes to death, suggesting that, in Western societies, death has become repressed both individually and socially and is consequently concealed from view. He suggests that modern death is repressed individually; being pushed into the unconscious with corresponding feelings of guilt. Death is also socially repressed, because it is increasingly associated with feelings of shame and embarrassment. This diminishing visibility of death is facilitated by the relative safety and predictability of life in Western societies; in such societies, it is difficult to appreciate how historically unusual it is to live free from fear of violent death. Here, 'death is a good way off,' the final stage of a natural process over which individuals have a sense of control. As a result, they are likely to respond rationally to death and have less need for religious ritual. However, people still fear their own mortality. The loneliness of the dying results from others' failure to engage with the dying person due to this absence of prescribed ritual. Moreover, in an increasingly secular society, people are likely to lack the skill required for offering words of comfort to the dying.

Elias's views on the management of death would lead us to believe that, in African societies, death might be less hidden and shameful; people do not live alone, become sick alone or die alone and, consequently, death and dying are inevitably integrated into everyday life. Death will therefore be publically and collectively managed in accordance with socially-agreed rules for managing grief. Additionally, a greater vulnerability to danger and death in such societies means that collective wishful fantasies will develop as a way of coping with frequent loss.

The suggestion that experiences of death and bereavement are historically and socially contingent is not unique to Elias. However, although Elias did not specifically refer to bereavement counselling in his work, figurational theory offers an explanation for these differences that is sympathetic to the aims of the present study. It provides an

explanation for, and analysis of, the societal variations in death, bereavement and grief of which the post-Freudian writers reviewed in Chapter 4 were empirically aware, but which they failed to incorporate into theoretical and conceptual paradigms.

5.9 Figurational Analysis: Bereavement Counselling

Figurational theory can be usefully applied to three components of bereavement counselling, namely: the organisation of counselling services, the way in which people make sense of their loss, and psychotherapeutic interventions. These points will be addressed in turn.

Firstly, from a figurational perspective, the progressive rise of specialist bereavement counselling services in Western societies can be understood as a consequence of the increasing differentiation of health and welfare provision which, in structurally simple societies, is offered by religious bodies and families. In structurally complex societies, the process of differentiation has led to a progressive division of counselling into specialist, independent organisations, entailing the formal training of counsellors in psychological theories, replacing informal socialisation into community mores. It also involves the emergence of market and bureaucratic mechanisms to bring counsellor and client together.

Secondly, the need for the client to make sense of his or her loss is a key feature of the bereavement response, and one often addressed in counselling (Davis et al., 2000). Application of figurational theory suggests that the way in which clients do this may be aligned to the structural complexity of a figurational setting and the dimensions of its corresponding habitus. In his work on *Involvement and Detachment* (1987a), Elias explains the rise of scientific interpretations of events as a feature of the long-term development of human knowledge. Elias suggests that individuals' distinction between living and non-living things has changed in Western societies, linking this development to civilising processes; a rise in self-control is deemed to be orientated with the increased ability to stand back, observe phenomena, detach oneself from them and, ultimately, formulate a theory or model to explain them. Public standards ultimately determine the degree to which scientific knowledge is accepted and, in structurally complex settings like NI, meaning making is increasingly objective, scientific and rational. An essential characteristic of modernity is the desire of individuals to have

control over all aspects of life, including the natural world, social forces and themselves (Giddens, 1991). However, Elias maintains that magical thinking is still present in the habitus of structurally complex societies; it is submerged into the personality, allowed expression through the arts, and wider cultural life (for example, in science fiction) and emerges in attitudes to sickness where individuals ask ‘what have I done to deserve this?’ In structurally complex societies, vertical differentiation contributes to the development of a folk habitus, with family and community operating as a popular subculture, but located within a society dominated by an official, institutionalised, rational, scientific and medical culture. In contrast, in structurally simpler societies, there is less vertical differentiation and hence less gap between the culture of the village and the hospital.

Turning to structurally simple societies, Elias postulates a different process of meaning-making to explain syncretistic belief systems. He concurs with other theorists in suggesting that meaning-making takes place through social interchange (Douglas, 1966; Rosenblatt, 2001). However where animistic and scientific explanations co-exist, Elias suggests a ‘double-bind’, or vicious circle, which maintains this dual understanding. That is to say, people hold animistic beliefs because of their inability to detach from an event. Their strong emotional and cognitive attachment is a consequence of a relative inability to control their dangerous environment. Whilst individuals remain vulnerable, causal explanations are insufficient because they do not meet their cognitive or emotional needs. Such insecurity helps to maintain their emotional involvement, and so the cycle continues. It is interesting to note that, even within Western settings, individuals’ ultimate inability to control death may be reflected in the existence of syncretistic belief systems and, here too, magical and superstitious beliefs may co-exist with scientific explanations.

Thirdly, figurational theory has been taken up and developed in the field of psychotherapy. It is acknowledged that Elias has made a significant contribution to this field in his insistence that psychology and psychoanalysis have not accepted the depth of the social in each individual (Pines, 2002). Moreover, the German group-analyst, S.H. Foulkes, one of the earliest psychotherapists to acknowledge the place of the social in the development of the self, incorporated Elias’ figurational theory into his group-analytic model (Foulkes, 1957). For Foulkes, the need to belong to the social remained one of the core organising principles driving human existence (Dalal, 1998). As a

consequence, he argued that individual therapy could only ever treat people 'artificially'. Figurational theory would seem to imply bereavement counselling should be offered in group settings rather than on an individualised basis.

In conclusion, it appears that similarities and differences in bereavement counselling between NI and Uganda can be understood in figurational terms. Thus, in NI, in comparison with Uganda, society is highly differentiated and individualistic, and chains of interdependence are long and complex. NI has many different types of institutions with narrowly defined functions. Higher levels of self-regulation and increasing foresight might therefore be expected. It might be anticipated that bereaved individuals would experience the death of their loved one in a private, sequestered and perhaps marginalised manner, with the possibility of repugnance and shame. There may be stronger repression of emotion, with few collective channels of mourning, few collective rules around the conduct of grief or how to make sense of loss and a tendency to experiencing a sense of guilt. Therapeutic models would be individualised, seeking to enable the individual to overcome his or her initial inhibition of emotion and construct an individual narrative to make sense of the loss.

Ugandan society, in comparison with NI, is less differentiated and chains of interdependency are shorter and fewer. There are fewer institutions, and those that exist have broader functions and are less formal and extensive. The habitus of bereavement counsellors and their clients might be expected to display a reduced tendency towards psychologisation and rationalisation, a greater degree of magical thinking, a lower propensity for shame and freer expression of emotion. Conduct might be expected to be externally controlled through socially agreed rules. Individuals may behave with more impulsivity, and seek more immediate goals. It might be expected that a bereaved individual has less need for counselling and that death will be integrated into everyday life. Consequently, there would be socially agreed rules for the conduct of grief, and a shared mythology for making sense of loss. In this context, the emotional distress caused by bereavement may be mediated by collective mourning rituals, which realign the bereaved individual within his or her community.

5.10 The Interpretive Value of Eliasian and Freudian Theory

In this and the previous chapter, two contrasting theoretical perspectives have been presented with the aim of explaining similarities and differences in bereavement counselling in Uganda and NI. The interpretive value of each will now be considered. This section will begin with a brief discussion of the relationship between the two theories.

It is clear that Elias drew on Freudian concepts in his own work. Van Krieken identifies the influence of Freud's *Future of an Illusion* (1927) and *Civilisation and its Discontents* (1930) which present Freud's opposition between instinctual satisfaction and the requirements of society, his assertion of the historically increasing internalisation of external constraints, and his views on the illusory characteristic of religious beliefs; Elias has developed similar themes in his own work. Scheff (2004) highlights the influence of Freud's *Three Essays on the Theory of Sexuality* (1905) on Elias's thinking around shame, disgust and repression. Elias adapted Freud's individual focus to incorporate social and institutional factors into an analysis of shame. Elias also adopted and developed Freud's (1923) psychoanalytic theory. However, Elias has been criticised for his selective use of psychoanalytic concepts (van Krieken, 2005; Stacey, 2003). Furthermore, Stacey (2003) presents the theories of Freud and Elias as two contradictory, incompatible ways of thinking. He argues that, for Freud, the mind was internal and the social systems external, whereas, for Elias, the individual and social are two aspects of what it is to be human. For Freud, the individual has primacy over the group, but, for Elias, neither the individual nor the group has primacy. For Freud, the psyche is located in innate universals, but, for Elias, it is embedded within particular social figurations that are constantly evolving. Arguably, Elias and Freud ultimately offer different perspectives on grief and mourning. Moreover, although a wide range of post-Freudian writers have criticised Freud, counselling theories and concepts have continued to promulgate an autonomous, individualistic, reflexive version of a Western self, and have not fundamentally changed the conceptual legacy of Freud.

Table 3 compares the utility of Elias and Freud in addressing the ideal type dimensions of the management of death and bereavement, discussed in Chapters 3 and 4.

Table 3: Evaluation of Eliasian and Freudian theories of death and bereavement

Dimension	Freud	Elias
Response to death	<p>Healthy grieving is deemed to require every person to engage in grief-work. This is viewed as a solitary, individual and intra-psychic process.</p> <p>This theory cannot account for collective responses to loss or the influence of contextual factors.</p>	<p>Grieving is deemed to be shaped by the social regulation of bereaved individuals, which varies according to the structural complexity of figurations.</p> <p>This theory can account for both individual and collective responses to death.</p>
Negative impact of death	<p>Grief-work is deemed to require the involuntary withdrawal of ego from a loved one. This process inevitably causes distress and depression.</p> <p>This theory does not address secondary losses, including economic concerns arising from loss.</p>	<p>Emotional expression is deemed to be motivated by the dynamics of social interdependence, linked to figural networks.</p> <p>This theory can account for societal differences in the negative impact of death. Overriding economic concerns may limit emotional expression.</p>
Mourning duration and intensity	<p>The severance and replacement of emotional ties is not considered straightforward. Grief-work is viewed as an interminable labour which is long and repressed.</p> <p>This theory cannot account for vicissitudes in emotional expression of grief according to socially agreed rules, and, in particular, for grief which is confined to brief but intense periods of mourning.</p>	<p>People in different figurations are deemed to experience different balances between emotional expression and emotional control, depending on shifting patterns of social interdependence.</p> <p>This theory can account for variation in mourning duration and intensity.</p>
Belief system	<p>Freud's mourning theory does not address the significance of religious belief. In his other theories (1927, 1930, 1939) religious belief is portrayed as a neurotic response to helplessness.</p> <p>These theories can account for the greater propensity to sacred belief systems in African societies, by portraying them as manifestations of a universal neurotic process.</p>	<p>The rise in scientific interpretations of events is deemed to be part of the long-term development of human knowledge and habitus.</p> <p>This theory can account for the greater propensity to sacred belief systems in African societies, in which scientific interpretations are associated with greater control over the environment.</p>

Death narrative	<p>Grief-work is deemed to be an individual narcissistic process, and therefore ahistorical, intrapersonally negotiated and decontextualised.</p> <p>This theory cannot account for variable systems of belief and behaviour in different social settings.</p>	<p>Death narratives are deemed to be aligned to the structural complexity of each setting and the rise in scientific habitus.</p> <p>This theory can account for variations in fundamental systems of belief between social settings</p>
Concept of self	<p>Grief-work is deemed to be instinct-driven, self-directed and autonomous.</p> <p>This theory does not account for grief reactions which are directed by, for and to others.</p>	<p>The concept of self may be autonomous or directed depending on the complexity of individuals' figurational networks, and power dynamics they represent.</p> <p>This theory can account for fundamental differences in the concept of self between social settings.</p>
Grief sharing	<p>Denial and repression are deemed to be inherent in the grief-work process. Therefore, death is deemed to be closed and hidden in order to maintain this denial.</p> <p>This theory cannot account for responses to death which are shaped by social norms.</p>	<p>As part of a long-term change in human subjectivity, there has been a historical shift, from societies where death is visible and integrated, to societies which are said to be in denial of death.</p> <p>This theory can account for fundamental differences in response to grief sharing between social settings.</p>

Critically, Elias's figurational theory appears to have much stronger explanatory potential than Freud's for explaining similarities and differences between social settings and wider social formations. Elias's figurational theory, with its emphasis on both the relational nature of social life, and its processual character, does offers a conceptual framework capable of interpreting and understanding variations in death and bereavement practices. Freud's ahistorical, psychic unity model would predict that the human psyche would be the same in all settings, accounting for similarities in each setting but offering little explanation for differences.

Elias suggests that grieving is shaped by the social regulation of bereaved individuals, which varies according to the structural complexity of the chains of figurational interdependencies that constitute the setting concerned. This allows us to view

mourning, at least in part, as figurationally generated and controlled, which may be a predominantly collective or individual experience. However, Freud's mourning theory, in which grieving is seen as an intrapsychic process, fails to account for these differential responses to death.

Elias also offers explanation for the negative impact of death which has a predominantly emotional or economic focus. Emotional expression is deemed to be motivated by the necessities of social interdependence, linked to figurational networks and associated habitus; as such, overriding emotional concerns may diminish emotional expression. However, for Freud the focus on intrapsychic processes does not account for the impact of economic concerns.

Cultural differences in the duration and intensity of mourning, whether it is long and repressed or brief and intense, are explained by Elias according to the ways in which people in contrasting figurations are deemed to experience different balances between emotional expression and emotional control. These variations reflect the dynamics of social interdependencies. However, Freud's focus on the severance and replacement of emotional ties presents grief-work as an interminable ahistorical process. This does not account for the observed vicissitudes in the emotional expression of grief according to socially agreed rules.

Elias's theory hypothesised long-term changes in subjectivity, accounting for predominately scientific or spiritual variations in belief systems relating to death. Whilst Freud's mourning theory does not address the belief systems of bereaved individuals, in his other theories (1927, 1930, 1939) explanations are offered for the greater propensity to sacred belief systems in African societies, by portraying religious belief as a neurotic response to helplessness.

Differences in death narratives, are, according to Elias, aligned to the structural complexity of the figurational interdependencies characteristic of each setting and the rise in scientific habitus and rationalistic interpretations of events. However, for Freud mourning is an individual ahistorical, intrapersonally negotiated and decontextualised process. This cannot account for socially generated belief systems incorporating a shared mythology associated with the loss.

For Elias, variations in the concept of self, which may be autonomous or directed, depend on the complexity of figurational networks, and power dynamics they represent.

For Freud, grief-work is deemed to be instinct-driven, self-directed and autonomous. As such this theory does not account for vicissitudes in grief reactions which are directed by others.

Finally, differences were identified in response to grief sharing. Understood within a figurational framework, as part of a very long-term change in human subjectivity, there has been a historical shift, from societies where death is visible and integrated, to societies which are said to be in denial of death. Elias's theory can account for changing patterns of grief sharing. However, according to Freud, death is deemed to be closed and hidden in order to maintain the need for denial. Consequently, Freudian theory cannot account for responses to death which are shaped by social norms.

5.11 Conclusion

This chapter has explored sociological perspectives on grief. The work of Elias was presented and its explanatory potential compared to that of Freud. Elias's figurational theory resonates with published empirical studies of bereavement in NI and Uganda, as well as helping to expand and clarify theoretical explanations offered by others. The concept of figuration makes it possible to define the notion of the 'context' of bereavement counselling much more precisely, in terms of more or less interlocking networks of social relationships within which encounters between counsellors and clients are brought into being. Differences in the manner in which these encounters are created, managed and resolved in NI and Uganda can be analysed in terms of levels of differentiation and complexity of societal, professional and communal figurations surrounding and constituting bereavement counselling. The concept of habitus provides a means of interpreting and understanding the way in which the theoretical legacy of Freud, described in Chapter 4, provides an, albeit often unacknowledged, professional paradigm and discourse that represents bereavement counsellors to themselves and to their clients.

Chapter 6 Research Design and Methodology

This chapter will discuss the research design, methodology, methods and process deployed in this study. It begins with a restatement of the research questions. Issues and debates pertinent to so-called ‘cross-cultural research’ will then be explored and an alternative approach presented. The methodology will then be discussed, and the chosen methods identified. Procedures adopted in conducting semi-structured interviews, desk research, participant and non-participant observation are described. Methods of data analysis are then presented and justified. Finally, issues relating to research ethics and researcher reflexivity are explored.

6.1 Research Questions

The overall research question was broken down into four subsidiary questions:

1. What are the similarities and differences in the context of bereavement counselling in NI and in Uganda?
2. What are the similarities and differences in the characteristics of counsellors, as represented by the informants in both settings?
3. What are the similarities and differences in the bereaved individuals who seek counselling in NI and Uganda, as perceived by the informants in both settings?
4. What constitutes the practice of bereavement counselling in NI and Uganda, as perceived by the informants in both settings?

The processes employed to address these questions will now be discussed.

6.2 Research Design: Issues and Debates

In conventional terms, this study might be described as an example of ‘cross-cultural research’. However, many issues and debates surround ‘cross-cultural’ methodologies (Denzin et al., 2008; Mabbett & Bolderson, 1999), not least the use of the concept of ‘culture’ itself. In response to these issues, an alternative figurational approach to conceptualising the present research is offered.

‘Cross-cultural research’ tends to be pluralist, characterised by a variety of definitions, methods and theories (May, 2001). The terms ‘cross-cultural’, ‘cross-national’ and

‘comparative’ are often used synonymously (Gómez & Kuronen, 2011). When narrowly defined, ‘cross-cultural research’ refers specifically to the study of the effects of certain aspects of ‘culture’ on other features of life in different settings (Gerstein et al., 2009; Matsumoto & van de Vijver, 2011; May, 2001). ‘Cross-cultural research’ can also be considered in a broader sense, referring to comparative studies of two or more sharply different social settings with divergent belief systems. These describe and explain similarities and differences in the same phenomena in different contexts, across large-scale social units, such as regions, nations, and societies (Gómez & Kuronen, 2011; Smelser, 2003).

A growing body of literature highlights different methodological approaches to ‘cross-cultural’ comparisons (Anttonen, 2005; Mabbett & Bolderson, 1999; Matsumoto & van de Vijver, 2011; van de Vijver & Leung, 1997). Many are employed in comparative studies which are relevant to bereavement and counselling. For example, Demmer and Bughart (2008) utilised semi-structured interviews to explore AIDS-related deaths of patients in both South Africa and the USA. Semi-structured written questionnaires have been used to undertake qualitative comparisons of responses to suicide in Australia and the UK (Rowling, 2000). Quantitative and mixed-methods comparisons have also been carried out; for example, Young (2009) analysed the Clinical Outcomes in Routine Evaluation (CORE) intake norms of students attending South African and UK University counselling services.

More recently, there has been a focus on the development of indigenous methodologies (Braun et al., 2014; Denzin et al., 2008; Ungar et al., 2005), many of which incorporate the principles of Participatory Action Research (PAR) and Community-Based Participatory Research (CBPR). PAR and CBPR do not describe distinct methodologies, but rather offer a set of principles which seek to engage communities in research with the intention of facilitating action or change (Braun et al., 2014) (see Glossary for a definition of these terms). These have been developed as a response to the perceived ethnocentric nature of much ‘cross-cultural research’, and an impetus to empower indigenous peoples to conduct and co-ordinate their own research (Denzin et al., 2008).

Despite this body of literature, the necessary methodological and theoretical support base for ‘cross-cultural research’ is currently underdeveloped (Broadfoot, 2000). There

is a disparate range of 'cross-cultural' methodologies utilised and little written about the methodological challenges of 'cross-cultural research' from a 'grass-roots' level (Mabbett & Bolderson, 1999).

An application of figurational theory (Elias, 1994a [1939]) suggests that the very concept of 'culture', as a reified object, is highly problematic. As is widely acknowledged (Garnham, 2001; Giddens, 1991), the concept of culture is ill-defined, encompassing a wide range of phenomena including, beliefs, values, practices, technologies and deep discourse assumptions. Garnham (2001) suggests that the term has become so indistinct that it is almost tantamount to referring to human life. The term can easily become reified, and seen as an autonomous force or causal agent driving attitudes, beliefs and behaviour. It can also be presented as an asocial and ahistorical concept, in which ideas are disconnected from the social context, or the network of interdependencies, in which they are generated and lived out. Thus, the concept becomes static, divested of the sources of dynamic contradictions inherent in the unintended outcomes highlighted by figurational analysis. Likewise, it is a homogenising concept, in which the nuances and diversity of belief found, for example, in different sub-groups, genders, ethnicities, and classes, are lost. This can consequently lead to what Wrong classically called, an 'oversocialised conception of man' (Wrong, 1961: 183), in which people are portrayed as puppets manipulated by the imperceptible influences of society, and consequently robbed of their agency, action and creativity.

Employing 'cross-cultural research' as a methodological framework in this study runs the risk of importing reified, over-socialised and functionalist explanations of the relationship between bereaved clients, the counsellors and the societies of which they are part. As an alternative, this study will seek to answer the research questions posed through a comparative analysis of habitus and figurations. As discussed in Chapter 5, the concept of habitus refers to the psychological dispositions which are reflexively inter-related with figurations. An analysis of figurations, compromising the ongoing intentional and unintentional actions of people in relations of interdependency, overcomes the problem of 'the oversocialised man' (Wrong, 1961) divested of agency and action. It acknowledges ever-present contradiction, struggle and change and transcends the dichotomies of culture and structure. Therefore, this study will be conceptualised, not as 'cross-cultural' research, but as a comparative figurational

analysis which seeks to enable a better understanding of the dynamic relationship between counselling context, counsellor and client.

In turning to consider the methodology, perhaps the central issue to consider in conducting a comparative figurational analysis is whether, and how, conventional methodologies should be adapted. The debate around the necessity for a unique set of procedures for such comparisons offers no conclusive advice (May, 2001). However, it can be argued that conventional methodologies can be utilised in this comparative study, as explained below.

Whilst all methods have to face tests of validity and reliability (Bryman, 2004), comparative methods face the additional danger of being too firmly rooted in one or other of the comparators under study (Broadfoot, 2000; Elias; 1994a [1939]). Social science research tools can never completely stand outside the societies in which they were created. Nevertheless, social science methods do incorporate systems of thought and analysis that can minimise the problems posed by ethnocentric approaches by utilising skills of reflexivity, rigorous conceptual argument, and the systematic collection and evaluation of evidence. The debate about the limitations of comparative research hinges on the extent to which it is possible to deploy intellectual tools that counter ethnocentrism and provide (if only relatively) an independent means of inquiry which acknowledges the difficulties of working across figurations.

Thus, in favouring the position that the problems faced by comparative researchers are no different in principle from those faced in other research (Bryman, 2004), this present study will utilise and justify the use of conventional methodologies. Issues which are pertinent to comparative research will be addressed by seeking to deploy those intellectual tools which counter ethnocentrism. The first step in this process was to anticipate the nature of these issues. Comparing the habitus of bereavement counsellors in two contrasting networks of figurations risks the nature of habitus in one setting becoming the measure against which the other is judged. Within the research literature, these issues are addressed in terms of the concepts of ethnocentrism and bias. Issues relating to bias and equivalence of concepts, and to factors associated with language and asymmetrical power relations, have been identified as key methodological concerns in much of the research literature (Broadfoot, 2000; Jowell, 1998; Matsumoto & van de Vijver 2011; May, 2001; Ungar et al., 2005; van de Vijver & Leung, 1997).

‘Bias’ is a term drawn largely from quantitative research and refers essentially to a systematic error, in which research findings depart from a ‘true’ finding (van de Vijver & Leung, 2011). However, the notion of bias raises broader issues. Since the research process is itself embedded in social relationships, the researcher is part of the data collection process, and will inevitably influence it. However, obvious and avoidable sources of bias should be identified and challenged (van de Vijver & Leung, 1997).

In this study, the potential for bias needed to be considered at each stage of the research process. Comparative researchers risk asking the wrong questions, focusing on issues that are important in one context and not another (Broadfoot, 2000; Mabbett & Bolderson, 1999). The initial formulation of the research questions required cognisance of variations in how bereavement counselling is constructed and understood. The research design had to be compatible with societal practices in each setting (Mabbett & Bolderson, 1999). At the data analysis stage, to avoid misunderstanding the deeper assumptions on which respondents’ answers were based, it was necessary to create checks and balances to ensure that findings were not interpreted by using an ideological framework rooted in the habitus and figurations of one setting as the norm and another as deviating from the norm (Pole & Burgess, 2000; Ungar et al., 2005).

The term, ‘equivalence’, is subject to various definitions (Matsumoto & van de Vijver, 2011). In the context of this study, it refers to the level of comparability of the research phenomena; that is, the extent to which the same practices are explored across settings. For example, definitions of ‘counselling context’, ‘bereavement counsellor’, ‘counselling client’ and ‘counselling practice’ needed to be broadly similar across the two settings. Equivalence is greatest when bias has been reduced and when research methods are congruent with each setting compared (van de Vijver & Leung, 1997).

Additionally, the conceptual framework of individuals in different settings can best be understood through an appreciation of the nuances of language; words, phrases and concepts. *‘Both the message that the respondent aspires to communicate and the understanding of that message by the interviewer is a social construction that is heavily culture-dependent’* (Broadfoot, 2000: 54). Even if researchers have a proficient understanding of respondents’ language, an understanding of the implicit meanings of words is necessary to ensure equivalence (May, 2001). Whilst English is the national language of Uganda, it is often spoken with different grammar rules and word

meanings; the potential impact of the linguistic differences of the researcher and researched must be acknowledged and addressed.

Ethical and methodological issues must be understood within the context of differential power relationships inherent in comparative analysis. Asymmetrical power relations are linked to issues of race and ethnicity, intrinsic in global figurations where one society is seen as dominant and often superior (Renganathan, 2009). Jowell (1998) is critical of the 'safari model' where researchers from 'developed' countries fly into research locations, imposing their methods on informants from less 'developed' countries. Ethical implications associated with asymmetrical power may be evident in consent procedures, research design, methodology and data collection. For example, within research interviews, issues relating to different levels of accepted disclosure and differences in pacing and formality need to be considered. Strategies to address these potential concerns will be identified and discussed in the remainder of this chapter.

6.3 Rationale for the theoretical framework

The rationale for utilising Freudian and Eliasian theory in developing an explanatory framework for this research has been discussed in previous chapters. As noted, this comparative study required consideration of the influence of both interpersonal, sociological, and intrapsychic, psychological, theories on bereavement practices, and the value of each for informing a comparative figurational analysis.

Freud provides the basic conceptual parameters of the theory and practice of bereavement counselling. He '*delineated the framework which would become the standard model of mourning*' (Hagman, 2001: 14). It was anticipated that an analysis of the influence of psychoanalytic theory on both the contemporary understanding of mourning and on the practice of counselling, might offer insights into counselling theories and approaches employed in NI and Uganda. However, the foregoing discussion has argued that Freudian and post-Freudian theory is not comprehensive enough to serve as an overarching conceptual framework for this study.

In contrast, Elias offers a comprehensive theory of human society (Quilley & Loyal, 2005), capable of bringing together macro and micro elements of the present findings. Moreover, Elias integrated insights from Freudian theory within a historical sociology of long-term processes of development (Loyal & Quilley, 2004). This theory does

appear to offer a satisfactory conceptual framework for this study. Thus, it has been possible to consider how figurational movement may shape the developing psyche and habitus of both clients and counsellors; ultimately, variations in experiences of bereavement counselling practice can be seen as the outcome of dynamic global, local and domestic forms of figurations. Moreover, the application of Elias's theory addresses criticisms surrounding the use of the term 'cross-cultural' research, and shapes decisions around the methodology, as outlined below.

6.4 Methodology

Initial methodological decisions focused on the relative value of qualitative or quantitative approaches. Quantitative research, which stresses the measurement and investigation of causal relationships between variables, tends to be conducted in order to test hypotheses which have been generated by theories, through the collection and analysis of numerical data (Bryman, 2004). Underpinning this process is an assumption of social reality as objective and external, and a deductive relationship between theory and research (Denzin & Lincoln, 2003).

Whilst some researchers may have difficulty in seeing the value of '*the quantification of human experience*' (McLeod, 2003: 41), quantitative techniques can be used to explore a large number of cases, or examine patterns of interactions between counselling variables, such as the association between treatment modality and client satisfaction. Since there have been few ethnographic studies of counselling to date (Árnason, 2001), quantitative methods could have possibly been used to map the 'big picture' in the chosen settings around numbers of counsellors, referral patterns or demographic characteristics of counsellors or clients.

However, the usefulness of such an approach in this study was limited for both practical and strategic reasons. In practical terms, Uganda lacks the infrastructure to conduct electronic, telephone or postal-based surveys, making large scale dissemination of quantitative research tools difficult. More fundamentally, quantitative approaches do not accord with the predominantly narrative culture of Africa (Ugwuegbulam et al., 2009), in which face-to-face dialogue is favoured. Moreover, quantitative approaches are arguably less suitable in exploring bereavement counsellors' underlying assumptions,

interpretations and perceptions of their counselling practice and client experiences, which is the core focus of this study.

Turning to qualitative research, Gómez and Kuronen (2011) suggest that comparative qualitative research enables an analysis of phenomena from inside a cultural and social context, providing opportunities for a deep understanding of behaviour, experiences and attitudes across countries. They locate the researcher in the world under investigation, making sense of phenomena in terms of the meanings people attribute to them (Mason, 2006). Such methods are considered suitable in bereavement research because of their potential to access in-depth, personal experiences and meanings associated with the loss (Neimeyer & Hogan, 2001).

'The application of qualitative paradigms to the study of loss ... begin to paint a picture of bereavement that is far more complex and less tidy than that suggested by the artificially simplified and controlled canvasses of quantitative questionnaires' (Neimeyer & Hogan, 2001: 113).

Whilst generalisations from qualitative methods may be restricted (Best, 2001), the use of other sources of evidence, such as document analysis, may help to redress these concerns (Neimeyer & Hogan, 2001).

In light of these considerations, and in order to acknowledge the value of face-to-face dialogue in researching the predominantly narrative culture of Africa (Ugwuegbulam et al., 2009), a qualitative interview approach was considered most suitable for this research. It was anticipated that secondary data collection, via desk research and participant observation, would also be useful in contextualising and supporting the interviews. A variety of qualitative research tools exist, encompassing differences in theoretical perspectives, research strategies and methods of collecting and analysing data (Denzin & Lincoln, 2003). In facilitating face-to-face dialogue, which sought the individual perceptions of counsellors, semi-structured interviews were chosen.

The use of semi-structured interviews provides an opportunity to clarify participants' responses, enables a broad scope of information to be gathered, and facilitates the development of rapport between researcher and researched (Best, 2001). Semi-structured interviews can vary in form, ranging from fluid conversations to those following a more structured schedule of pre-determined questions, the latter form being used in this study (Appendices A and B). Whilst there are advantages in using both

open and closed questions, open-ended questions predominated in the present research to enable informants to respond in their own terms, and minimise the risk of researcher influence (Neimeyer & Hogan, 2001).

Comparative researchers risk misunderstanding the deeper cultural assumptions of informants (Broadfoot, 2000). In the present study, the development of research questions was based on my working knowledge of relevant theoretical, discursive and empirical literature. In addition, my experience of living and working in both Uganda and NI prior to the beginning of this study facilitated my construction of the interview schedule, helping to ensure that questions had equivalence across settings and that they were phrased in ways which were meaningful within either setting. The initial pilot interviews also assisted in this process.

Many of the interview questions were similar in both settings, with some changes being made to reflect contextual differences. Additionally, a small sub-group of questions were unique to each setting, exploring issues which were particular to that context, and also, in the case of NI, issues which had emerged from the initial reading of the earlier Ugandan interviews (Appendices A and B). Whilst the questions addressed the four broad research foci, the sequence of questions differed slightly across settings, to promote the flow of the interview, as outlined below.

In both Uganda and NI, the interview began with a focus on the demographic details of each informant. In NI, this information was obtained through a written questionnaire administered at the beginning of the research interview (Appendix B). Counsellors in this setting were familiar with form-filling of this nature. However, in Uganda, similar information was gathered through discussion, as this was understood to be more appropriate. In each setting, information on age, gender, ethnicity, job role and training was sought.

In Uganda, this was followed by a subgroup of questions that was absent from the NI questionnaire. Here, in order to avoid making assumptions about the nature of counselling in this setting, some preliminary open-ended questions were used to examine the general practice of counselling before the specific practice of bereavement counselling was explored. Generic counselling questions related to demographic characteristics of clients, referral practices and the nature of counselling. Questions on bereavement counselling practices were similar in NI and Uganda, and began with an

exploration of the counsellor's perception of who comes for bereavement counselling. This included identifying counsellors' perceptions of the demographic characteristics of a 'typical' client. These questions were followed by a discussion of referral criteria and practices. Next, in both settings, informant perceptions were sought of clients' presenting problems. Here, an open-ended question was followed by trigger questions which identified common bereavement concerns, elicited from the bereavement literature (Hansson & Stroebe, 2007), these included emotional, financial or practical, relational and spiritual issues.

One specific concern related to the history of armed political conflict, and its continued influence, in either setting. In the first round of interviews, in both settings, informants were asked indirectly about these issues, being invited to identify any particular circumstances surrounding the death from which someone is likely to seek counselling. These questions were deliberately phrased in an open manner to avoid unduly influencing participants' responses, a strategy which seeks to minimise researcher influence and avoid researcher bias (Neimeyer & Hogan, 2001). My approach was to allow informants to set the agenda. NI informants made very limited comments about sectarian or Troubles-related issues; however, several Ugandan informants identified issues associated with violent deaths. Consequently, in the second round of interviews, Ugandan informants were specifically asked to comment on the impact of such deaths on help-seeking practices (Appendix A).

Questions on clients' reasons for seeking help were followed by those exploring the ways in which informants typically intervened to address these presenting problems. In NI, different types of counsellor interventions were explored, including: education, practical support, psychological support, the use of risk assessment models, differences between immediate and ongoing interventions, and differences in client and counsellor expectations. In Uganda, questions tended to be more open-ended, to avoid making assumptions about which type of intervention might be offered in an African context. The nature and perceived importance of the therapeutic relationship was discussed in both settings. Whilst the provision of individual counselling was the primary focus of this study, group counselling was discussed if this was provided by any of the informants.

Following an exploration of counsellor interventions, the role of the community in supporting bereaved clients was discussed. In Uganda, these questions focused on the relationship between counselling and the pre-established cultural support mechanisms surrounding death. Attention then turned to the bereavement counsellors themselves. Counsellors' motivations and goals for counselling were explored, along with the training requirements for the role, and the main theoretical framework underpinning their practice. Counsellors in both settings were also asked about counselling goals. The personal impact of bereavement work was also explored. In Uganda, the interview concluded with a discussion of informants' perceptions of the nature of counselling and how this might differ from Western practices. In NI, generic questions were asked about overarching issues in the provision of bereavement counselling. These questions differed, as the counsellors in Uganda were trained in Western counselling models and might be expected to have some awareness of Western counselling practices, while the NI counsellors typically had no engagement with African counselling practices.

6.5 Desk Research

While interviews comprised the main source of research data, secondary sources were used to contextualise and support these interviewees' perceptions. An exploration of the counselling context is a central aspect of this study, often acknowledged as a gap in counselling research (McLeod & Machin, 1998). Information on context came largely from desk research and participant observation. Often, counsellors are members of, and accountable to, both employers and professional organisations. Information concerning the professional systems surrounding the counsellors, including policy and procedural guidance, was obtained, enabling an assessment of the differentiation of institutions in either setting. To gather this information, a range of documents was accessed, including those derived from the statutory and voluntary sectors, and those from private and public sources (Babbie, 2007). Documents relating to NI included statutory sector policy and procedural guidance relating to bereavement care and counselling. These included documents produced specifically in and for NI, and those relating to the UK as a whole. Available information from the voluntary sector tended to focus on advice and support for patients and bereaved relatives. BACP documents were also accessed. Within Uganda, government documents relating to the provision of bereavement services and to counselling were extremely limited. Information was accessed from a

range of charitable counselling organisations and from the Uganda Counselling Association (UCA) (Appendices C and D). These supporting documents helped to situate the interview findings within a formal context, in essence providing a form of triangulation of the data (May, 2001).

6.6 Participant Observation

My professional work in both settings enabled direct observation of, and participation in, the provision of services for bereaved individuals (Appendix E). Participant observation generally involves the immersion of the researcher in the social setting under enquiry for a relatively prolonged period of time (Bryman, 2004; McLeod, 2003). Gans (1968, cited in Bryman, 2004) offers a classification of participant observation, outlining three potential roles: ‘total participant’, ‘researcher participant’, and ‘total researcher’. I had the opportunity to act in each of these roles in both NI and Uganda.

In Uganda, I worked as a counsellor for approximately four years prior to the commencement of this research. During this time, I fulfilled the criteria for ‘total participant’. I provided bereavement counselling to Ugandan clients and was a member of the UCA, attending their conferences and training events (Appendix E). During this time, I kept a personal record of my impressions of life in Uganda. Additionally, records were kept of my counselling practice, which were subject to a reflective supervision process (Appendix F). Working as a counsellor in both NI and Uganda enabled me to act as a potential informant and to compose personal answers to the interview questions. These are drawn upon as a distinct data source in the findings chapters. On the commencement of this research in 2008, I sought opportunities which would enable me to act as a ‘researcher participant’. In my day-to-day observations, one of the most striking aspects of Ugandan life was the prevalence of violent crime. Participant observations provided insights into some of the consequences of this violence. For example, I was one of a team of counsellors offering psychological support in the form of a structured group debriefing session, following a malicious fatal fire in a school, ‘Junior B’, in which 20 young girls aged seven and eight died. I also co-facilitated a three-day training event for Ugandan counsellors on bereavement issues and critical incident stress debriefing (CISD) (Appendix F). During this time, I was also a ‘total researcher’, conducting interviews with informants and reflecting on the research process (Appendix F).

I had previously been a ‘total participant’ in NI having worked for 20 years as a social work trainer and as social worker based in a psychiatric hospital. I also worked as a volunteer counsellor in a charitable counselling organisation. In each of these roles, I offered counselling to bereaved individuals (Appendix E). Since returning to NI in July 2008, through membership of various fora I was involved in establishing the strategic development of NI bereavement services and was a member of a Troubles-related Trauma Advisory Panel (TAP). This work provided insights into how the voluntary, statutory and community sectors were continuing to deal with the legacy of the Troubles. I also delivered training on bereavement in both practice and academic environments (Appendix E). I acted as a ‘total researcher’ in NI, conducting interviews with informants between February and April 2010 (Appendix G). My participant observations were not used as primary data in this thesis, but they were, however, useful in assisting the initial problem formulation and the construction of the interview schedules. They also informed the conduct of the interviews and facilitated access to the informants.

6.7 Semi-structured Interviews: Sample Selection

In this study, the term, ‘bereavement counsellor’, was broadly defined (Neimeyer, 2010). It included paraprofessional volunteers, and professionals from a range of disciplines, such as social work and nursing, who had relevant counselling training and experience. Informants were required either to have membership of a professional counselling body, or to be employed in an agency that provided bereavement counselling. Informants offered bereavement counselling in the pre-bereavement stages, to people facing their own death, as well as to loved ones following bereavement. Informants who offered services to adults or children were included, although the majority of informants offered counselling exclusively to adults.

The interviews were conducted in two phases. Initially, interviews were carried out with 18 bereavement counsellors in Uganda, and 17 in NI. Towards the end of the project, an additional three informants were interviewed in NI. In Uganda, three original informants were re-interviewed as no further counsellors could be identified who provided bereavement counselling in Uganda. These additional interviews sought to ensure that saturation had been established and that categories emerging from the findings were clear, the relationship between the categories was well established, and no

new or relevant data was emerging in relation to a category (Bryman, 2004). In total, 41 interviews were conducted with 38 informants. Brief informant profiles are provided in Appendix H, while participants' demographic characteristics are summarised in Table 4. Participants were selected through the technique of purposive sampling (Bryman, 2004). It can be difficult to ensure matched or equivalent samples of informants when conditions governing access may vary and bias in sampling can reduce the validity of the study (Broadfoot, 2000). However, due to my established relationships and networks in each setting, I had access to key figures who were representative of the counselling world as a whole, and who could identify a range of informants. Counsellors who were indigenous to, and had trained in, either setting were in the majority. However, indigenous counsellors who had trained or worked elsewhere were included, as were counsellors who were not indigenous to the setting in which they worked. Informants in these latter categories may have been able to take a more comparative view of their practice and its context.

In Uganda, as a member of the UCA, I made initial contact with the chair of this organisation. She identified counsellors who might offer bereavement counselling as a distinct component of their job. Twelve counsellors were selected. One was the director of an MA counselling programme, based at a university in Kampala, who subsequently identified a further five counsellors; another was identified through word of mouth. Thus, 18 counsellors were identified in all, out of a total UCA membership of 400. It seems probable that only a small proportion of the total number of counsellors in Uganda specifically classify their practice as providing bereavement counselling.

The Ugandan counsellors represented a variety of sectors: NGOs, hospices, university counselling departments, corporate organisations and private practice. The two categories with the highest representation were NGOs and private practice. Rural- and urban-based counsellors, and those from different ethnic groups, were included. In addition to their role as counsellor, the majority of informants had other roles and responsibilities, such as lecturing and managing their counselling organisation. All the counsellors contacted agreed to participate in the project. Seven counsellors worked in private practice and would therefore be charging clients a fee. The UCA indicate that this fee should be around 30,000 Ugandan Shillings per session (approximately equivalent to £10, or the salary of a Ugandan teacher for one day).

Table 4: Demographic characteristics of informants

Category		Northern Ireland	Uganda
Age:	Range:	26-66	30-58
	Mean:	50	45
Gender:	Female:	19	16
	Male:	1	2
Ethnicity:		Northern Irish: 9 Irish: 6 British: 5	Mugandan: 8 Other Ugandan: 7 American: 2 British: 1
Employment sector:		Voluntary: 8 Statutory: 8 Independent/Private: 2 Hospice: 2	NGO: 6 Private: 7 University: 2 Hospice: 2 Corporate: 1
Job role:		Counsellor 8 SW/counsellor 5 Manager/counsellor 5 Nurse/counsellor 1 Chaplain/counsellor 1	Counsellor 8 Lecturer/counsellor 6 Manager/counsellor 4
Highest Counselling Qualification	PhD	0	2
	MA	2	6
	BA	0	3
	Diploma	7	3
	Certificate	4	4
	In-service	7	0

Within NI, in the absence of a central register of counsellors, it was difficult to determine the total number of counsellors practising and the total number who focused on bereavement issues. However, the government review of counselling in NI (DHSSPS, 2002) identified 111 counselling organisations, of which 86% claimed that they were working with clients who had experienced a bereavement. In accessing

informants in NI, I contacted the bereavement coordinator within a Health and Social Care Trust (HSCT); this was one of five such Trusts in NI, and covered the largest geographical area, encompassing both rural and urban communities. Suitable informants were identified by the bereavement coordinator, including professional counsellors, community nurses and social workers who provided bereavement counselling as an explicit part of their job.

Additionally, key voluntary sector bereavement agencies were identified through regional and local publications identifying counselling resources in NI (DHSSPS, 2013; NHSCT, 2009). Senior staff in each agency were approached and asked to identify potential informants. Key counselling staff in the two Belfast-based hospices were also contacted. Of the counsellors identified in the two phases of the study, over half came from the voluntary sector, perhaps reflecting the greater provision of bereavement counselling in the NI voluntary sector compared to the statutory sector (Gallagher et al., 2005). Only two informants were identified from the independent or private sector, which is indicative of the disproportionate contribution of the non-independent sector in other aspects of life in NI (Department of Enterprise Trade and Investment [DETI], 2006). These two counsellors would charge clients a fee, with the BACP suggesting this should be in the region of £60 a session. Rural- and urban-based agencies, and those from perceived Catholic and Protestant traditions, were included. In addition to their role as counsellors, some informants had managerial responsibilities, and one was also a Chaplain. Others worked as professional nurses or social workers, delivering bereavement counselling as a core aspect of their job. All counsellors contacted agreed to participate in the study.

6.8 Pilot Study

In each setting, a pilot interview was conducted with one of the informants in the study, after which minor changes were made to the interview schedule. These interviews were included in the overall data set. Each pilot interview was analysed to see if the information gathered met the objectives of the study. In addition, the pilot informants gave feedback on the interview process. In NI, the draft interview schedule began with a question on personal motivation. During the pilot interview, this seemed like an intrusive personal question with which to begin, and the sequencing of questions was consequently adjusted. In Uganda, the schedule was adjusted to refine the gathering of

demographic details. Additionally, thought was given to the remuneration of informants for travel and time. In NI, this was not usually considered necessary as most informants were recompensed in the normal course of their work, and the two private-practice counsellors refused any remuneration. In Uganda, informants were offered a small token of remuneration in the form of counselling literature. Additionally, private counsellors were offered the normal fee for a session. Two informants accepted this.

6.9 Interviews

In Uganda, the first cohort of interviews was conducted in English between March and June, 2008, in person. A cultural understanding of language is required in promoting equivalence of meaning across settings (May, 2001). Whilst English is the national language of Uganda, it is often spoken with different grammar rules and word meanings; this includes a linguistic tendency for the person to make a statement by posing and answering a question.

By living in Uganda for four years prior to this research, I had already developed familiarity with the common communication styles and had developed a basic fluency in the second national language of Lugandan. I had also become accustomed to some differences in customs and lifestyle. For me, these included a much more frugal use of resources (including electricity, water and food), a lack of privacy, very different rules around health and safety, and a general environment which was hot, vibrant, busy and somewhat chaotic, compared to my more regimented life in NI. I was familiar with hierarchical structures within communities, which prescribed rules around greetings, and was conscious of a different set of priorities which came with a person-orientated, as opposed to time-orientated, culture. The potential influence on data collection of my personal characteristics, including gender and race, and my affiliation with a faith-based NGO, will be discussed shortly, in section 6.12.

Given my day-to-day experiences, I expected that completing the interviews would not proceed smoothly, and anticipated practical issues around co-ordination, travel and privacy. Somewhat surprisingly, the interviews proceeded to a large extent in a timely and efficient manner. Each lasted between 45 and 75 minutes, with the majority lasting 60 minutes. Interviews were audio-taped, using a battery-powered digital recorder.

Choice of time and location was given to each informant. Two informants travelled to my office, which was in the town of Entebbe, about 40kilometres outside the capital city, Kampala. All other interviews were conducted in the informant's office or another venue of choice. This included, on two occasions, conducting the interview outside under a tree. Insights gathered in this process contributed to the overall findings. The interviews were rarely private and confidential; the majority conducted with indigenous Ugandan counsellors were interrupted. During two interviews, informants locked their office door to try to minimise disruptions. This resulted in people coming to the window to converse with the informants (Appendix F). In several of the interviews, there was significant noise disruption, such as loud music and dancing from nearby events.

Many interviews in Uganda began with questions about my personal life. The informants often asked '*How are those at home?*', expecting some disclosure about my private life. I answered these by describing brief details of my family, and the purpose of my work in Uganda and engaging in some dialogue about the informant's family.

In NI, the first cohort of interviews was conducted, in person, between February and April 2010. Choice was given to the time and location of the interview; seven were conducted in my own office and the others within the workplace of the informant. These locations felt very ordered and private following my experience in Uganda. All informants contacted agreed to be interviewed and all interviews were conducted at the planned time and location (Appendix G). These lasted between 50 and 65 minutes, with the majority lasting 60 minutes. They were audio-taped and fully transcribed. These 17 informants were then invited to a 'talk-shop' type discussion (Sinclair et al., 2004), at which I presented an analysis of the collated interviews and guided discussion on how well the findings reflected the meaning of the original interviews. An independent researcher was present and made a written record of this discussion.

In a second data-gathering phase, additional interviews were conducted in both settings. In NI, three further interviews were conducted in January, 2013, using the same interview schedule. In December, 2012, in Uganda, three key informants were selected and re-interviewed as there were no further counsellors identified who provided bereavement counselling in Uganda. A summary of the earlier interview findings and associated questions was emailed to each informant in advance (Appendix A). This was followed by an internet voice-link interview, which was digitally recorded and

transcribed. An additional purpose of these interviews was to verify the findings obtained from the earlier interviews in Uganda, by checking how well the collated analysis of Ugandan interviews reflected the meaning of the original interviews. This was similar to the goals of the ‘talkshop’ held in NI. Across both settings, there were 41 interviews completed in total.

6.10 Interpretation of the Data

The strategy chosen to analyse the 41 interviews was that of thematic analysis. In contrast to analysing quantifiable data, few well-formulated and widely-accepted rules exist for the analysis of qualitative material (Bryman, 2004).

‘the analyst faced with a bank of qualitative data has very few guidelines for protection against self-delusion. ... How can we be sure that an ‘earthy’, ‘undeniable’, ‘serendipitous’ finding is not in fact, wrong?’ (Miles, 1979: 591).

Moreover, it is easy to misinterpret data gathered in an unfamiliar context (Broadfoot, 2000). Reviewing the ‘how to’ literature offers little consensus on the principal methods of analysing qualitative data. For example, Babbie (2007), Bryman (2004), Elliot and Timulak (2005) and Seale et al. (2004) each propose a different core range of analytic methods; these include grounded theory, conversational analysis, content analysis, interpretative phenomenological analysis and hermeneutic interpretative analysis.

Grounded theory (Glaser & Strauss, 1967) is perhaps the most widely used analytic tool, although there have been many deviations from the original model (Bryman, 2004). It is concerned with the development of theory arising out of data, using an iterative approach in which data collection and analysis proceed together (Strauss & Corbin, 1998). However, its emphasis on theory-neutral observation does not fit well with this study because of the prior development of a theoretical framework.

Conversational analysis is seen as the meticulous scrutiny of how we converse with each other (Seale et al., 2004). Content analysis has similar goals, although it is particularly suited to the study of recorded human communication (Babbie, 2007). Discourse analysis also focuses on human communication in exploring the use of language in social contexts (Denzin & Lincoln, 2003). Whilst each of these approaches provides a clear, systematic, account of textual content on which to base analysis, the

present study is primarily concerned with informants' perceptions of specific topics and not with an analysis of communication processes.

Finally, interpretative phenomenological analysis (IPA) seeks a detailed exploration of the subjective world of the informant, offering insight into how particular individuals, in particular situations, make sense of their world (Smith & Eatough, 2006). If the focus of this research was on the personal impact of bereavement, then IPA would offer an appropriate methodology for the interpretation of the data. However, the focus here, on counselling practice rather than personal experience, requires an analysis of informant perceptions rather than subjective experiences.

The methods utilised to analyse qualitative data have at their core common principles and techniques, within which there can be relatively minor distinguishing features (McLeod, 2003). In reviewing these features, Elliot and Timulak (2005) outline core tasks of data analysis for descriptive and interpretative qualitative studies, encouraging researchers to use whatever combination of methods best suits their research objectives. In a similar vein, Braun and Clarke (2006) suggest that 'thematic analysis' is not just an analytic tool, but an analytic strategy in its own right, sharing equal status with 'named' methods of analysis such as grounded theory (Glaser & Strauss, 1967) and interpretive phenomenological analysis (Smith & Eatough, 2006).

Braun and Clarke go on to suggest that, in selecting the most suitable method of thematic analysis, a number of theoretical, epistemological and ontological concepts need to be addressed. They note that the chosen epistemological approach influences both the type of data sought and its method of analysis. Decisions must be made concerning the breadth and depth of the concepts to be explored. For example, a rich description of an entire data-set may suffer from a loss of depth and detail. Researchers must also consider whether they are seeking to carry out an inductive analysis or a deductive analysis, and whether they wish to explore surface-level, semantic themes or latent themes embedded in underlying systems of belief.

There were five distinct stages of qualitative data analysis in the present study. The first entailed familiarising myself with the transcripts. Interviews generated 35 audiotapes of approximately 60 minutes each. These were fully transcribed, providing a verbatim account of each interview. I personally transcribed the majority of tapes in order to become familiar with the breadth and depth of the material, whilst an experienced

audio-typist transcribed a sub-group of seven. Each informant was given a pseudonym to ensure confidentiality, and the date of the interview and the venue were recorded. Transcriptions were read in their entirety as soon as possible after interviews were conducted, and they have been reread many times since.

In the second stage of analysis, initial codes were generated. In rereading the transcriptions, I manually applied codes to every sentence or short group of sentences using a colour and letter scheme of identification. Each 'data chunk' was given a code, and many were coded more than once. These codes identified semantic content. The coding process is said to differ depending on whether the desired analysis is to be 'theory-driven' or 'data-driven' (Braun & Clarke, 2006). Since I wished to carry out an initial 'data-driven' analysis, I read these texts, as far as possible, without reference to the research questions or any prior theoretical predictions. This inductive, bottom-up process potentially enabled unexpected codes to be identified with the consequent minimising of researcher bias. However, this process was inevitably influenced to a degree by my own knowledge of the literature. I then repeated the coding process with an explicit theory-driven focus, by approaching the data with my four specific research sub-questions in mind. Coding was completed separately for informants in NI and Uganda. However, if a code was identified in one setting, the informant's response to this same topic in the other setting was reviewed, and either coded the same or a new code generated. Many similarities in coding across the two data sets were identified, although several substantially different codes also emerged. This process led to the accumulation of approximately 260 pages of data chunks, coded according to both the informant and place within the original text. Theory-driven and data-driven codes were then reviewed and compared, followed by a final sweep of the data to ensure that all data was coded.

In the third stage, the disparate codes were collated into a series of potential themes. Two separate processes of collating themes were conducted. Firstly, my goal was to compile a data-driven structure in which codes were collated into themes according to the emphasis placed on them by informants. The question here was, 'What do bereavement counsellors see as important in relation to each of the four topic areas?' A second process focused on a theory-driven analysis asking 'What similarities and differences are identified within each topic area?' In this second process, the same disparate codes were used but, here, they were collated in line with the research

questions. Typically, a major theme was identified when more than a quarter of informants discussed it; within each major theme, variations in the topic were identified and collated into minor themes. If a topic was emphasised in one setting, then the informants' responses to this same topic in the other setting were reviewed. Broadly similar themes were identified across settings; in particular, major themes were similar, with greater variations noted within minor themes. In addition, to aid validity in each setting, '*inter-rater reliability*' (McLeod, 2003: 58) of findings was established, through agreement with other researchers who categorised the same data. In NI, an independent researcher read and analysed six transcripts and the coding structure and themes were agreed between us. In Uganda, transcripts of two Ugandan interviews were analysed by an indigenous researcher who was independent of the research process, (the only researcher who was known to be willing and available to analyse transcripts, agreed to read only two transcripts). Unfortunately, this process was of limited value as the independent researcher tended to summarise the transcriptions rather than coding them.

The fourth stage involved the process of reviewing the identified themes to achieve '*internal homogeneity and external heterogeneity*' (Braun & Clarke, 2006: 91). Braun and Clarke, identify two levels of analysis here. In accordance with their first level, themes were reviewed to ensure that the coded data within a theme formed a coherent pattern. In accordance with their second level, they were reviewed to ensure they reflected the meanings in the data as a whole. This required re-reading the entire data set, to consider if the themes accurately represented the findings. This precaution addressed the possibility that my personal curiosity relating to the relatively unfamiliar culture of Uganda could have obscured the relevance of more personally-familiar data generated by NI informants.

NI informants were invited to a talkshop with the intention of reviewing the findings to ensure their original intended meaning was accurately conveyed. They suggested minor changes and these were incorporated into the final data set. A second stage of data gathering was then carried out in both Uganda (in December, 2012), and NI (in January, 2013). As noted above, in NI interviews were conducted in person. However, for logistical reasons, in Uganda, internet voice-link interviews were conducted and were digitally recorded. This led to an additional six interviews which were also transcribed. The earlier stages of data analysis were re-applied to this newly-collected data. As no new codes were identified, the data from these six interviews were merged within the

existing themes. In the case of the Ugandan interviews, this second round was also used to confirm with informants that the analysis of the original Ugandan interviews matched their intended meaning (Appendix A).

The fifth stage of data analysis occurred at the end of both data gathering stages, and entailed the formation of a thematic map of findings. Here, themes were named and definitions developed. These themes were then positioned within the four main research foci, namely: the counselling context, the characteristics of clients, the characteristics of counsellors and counselling practice. A hierarchy of themes was developed; major themes were consistent across NI and Uganda although the subsidiary themes showed considerable variation. Details of these themes will be provided in Chapters 7-10.

Finally, an additional sweep of the NI transcripts was carried out specifically to look for references to sectarian issues and armed conflict when these did not appear in the first thematic analysis.

6.11 Ethical Considerations

In this study, I sought to be guided generally by the ethical principles that should underpin all research (McLeod, 1996), with cognisance of the principles specific to bereavement studies (Parkes, 1995) and the University of Leicester's Research Ethics Code of Practice (2006). Ethical approval was granted by the University of Leicester at the outset of this study (Appendix I). Whilst there were no organisational level processes for gaining ethical approval in Uganda, the same standards of ethical practice were applied here, as in NI.

Within NI, additional ethical approval was required to access informants in the statutory sector (Appendix J). Here, formal ethical approval was granted by a director in the relevant Health and Social Care Trust. As staff, not patients, were acting as informants, it was not necessary to submit an application to ORECNI (Office for the Research Ethics Committees for Health Services in Northern Ireland).

In order to ensure participants did not feel unduly pressured to get involved, a written description of the project was initially sent by email to potential NI informants before final agreement to an interview was given (Appendix K). In Uganda, for logistical reasons, it was not possible to send these letters; therefore written information was given during the first meeting. In both settings, this written material included

information on confidentiality, described the use of audiotape in the interview, and outlined how the material gathered from interview would be anonymised before being used for research purposes, including possible publication. A consent form was also attached (Appendix L). Differences in the structure of the consent forms reflected the more informal format used in Uganda, which was in keeping with the less bureaucratic approach of that setting, compared to NI.

The guidelines contained in the Data Protection Act (HMSO, 1998a) informed confidentiality throughout the research process. Both the informants' and their clients' human right to privacy were respected: informants' details were securely stored, care was taken to ensure that no informant could be identified, and no client names or identifying details were given in the interview nor within any subsequent report.

Whilst the interviews were not a therapeutic encounter, the subject matter was sensitive and so care was taken to conduct the interviews in a sensitive, balanced and suitably-structured manner (Kvale, 1996). This included: providing clear introductions, outlining and agreeing the boundaries of the interview, ensuring an appropriate tone and pace, remaining vigilant to possible informant distress or discomfort and using inclusive language throughout the interview.

6.12 Reflexivity

Replication, reliability and validity are perhaps more complex concepts to consider in qualitative studies, compared with quantitative research (Bryman, 2004). The issue of 'trustworthiness' has been considered a more appropriate criterion to evidence in studies which are predominantly qualitative (Lincoln & Guba, 1985). In this study, therefore, it was important to consider whether the identified differences and similarities between the two settings were trustworthy, that is, believable and cognisant, in comparison with other, established theoretical constructs and published research.

A key concern was to ensure similarity of concepts across settings. This was aided by my long-term experience of living in each country and consequent participant and non-participant observations. The analytic strategy included techniques to promote inter-rater reliability. I also sought to establish processes which would mediate against the introduction of culturally selective filters in analysis and reporting of findings (Broadfoot, 2000). The use of document analysis also helped to test and refine the

findings of the interviews. I maintained accessible records of the data collection to enable the process to be independently audited, if required (Guba & Lincoln, 1994). However, I cannot claim that findings are legitimate and true by appealing to the virtues of a rigorous methodology alone (Ortlipp, 2008). A key feature of qualitative data analysis is the ability of the researcher to critically reflect on his or her role within the research process. This will now be attempted.

Conventionally, the subjectivity of a positivist researcher has not been considered important (McLeod, 1996: 2003). However, it is now commonly acknowledged that complete research objectivity is an unobtainable ideal (Grafanaki, 1996). Within social research, representations are always partial and selective, with many possible interpretations of data in '*the fallacy of the single reading*' (Miller & Brewer, 2003: 261). Reflexivity is said to be particularly important in comparative and qualitative research (Ægisdóttir et al., 2009; Renganathan, 2009), but also remains important in other contexts where differences are less obvious (Ortlipp, 2008). Research 'insiders' and 'outsiders' will see different things in data, with different advantages and disadvantages associated with either position (May, 2001). For example, Colin Turnbull (1978) famously maligned the Ugandan 'Ik' tribe, by presenting them as cruel, loveless and unlovable. However, Turnbull acknowledged that his own Western values and experiences influenced what he saw and how he interpreted it. Similarly, Brewer argues that, in NI, everyone either covertly or overtly takes a position on the political and religious debate: '*NI sorely tests the value-free notions of our training*' (Brewer, 2001: 780).

As the researcher, I am exploring the habitus and figurations characteristic of bereavement and grief in two different settings. However, my personal history is rooted in one of these settings. It was therefore necessary to consider whether it was desirable or possible to achieve detachment from either setting and, if so, how this could be done.

Some personal characteristics of mine, which could have impacted the research process were shared at the beginning of this thesis. Assumptions are often made around which of the wide range of potential researcher characteristics could influence the research process (Reissman, 1987). Whilst ethnicity obviously played a pivotal role in the dynamics of the present research interviews, other social characteristics may also have influenced them. Research interviews, as collaborative processes, are said to be aided by

congruity of gender, class and cultural identity between researcher and researched, although total congruity is rarely achieved (Reissman, 1987). However, Simmel's essay on 'the stranger' (1907) suggests that being at a social distance from a group may also have advantages in removing inhibitions and potentially facilitating others to be more open (Rogers, 1999).

The ability for researchers to be self-aware, to engage informants appropriately, and to be reflective in that process, are indicators of the validity of research (Babbie, 2007; Etherington, 1996). In Uganda, my interviews were clearly impacted by differences in race and ethnicity, which are linked to the dynamic of power. Asymmetrical power relations clearly have ethical implications. As a white woman, I represented a culture which was dominant and had connotations of superiority and privilege. Furthermore, African culture promotes hierarchy in which people defer to their leaders, with rank, status and authority representing important defining characteristics (Kohls & Brussow, 1995). For example, Ugandan women greet their social superiors, including many men, by kneeling in front of them. Vella (1997) suggests that, in African cultures, there is a bias towards telling people in authority that they are right. The potential issues which this raises in a research context are obvious; there is clearly a likelihood that informants may offer answers felt to be most acceptable to the researcher.

Conversely, however, I possessed some social characteristics with which the Ugandan informants appeared to identify. As I was working in a faith-based NGO, many informants described an alliance relating to Christian faith. Similarly, many informants implied a connection around being a counsellor, a woman and a mother. However, where the informants were male, it is unclear whether my ethnicity would have overruled my socially inferior position as a woman.

In NI, I shared the same race and ethnicity as my informants. However, I would immediately be identified as a Protestant (this would be apparent from my name), introducing the potential for a sectarian dynamic in the research process. As I was practising at a managerial grade in a Health and Social Care Trust (although I was not in a management role with any of the informants), I was considered an insider to informants who worked in the same Trust and an outsider to others; this also raised issues of hierarchy since I was in a more senior position in the organisation than many of the informants. Unlike Uganda, attitudes to my personal belief system and family

details were not revealed in the research process, which took on more ‘formal’ boundaries, perhaps related to my well-engrained sense of professional distance. In a stance similar to that described by Ortlipp (2008), I revealed personal opinions and experiences if and when this seemed appropriate.

While acknowledging these power dynamics, I sought to create optimum conditions in the interviews for gathering data in an ethical and respectful manner. In so doing, my goal was to be trustworthy and safe. I was aware of the importance of the quality of relationship between researcher and informant (McLeod, 1996). Verhoeven (2000) identifies the need to convey mutual respect in ‘cross-cultural’ interviews. I sought to treat my informants respectfully, and explicitly considered the use of self as an important factor in the research process, maintaining a ‘*certain degree of personal presence in the interviews*’ (Ortlipp, 2008: 73). I used my knowledge and experience of each setting, thinking carefully about the use of words and phrases; for example, I avoided using terms which could have sectarian meaning in NI, and potentially elitist counselling jargon in Uganda. I was conscious of levels of disclosure; ensuring informants were free not to answer any question which might feel intrusive. Care was taken to redress the power dynamic through attention to dress, tone and pace of speech, and non-verbal communication. Additionally, in Uganda, I sought to minimise the symbols of wealth and status; for example, I parked my car at a distance from the interview.

I was also aware that my counsellor training could impact this interview process. Although potentially advantageous for achieving depth and quality in interviews, a researcher who is also a counsellor may be tempted to adopt an overly therapeutic manner (Etherington, 1996). It was difficult to differentiate myself as a researcher from myself as a counsellor, as the two are so essentially connected. Arguably, my aptitude for engaging people in meaningful conversation aided the interview process. However, I was aware of my tendency to analyse conversations and explore hidden meanings. I consciously sought to limit this process; for example, if an informant talked about their own loss, I did not seek to analyse this in a therapeutic manner.

Finally, I used my supervisory process to promote reflexivity. Whilst the sharing of ethnicity with my research supervisors arguably limited objectivity in one sense, I was

encouraged throughout tutorials to reflect on many aspects of the research, and to identify potential blind spots and bias in both settings.

6.13 Conclusion

This chapter has argued that the present study is best understood as a comparative analysis of the habitus of bereavement counsellors and clients in two networks of interdependencies of varying complexity. The chosen research methods were then explained and justified. A description was offered of the process of conducting 41 semi-structured interviews and of gathering secondary sources of data. Issues relating to research ethics and researcher reflexivity were also explored. The chosen research methods were intended to facilitate a research project that was trustworthy and meaningful, and conducted in a manner that empowered the subjects of the research.

Some of the issues identified in this chapter will be further explored in Chapters 7 – 10, which will each address one of the four key areas of research interest, namely, the context of counselling, the characteristics of informants, informant perceptions of their counselling clients, and counselling practices. In each chapter, the identified major themes, which are consistent across settings, will be explored alongside the identified minor themes, which tend to vary between settings. The themes highlighted in Chapter 7 are a product of the semi-structured interviews, desk research and participant observations, as well as academic texts. Those highlighted in Chapters 8, 9 and 10 are largely a product of the interviews, being generated both by data-driven and theory-driven readings of the transcribed data; however, these findings are supported by participant and non-participant observations. Typically, a major theme was identified as such when a quarter or more of informants discussed it, while subsidiary themes were noted by fewer informants. In the following four chapters, the actual numbers of informants who contributed to specific themes are quoted where this contributes to the discussion.

Chapter 7 Findings: Counselling Context

This chapter presents empirical research findings with respect to the context of bereavement counselling in NI and Uganda. The context of counselling has been identified as a complex, multi-faceted set of influences which is difficult to conceptualise within the individualistic framework of psychology (McLeod & Machin, 1998). However, as has been argued in this thesis, figurational theory offers a possible solution to this problem. This chapter will commence with an examination of the wider societal context of counselling in each setting, including their levels of structural differentiation. It will then turn to consider the local community context, including local social networks, and customs relating to death and mourning.

7.1 The Wider Societal Context of Counselling in Uganda and NI

Major and subsidiary themes relating to the wider societal context in NI and Uganda have been identified from semi-structured interviews, desk research and participant observations (Appendices C, D and E), as well as academic texts. These themes are presented in Table 5, in which Uganda and NI are compared with reference to the historical, institutional, policy and professional context of bereavement counselling.

In Uganda, prior to the introduction of professional counselling, traditional community-based support systems were established, and guidance and counselling were offered in schools around educational issues (Senyonyi et al., 2012). The development of professional counselling beyond the educational sector has been associated with advancing globalisation, leading to a shift in balance from rural to urban communities, the subsequent decline of traditional support mechanisms, and the enhanced influence of Western agencies and institutions (Grinstead & van der Straten, 2000; Senyonyi et al., 2012). The AIDS pandemic prompted the arrival of international aid agencies (UNAIDS Report, 2010). A number of these introduced the Western practice of counselling, such as *The AIDS Support Organisation* (TASO), founded in 1987, *Hospice Africa, Uganda* founded in 1994, and *The Mildmay Centre, Uganda* founded in 1998. Furthermore, the resultant large numbers of sick and dying people overwhelmed the availability of traditional community support for bereaved individuals. Counselling initially focused on pre- and post- HIV testing and, although it has subsequently

widened to address many other issues, *‘In many people’s minds in Uganda, only people who have HIV/AIDS need counselling’* (Ochieng, 2006: 3).

Table 5: The wider societal context of counselling

Major theme	Subsidiary themes	
	Uganda	Northern Ireland
Historical context	<p>Counselling has arisen from HIV management and traditional social practices.</p> <p>Response to globalisation and changes within the community.</p> <p>Counselling uncommon: not the first line of intervention.</p>	<p>Counselling has arisen from philanthropy and religion.</p> <p>Response to professionalisation of society.</p> <p>Counselling is a mainstream activity.</p>
Institutional context	<p>Indigenous services are undifferentiated.</p> <p>International NGO specialisms around HIV.</p> <p>Flat, non-hierarchical structures.</p>	<p>Highly differentiated into voluntary, statutory and independent sectors.</p> <p>Sub-groups and specialisms in each sector.</p> <p>Institutions characterised by hierarchical systems and bureaucracy.</p>
Policy context	<p>Currently no government policies for general counselling or training.</p>	<p>Range of policies shape strategic direction of counselling provision.</p> <p>Government influence on psychological services through NICE.</p>
Professional context	<p>Informants belong to one counselling body, UCA.</p> <p>Move to regulate counselling services.</p> <p>Limited supervision systems in place.</p>	<p>Informants belong to a range of professional bodies.</p> <p>Move to regulate counselling services.</p> <p>Supervision regulated and professionalised.</p>

As HIV counselling became established, several short counsellor training courses were offered, with some students on these courses identifying the need for more systematic

and in-depth training. A small group of key figures (many of whom were informants in this study) established a Master's Degree in Counselling Psychology in 1997, closely followed by the establishment of the UCA.

Since the development of the first Master's Degree in Counselling Psychology, at least 20 higher learning institutions now offer courses in counselling at different levels (Senyonyi et al., 2012). The growth in counselling has been rapid; the membership having doubled from 400 members in 2008 to 800 in 2012 (Senyonyi et al., 2012).

Turning to the UK, Aldridge (2012) charts the emergence of the professional practice of counselling in the UK from 1890 to 2009. In so doing, she describes a process in which counselling has arisen from philanthropy and religion in which '*a distinct activity with aspirations to professional status*' emerged from that which '*happens naturally as part of human relationships in families and friendship and work groups*' (Aldridge, 2012: 160). She attributes this to heightened levels of education, heightening 'self-surveillance' and the continued growth of professionalisation in society.

There have been some similarities in the struggle to develop counselling as a recognised professional activity in NI and Uganda. There have been difficulties in both settings in agreeing a definition of counselling, with protracted debate around its nature and scope (Aldridge, 2012; Ochieng, 2006; Senyonyi et al., 2012). In both settings, the establishment and influence of a professional counselling body – the BACP in the UK, and the UCA in Uganda – has played a significant role in promoting counselling as a professional activity.

The UCA, established as an NGO in 2002, aims to promote ethical and competent counselling through regulating practice, ensuring professional development of counsellors and providing a forum for networking (UCA, 2013). The UCA has recently sought to define the term, 'counsellor', as it had previously been used very loosely and could refer to anyone who had completed training lasting from three days to three years. It now differentiates between 'counsellors' (who have completed a formal diploma programme and have met a series of practice requirements) and 'para-counsellors' (who have more limited in-service training) (Senyonyi et al., 2012).

In the UK, the term, 'counsellor', was first used in government documents in 1963. By 1977, the British Association of Counselling (BAC) was established, and in 2000, this became known as the BACP (Aldridge, 2012). The BACP sets standards for therapeutic

practice, providing information for therapists and clients. It also seeks to increase public understanding of counselling, raise awareness of what can be expected in therapeutic processes, and promote the education and training of counsellors, including research training.

A lack of standardisation of counselling training courses and a move towards regulation are also apparent in both settings. In 2003, the UCA issued a 'code of ethics and practice' (revised in 2009), which clarifies responsibilities and duties of counsellors, and establishing standards for training and practice. Similarly, in the early 1980s, the BAC laid down its minimum training requirements and developed an ethical practice framework for counsellors (Aldridge, 2012). This was subsequently developed by the BACP which revised its ethical framework in 2013, with the aim of promoting a more inclusive, and contextually sensitive service (BACP, 2013).

In Uganda, in 2008, a Department of Guidance and Counselling was established within the Ministry of Education, with a mandate to promote counselling around HIV issues and psychosocial support (Government of Uganda [GOU], 2008). However, these initiatives did not extend to counselling outside the education sector. Consequently, the UCA are currently pursuing legal authority from the Ugandan government to regulate generic counselling practice and training (Senyonyi et al., 2012), with a *Draft Uganda Counselling Association Bill* (UCA, 2013), currently before parliament. This Bill promotes the establishment of a database of counsellors, formal referral process, and counsellor supervision or accountability systems.

In the UK, the BACP has sought to actively engage with government and has contributed to the debate around regulating psychological services (Aldridge, 2012). Whilst counselling is not yet a regulated service, the *Counsellors and Psychotherapists (Regulation) Bill 2013-14*, promoting the voluntary regulation of counsellors, is currently before parliament (Her Majesty's Government, 2013).

However, considerable differences between the two settings are also evident. These are apparent in the differing levels of structural complexity, regulation, and bureaucracy characteristic of counselling and bereavement services. In the UK, there is a highly differentiated counselling workforce, variously practising as counsellors, psychotherapists, psychoanalysts, counselling psychologists, clinical psychologists and social workers (Aldridge, 2012). Further differentiation is found in bereavement

services. In NI, these include services for people bereaved through the Troubles, people bereaved through suicide, people affected by cancer, bereaved children, and families affected by neonatal death. In Uganda, there is still a largely undifferentiated counselling workforce; whilst international NGOs focus on AIDS support, all other counselling is provided in generic settings. Counselling supervision is limited in Uganda.

In the UK, but not Uganda, there is an extensive policy framework designed to govern practice and determine the strategic direction of service provision. For example, in NI, nine statutory sector policy and guidance documents prescribe procedures for supporting families at the time of death and afterwards (Appendix D). Informants from NI described highly bureaucratic employing organisations with a strong ethos of accountability and governance, often through supervisory relationships:

'I mean the structure of [name of employing organisation] as an organisation I think is very hierarchical; I think it's very bureaucratic, I don't think it functions. What it tends to do is, it tends to take away from what we're really here for, which to me is to support people who are bereaved'. Colin, Voluntary agency, NI

'The funders continually keep changing, they keep introducing tighter criteria, like what I have to do you know, every date, every person, every counselling session, "Did they attend?" "Did they not attend?" "Why did they not attend?" All of this paper work. I appreciate there has to be some accountability but it's just gone too foolish, to extremes'. Grace, Voluntary agency, NI

Ugandan informants described generic counselling offered to both adults and children which included: 'crisis counselling' 'rape, child defilement or snatching children', 'pre-marital and marital work', 'counselling for adolescents', 'grief counselling' and 'career guidance'. This lack of specialism among counsellors, was attributed by informants to a lack of counsellors.

'We have not specialised particularly because we are very few counsellors around and we believe that a one-eyed person is better than one without an eye, so we cannot send away a client because they are not within our specialty'. Jane, Private practice, Uganda

This brief overview has identified both similarities and differences between settings in the establishment of counselling as a professional activity, and in its policy, organisational and institutional context. Seemingly, counselling organisations in Uganda are much less differentiated than those in NI, reflecting differences in these societies' overall levels of structural differentiation and complexity.

Finally, exploring the wider societal context of bereavement counselling in Uganda and NI requires a reflection on the specific socio-cultural history of death and mourning in each setting (Campbell, 2007; Maasdorp & Martin, 2009; McNally, 2007, 2011; Prior, 1989). In both NI and Uganda, this relates to a long history of violent political conflicts which will have a lasting impact on these communities (Cohen, 2001). In NI, whilst the armed conflict has stopped, sectarianism remains an issue, functioning at many levels; its insidious effects are often reflected in everyday thoughts and actions (Campbell, 2007). Since the ceasefire of 1994, a number of reports have explored the impact of the Troubles on local communities (Bloomfield, 1998; Bolton & Rankin, 2008; Smyth, 2012). These have identified high levels of trauma for victims and their families, acknowledging 'secondary effects' of violent death on bereaved individuals which may include a reduced standard of life for dependants. Recommendations have been made to enhance the voluntary and community sectors in dealing with the legacy of the Troubles, through the establishment of specific support organisations.

Within Uganda, the memory of political murder, under the military dictatorship of Idi Amin, remains strong. In addition, the magnitude and longevity of the activities of the LRA has led to it being described as one of Africa's longest running armed conflicts and neglected humanitarian emergencies (Kiboneka et al., 2009).

A number of studies in Uganda have identified mental health needs of victims of the LRA, highlighting high levels of depression and PTSD (Derluyn et al., 2004; Roberts et al., 2008; Vinck et al., 2007). Community support for bereaved individuals in northern Uganda is complicated by the fact that child soldiers may have been responsible for the deaths of members of their own communities and consequently face huge problems reintegrating back into these communities (Roberts et al., 2008).

Contrasts and similarities between the settings were also apparent with regards to informants' accounts of the local community context.

7.2 The Local Societal Context of Counselling in Uganda and NI

Table 6 compares the local community context of counselling in Uganda and NI, as described by informants.

Table 6: Informant perceptions: the local societal context of counselling

Major Theme	Subsidiary Themes	
	Uganda	Northern Ireland
The role played by the family and the community	Local communities have made provision for supporting members.	Grief is unique to the individual; families find it difficult to offer support.
	Mourning rituals are tightly prescribed, collective and therapeutic.	Mourning rituals are less tightly prescribed by collective scripts. A 'normal' response is understood within the context of an individual's own experience.
The decline of family and community support	Ugandan society is changing. Increased urbanisation and globalisation has impacted communities. Bereaved individuals experience decreasing support.	Limited community support is not a new phenomenon, however, support is decreasing. Bereaved individuals are silenced by a society which limits the time allowed to grieve.

Two main themes emerge from the semi-structured interviews. Firstly, the role played by the family and the community was presented by informants as an important contextual factor in how grief was managed. Secondly, informants highlighted the ways in which changes within family and community relationships impacted on the support offered to bereaved individuals and consequently on the need for professional interventions.

7.2.1 The Role Played by Local Communities

In Uganda, all informants commented on the collective nature of their life, and noted that bereavement counselling was understood first and foremost as a community service for community members. In NI, the relationship between the bereaved individual and

others was also emphasised. However, informants in NI described a more individualistic belief system, with grief being largely managed individually. In NI, the term, 'community', was understood by respondents to mean the provision of services by community organisations, and not by kinship relationships or geographical neighbourhoods.

Throughout the Ugandan interviews, there was a continual and repeated declaration by informants that individuals were essentially connected to their community, and that any understanding of counselling must be premised on an understanding of the collective nature of life.

The majority of Ugandan informants emphasised a sense of belonging, as highlighted in the following quotations:

'There is no way that you can be whole without other people around you'. Lynn, Private practice, Uganda

'You have to leave room because this is the community where she lives and she needs to be affirmed by that community. If she's not she will be an outcast and it's very difficult to be on your own in this culture'. Roberta, Corporate agency, Uganda

'In most of our societies which we still have, which I think most of the Western don't have, which they are losing, the kind of relationships that, the fabric, the family fabric, the society fabric, the communities together that is so, so vital I think'. Thelma, Private practice, Uganda

More specifically, informants emphasised the importance of the support of community members following bereavement.

'They are so important because if you are to support a client you can't look at him or her in isolation of those other systems, cause they are very influential in helping this client cope with the grief, with the death, they are so important, in case you have to involve them'. Priscilla, NGO, Uganda

'As soon as I hear someone I know has lost a relative, family, friends, neighbours and all connected people will come. They are saying sorry about what has happened, they are crying with you, they are grieving with you, and

somehow you feel comforted. ... All the neighbours are obliged, it's a social obligation that they have to come'. Jane, Private practice, Uganda

Participation in the response of the community following a loss was seen as an insurance policy against one's own loss when it came:

'It's actually an African culture and at the same time it depends on your relationship with your people. You know, here it is very important to bury so, if you are somebody who has not been burying others, they too will not come, they will not be there for you'. Martha, Private practice, Uganda

Underlying these accounts was a sense that death was integrated into the life of the community.

'I find it very interesting that, when you watch horror movies, you are afraid of dead people, but when you are there you are not, because you don't associate it with horror. "This is the person I have known"'. Sandra, NGO, Uganda

The integration of death is observed in the self-reported accounts of informants talking openly about death to their clients.

'We may counsel the family members, or even before the client has died we prepare these people for the death, you know: "this person, where he has reached, there is little hope for his recovery". So we prepare this person. "How are you going to handle the death, suppose this thing happens, how are you going to handle this?" We help them to accept the death sometimes even before it occurs or even after it occurs, to cope with the death'. Priscilla, NGO, Uganda

In Uganda, counselling was often described as a new concept, not widely known about, understood or seen as the first line of help. Essentially people only sought counselling when other help had failed. The UCA reports that it has been difficult to establish counselling as a professional activity because social support has been so much part of community life; *'Clients fail to understand why they have to pay for someone to talk to them'* (Ochieng, 2006: 3).

'Maybe I need to explain that in Uganda the culture of counselling has not gone down to the ground, and it is not until people feel that they are really feeling out of place. So they don't visit us as a first line of intervention. It is much later

when they have seen either negative symptoms or they have tried everything else, they have tried to cope naturally, and it is not coming on, that they may seek counselling, but not all of them'. Jane, Private practice, Uganda

'If the culture is not there to do what it is supposed to do, or even if it wants to and is not being recognised, the only alternative is to go for counselling'. Lynn, Private practice, Uganda

The consistent and central theme of Ugandan informants was that life is lived collectively; a sense of belonging to one's community was of utmost importance. In Eliasian terms, individuals were perceived as existing within interdependent networks in which reciprocal power dynamics influenced how they might act. Within their kinship group, people were largely self-sufficient following a death, with limited integration outside their own community. Informants identified a common moral code in which supporting a bereaved neighbour was a social requirement. This theme was continued in discussions around highly prescribed collective mourning customs. Whilst Ugandan informants identified somewhat different customs according to their particular ethnic group, each informant who commented described collective mourning practices, highlighting how these were both tightly scripted and therapeutic. The knowledge that someone has died is gained from both informal word of mouth and a formal notice of death, which is placed in a local newspaper or on television. The ensuing wake usually takes place in the home; if individuals have moved to the city, the wake occurs in their home village. It is considered important to view the dead body, which is placed in a central place within the home or the surrounding compound.

'So usually the time to view the body, I think it is very important for us to see the body, so they will put it in the sitting room, the corpse, and people will sit round and sing. Everyone who comes in has to see, so I think that helps to bring closure'. Sandra, NGO, Uganda

'When you lose someone, people gather around, there is talking and you are supposed to cry. 'You find a husband giving a talk on his wife, you find that he can talk about the days they met,... and you and I know, as counsellors, that that is the beginning of healing'. Martha, Private practice, Uganda

Following the burial, there is an elaborate series of rituals, often with the purpose of casting out evil spirits and choosing the heir who will inherit the deceased's estate. This is usually the first-born male, or in his absence, another male relative may be identified. Often, there are very few material goods to leave (Williams et al., 2009). Some groups also practice the leviratic marriage custom which requires a widow to consummate a relationship with her late husband's brother.

The stories told by the Ugandan informants are consistent with other accounts identifying the purpose of such rituals as having to make real the fact of death, identify the mourners and give them status, and reinstate tribal beliefs about the death. It is believed that, in this process, the dead are launched into the next stage of their journey (Lovell et al., 1993; Nwoye, 2000). However, Hockey (1990) suggests that these rituals may not meet the psychological needs of all bereaved individuals, a point that is acknowledged by some informants in this study (see Chapter 10).

Ugandan informants described their clients as being subject to a high level of control by others in their communities, with highly sanctioned rules around emotional expression. During the wake, expressed emotion is required. This is usually loud and public. Wailing is common and, indeed, some ethnic groups employ professional wailers, while others express emotion through dancing and an elaborate series of other rituals. Outside these rituals, emotional expression is largely prohibited. Sandra acknowledges how her elders would question her if she were grieving excessively over any individual:

“‘Why are you crying so much about that one, what was going on there?’ and what not’. Sandra, NGO, Uganda

Sandra is here describing disenfranchised grief (Doka, 1999), in which her expression of grief is not considered appropriate in accordance with the socially recognised relationship.

Lynn describes a punitive response in her social setting when bereaved individuals do not express emotion according to the custom:

‘But then my mother told me a story when I was a little girl in primary that when she herself was a little girl. When you lose a husband or you lose a very close relative who you know is very close, or a child or a sibling, and you don’t weep, they beat you. Then I ask, “but why should we do such a thing?” She told me

“because if they don’t beat you then you fall sick”. That is basic, you know. If you don’t give time to weep and mourn over the person, then you fall sick’.

Lynn, Private practice, Uganda

In this process, bereaved individuals who cried too much, and those who did not cry enough, were challenged for not conforming to social norms. The power of the elders in these figurational networks is apparent. These findings concur with anthropological accounts of death in Africa (Rosenblatt, 1997) and, more specifically, those relating to Uganda (Middleton, 1987[1966]; Muhwezi et al., 2007; Nwoye, 2000; Turnbull, 1972). They are consistent with the characteristics of structurally simple settings, both in terms of power dynamics and in the way in which death and mourning are managed (Elias, 1994a [1939], 2001[1982]).

Turning to NI, most informants here also highlighted the interaction between the bereaved individual and others as an important element of the grieving process. However, a major theme in NI was that grief is unique to the individual, and families therefore find it difficult to offer support.

‘My perception is that often families don’t know what to do to help, they don’t know how to help, it’s almost like a skill and they feel deskilled’. Ellen, Statutory agency, NI

‘Where you have even a close family who has experienced a bereavement, often you’ll find that the experience of each individual is so unique that it doesn’t really help, that they can’t help each other you know, so there are inevitably stresses and strains in the family’. Patsy, Hospice, NI

‘When they’re so devastated ... they have nothing to give to the other person, or even maybe to the family, sister and brothers that are left. Like, I suppose, when bereavement comes to a family everybody is dealing with it in their own way, and there’s something about, they can’t really get together in their grief so relationships can really kind of drift apart’. Orla, Independent agency, NI

Here family support is seen as problematic, further contributing to the need for professional intervention in such cases. This concurs with the literature in which the availability and quality of family support is deemed to be a critical factor influencing

help-seeking behaviour (Traylor et al., 2003; Wimpenny et al., 2007). Thus, individuals who are most in need of bereavement interventions are those lacking social support.

When asked about community support, informants in NI referred to community organisations. Community support was identified as that provided by institutions, structured and differentiated into churches, voluntary groups and other facilities.

'So for some people, yes there are supportive family members, there are supportive churches, there are supportive social workers, and there are supportive GPs, okay. So it's about identifying those support networks for those people and at the same time maybe helping them to understand that sometimes those relationships change. ... Sometimes you get people coming along who don't have any support network. There is nothing there for them'. Jan, Statutory agency, NI

In interpreting the term, 'communities', to mean organisations within the community, NI informants effectively adopted a relatively individualistic conception of bereaved clients. In Eliasian term, this suggests the presence of a dominant 'I-identity' which differs fundamentally from the dominant 'We-identity' evident among Ugandan informants. However, perhaps in contradiction to this, informants nevertheless often directed their clients towards communal support networks, through churches and community organisations which often provided bereavement support groups.

In discussing the process of mourning, the majority of informants in NI offered an individualistic response in which there was no right or wrong way to deal with death:

'I think it's just dealing in different ways and knowing that everybody is unique in how they deal with it. There's no right and no wrong way. I think I try to tell them that'. Orla, Independent agency, NI

'It's alright to grieve, it's not abnormal if they want to do something, to go to the graveside, or if they don't want to go to the graveside. That's very individual and that's all right'. Tanya, Independent agency, NI

Thus, NI informants identified a limited shared script governing the correct process of grieving. They subscribed to an 'I-identity', differing fundamentally from the 'We-identity' and strong network of interdependences recognised in Uganda. This concurs with Gorer (1965) who suggested that the style of mourning in Britain is a matter of

individual choice. In this context, individuals sought help from counsellors in negotiating their own unique responses to loss, in which *'the grief process has replaced traditional mourning as the main construct by which grief is structured'* (Walter, 1999: 125). Moreover, Seale (1998) suggests that these therapeutic interventions provide socially prescribed scripts for managing loss. It can be argued then, that, counselling has become a safe place for clients to process their inward struggle to accommodate the changed reality that death brings (Neimeyer, 2001).

A predominant concern of clients was that of knowing whether their grieving processes were 'normal'.

'That was the first thing, "Am I normal?" was a big issue'. Averill, Statutory agency, NI

'Probably, they are wondering if what they are suffering with is 'normal'...' "Am I OK?" ... 'Later on, assuring someone that it's OK. It's alright to grieve, it's not abnormal'. Tanya, Independent agency, NI

'They feel as though it's not normal or not natural, and part of our work then is really placing it all in context'. ... 'I suppose that is a hugely important part, and actually validating people's experience and understanding, so that they have some sense that what they are feeling is normal within the context of their experience'. Patsy, Hospice, NI

In another study, English bereavement counsellors identified a key aspect of their role as offering normalising assurances; reassuring clients that they were not going mad (Árnason & Hafsteinsson, 2003). Arguably, individualised grief brings a sense of uncertainty and vulnerability. Elias suggests that a declining conventional code of conduct *'inevitably brings with it a widespread feeling of uncertainty to many people who are caught up in the turmoil of change'* (Elias, 1987a: 25). However, variations exist within complex Western societies, and even in highly individualised societies, some collective practices are evident (Walter, 2012). Funeral and mourning rituals have been studied in Western contexts (Blanche & Parkes, 1997); for example, in Belfast (Prior, 1989) and in the East End of London (Howarth, 1996). It appears that whilst mourning rituals may exist at the time of death, the subsequent grieving process may be problematic as a shared script or other external validation of grief is limited. Moreover,

it is possible that traditional rituals, such as the funeral, no longer bring solace to highly individualised personalities.

7.2.2 The Decline of the Community

Another major theme, which emerged in relation to the local community context in both settings, related to a reduction of, and limitations in, these supports. In Uganda, nine informants identified changes within their local communities; these were seen to impact negatively on the support offered to bereaved individuals. NI informants suggested that death is sequestered from day-to-day life, and that bereaved individuals should not expect support beyond the initial period of mourning. Four informants in NI identified an increasing absence of support.

Informants in Uganda suggested that people no longer have time for each other; they were becoming more individual, isolated, withdrawn and secretive.

'Modern culture has failed its people, and is running away from its responsibilities'. Thelma, Private practice, Uganda

'Well, the community doesn't fulfil that role any more. I mean we are all in walls, houses that are; we don't have that extended family that we used to have. Of course I am not saying that it has all gone, it still does happen, but I think there is more individualism that has crept into the country, people are on their own so there are more problems because of that. There is no social support that there used to be'. Roberta, Corporate agency, Uganda

'It is the same thing, we used not to need counselling because there were always people around us, they were concerned, "But Lynn, why are you not here today?" There is somebody concerned and you were able to talk to them because living in the community, like you belong to the community. Everybody is concerned when you are happy, sad, when you are anxious. There is somebody looking out. But right now, if you live on your own in isolation. I live in my house with my children, the person next door I don't know, so it is just like, let's say the problem is coming from within, there is nobody who can help me apart from a counsellor. But if I am living in a community there will be concern'. Lynn, Private practice, Uganda

Many Ugandan informants described recent changes to mourning rituals, with an increasing tendency to concentrate the practices into a short period of time. Informants suggested reasons for these changing rituals:

'I am worried it will die out with time, because it has started dying out. Now people have to rush. Initially, when a person dies, those days all the village wouldn't go to dig, they wouldn't go to work, and they would all come to support the family who have lost a loved one by bringing food, by digging the grave, by putting up small huts for people could sleep by'. 'But now people have realised that it's important to run away from such indigenous type of doing this, it is all working'. Joyce, NGO, Uganda

There was a strong argument, noted by half of the Ugandan informants, that the country was in transition. Different reasons were advanced for this change, including 'globalisation', 'the influence of the West', 'as a result of HIV' where the volume of deaths meant people no longer had the time to mourn appropriately, and 'the impact of the Kony war', where mourning rituals have been abandoned.

'It's becoming less, I think it's with modernisation and globalisation. People becoming more Western than African'. Rose, NGO, Uganda

Another suggestion offered was that the decline in community support was linked to a shift in balance between the urban and rural populations caused by people moving away from rural settings. Some Ugandan respondents identified differences between social settings within their country. Five Ugandan informants discussed the rural-urban divide. A similar dynamic has been noted in Western societies where the decline in rural communities has led to a decline in familiar rituals around death (Howarth, 2011). From a figurational perspective, it can be argued that the consequences of the emergent processes of societal differentiation are reflected in these changing customs.

'Well, the role of counsellors can still be useful, particularly now that urban centres are becoming more and individualism is setting in. Where the person next to you may not necessarily be a relative who will sympathise, and that is when the urgency for counsellors comes. But where you have a homogenous group socially linked, then they will definitely give the social support, which will need less counselling'. Joyce, NGO, Uganda

Valerie outlines the changes that occur when people become more independent and move away from these close-knit rural communities. Wealthier Ugandans appear to adjust their behaviours and, in this example, are less willing to express their emotions:

'It's usually the wealthier people, the people in the city are becoming less in touch with their cultures and more polished and less as willing to express emotions, and they are the ones who are more likely to hire the mourners'.

Valerie, Expatriate counsellor, Uganda

The decline in community support highlighted by these informants resulted in bereaved individuals needing input from a wider range of services. Professional mourners provided emotional expression at funerals. Professional counsellors were seen as meeting a need once provided entirely within a kinship group.

Turning to NI, some informants suggested that an inherent feature of NI was that death is sequestered from day-to-day life, and is largely ignored.

'I think we have a really mad chaotic approach to death in our society. We don't respect it, we don't value it, we just try to ignore it and then that's how we deal with lots of difficult issues'. Ellen, Statutory agency, NI

Other informants suggested that there was decreasing support for bereaved individuals.

'I think there is a great need out there to address the suffering of people. I think our whole society has turned away from that, with the breakdown of families and communities and all of those things'. Grace, Voluntary agency, NI

NI informants perceived a strong societal message to bereaved individuals that they should not expect support beyond the initial period of mourning. This may be understood according to an absence of ritual and to the rise of individualised grieving processes. People avoid talking about grief because they have no shared framework in which to do so (Gorer, 1965). The first quotation comes from an informant who was herself bereaved through suicide.

'I now say to the bereaved, "Don't expect anything off anybody, you know, because you'll be disappointed. So look after yourself and get the help for yourself"'. Maureen, Voluntary agency, NI

'Often clients will say to be able to talk about it is important and I think that is a big issue. Again, back to the madness of our society we don't let people talk, we get bored with them talking, or in our minds we have a period of time in which that's appropriate and then we move on because we want to and the grieving person is left in a place where they're silenced by the whole process'. Ellen, Statutory agency, NI

'Or there's some kind of sense that people are not normal if they're behaving in an upset kind of way or whatever, so that suppresses them'. Ellen, Statutory agency, NI

Informants identified a pressure on clients to process their grief quickly.

"'You should be over it by now" or "Catch yourself on" or "Have a cup of tea and everything will be okay"'. Colin, Voluntary agency, NI

'At the time there can be a lot of family and very often people say, the bereaved person who is coming for counselling, will say, " everyone was round at the time but there's nobody now". Tanya, Voluntary agency, NI

'A lot of people say, "Who really wants to listen to you?". It's OK for a wee while, people support you, but after that the expectation is that you get on with life'. Orla, Independent agency, NI

Informants in both NI and Uganda perceived bereaved individuals to be offered decreasing (Uganda) or limited (NI) support. Bereaved individuals in both settings had only a short time in which to express their grief, albeit for very different reasons. In Uganda, informants identified a clearly defined, highly prescribed short period of mourning, with strict rules around behaviours which follow this period. In NI, the absence of such rules and norms was apparent; whilst social support may be given initially, people soon stop talking about the death because they lack a shared script for processing death. These findings would suggest that grief in NI is sequestered and individualised, perhaps more in keeping with a process of denial than revival (Walter, 1994).

7.3 Reflective summary: Counselling context.

Practicing as a counsellor in both NI and Uganda has enabled me to observe first-hand national differences in bereavement counselling practice. I observed that the role played by the family and the local community influenced how grief was managed in both settings. In NI, my counselling clients identified a lack of community support, often coming for counselling because they felt isolated in their grief:

'Clients dealt with their loss individually. They often describe a tension where family and friends stop talking about their loved one, expressions of sympathy end soon after the funeral and return to work. Counselling appears to provide a forum for support, which is clearly absent in other contexts' LM: Personal response to interview questions

In NI, whilst I was also aware of the potential influence of issues relating the divided community, these were most often unstated.

In Uganda, I was much more aware of the role of the wider communities in supporting bereaved individuals. In many ways it seemed contrary to Ugandan societal norms for bereaved individuals to seek professional counselling. In my participant observations and counselling practice, I became aware that bereaved individuals tended to seek professional help when community structures were unavailable, or where community elders supported counselling. For example, the psychological debrief I co-facilitated was supported by community elders and school leaders, and became part of the validated community response. It was consequently attended by a wide range of people as seen in my journal record:

Groups who attended the debrief: Parents and relatives of children who died; Children who were survivors of the fire and were in the dormitory that went on fire, along with their parents and relatives; Parents and relatives of children who attended the school; School staff; Any other person who considered themselves to be impacted by the fatal fire. LM: Psychological debrief: Journal entry: Appendix F

The Ugandan clients, who came to me for counselling, were mostly employed by the NGO in which I worked. Each of them had moved away from their communities and, as

a consequence, did not receive the same level of ongoing support following bereavement.

In Uganda, whilst I was conscious of incidents of violence within my local community, I felt distanced from the terrorist activities of the LRA. Knowledge of these activities did not feature widely in day-to-day life outside of the geographical areas in which it occurred. This may be explained by the limited opportunities for media coverage available in Uganda.

7.4 Conclusion

This chapter has explored the context of bereavement counselling from the perspective of bereavement counsellors in NI and Uganda, with interview data supported by desk research and participant observations. Similarities and differences were identified in the establishment of counselling as a professional activity, and in the organisational and institutional context of counselling. Organisational structures in Uganda are less differentiated than those in NI, reflecting differences in overall levels of societal differentiation. At the local level, differences were identified in the relationships of bereaved individuals within their communities. In Uganda, the emphasis was on the collective nature of life, with an individual's connectedness with family, clan and community being highlighted. There was a strong sense that community engagement and mourning rituals were sufficient to support the bereaved. Consequently, it was in many ways against the grain of established collective practices for a bereaved person to seek professional counselling; informants perceived that counselling was necessary only because the community had failed in its duty to support (Seeley & Kajura, 1995; Senyonyi et al., 2012). This community failure has been associated with the onset of the AIDS pandemic, and factors relating to globalisation and urbanisation (UNAIDS, 2010).

In NI, informants described an individualised response to death, highlighting limited externally-validated mourning processes. Although some references were made to supportive churches and community groups, to a large extent death was sequestered and the bereaved individual silenced by a society in which family and community appeared to have few channels for offering support.

Both Ugandan and NI informants made limited references to political conflicts. The informants' focus was largely on their location within organisations, communities or families; they did not generally refer to their socio-cultural or historical locations. This may suggest that counsellors are insulated in their profession from these events, or that these events have become so normalised that they are not recognised. Alternatively, in the case of NI, counselling with respect to Troubles-related issues may have become a differentiated professional specialism in its own right. This appears to represent a paradox in the findings, and will be discussed further in Chapter 11.

The differences in counselling context in NI and Uganda identified in this study concur with some of the key constructs identified in Chapter 3, Table 1, which differentiate death and bereavement in structurally complex and simple settings. The interview transcripts revealed clear differences in the manner in which death and mourning are managed in each setting. Death is more open, visible and integrated in Uganda, and more closed, sequestered and individually processed in NI.

In seeking to understand and explain national differences in counselling, it appears that whilst Freudian theory offers little help explaining such differences, post-Freudian writers have acknowledged substantive differences in mourning of the kind revealed in the research interviews. The relevance of Doka's (1999) theory of disenfranchised grief was most evident in the highly sanctioned rules around emotional expression observed in Uganda, in which expressions of grief which deviated from these norms were unacceptable to community elders. Similarly, Niemeyer's (2001) concept of meaning reconstruction helps to explain why bereaved individuals in NI sought help from counsellors in negotiating their own unique responses to a loss. However, while post-Freudian theories are useful in explaining certain counselling practices, they do not offer a framework for encompassing the relationship between structural features of societies and bereavement practices. Elias's figurational theory however does help to explain how macro-level structural factors might be associated with bereavement practices. The emotional and intellectual dispositions of bereavement counsellors and their clients can be located within relational networks of interdependence.

The findings described in this chapter confirm that NI and Ugandan counselling services differ considerably in their levels of structural differentiation and the density and complexity of their interdependency networks. Moreover, patterns of emotional and

psychological reaction to grief appear to be congruent with those described by Elias in the 'civilising process'. It was anticipated that bereavement practices would reflect the relative degree of structural differentiation in either setting, and this expectation appears to be confirmed. In Uganda, death is integrated into everyday life; there are socially agreed rules of conduct for grieving and there is a much less individualised sense of self together with a shared mythology for making sense of loss. In NI, traditional rituals and the external validation of the grieving processes are limited.

Chapter 8 Findings: The Characteristics of Counsellors

This chapter will examine the characteristics of bereavement counsellors in Uganda and NI, as represented by the study's informants. It will begin by presenting the demographic profile of interviewees, before exploring broader issues concerning motivation, goals, the personal impact of the counselling role and their models of professional intervention. Reflective comments on my own role as a counsellor in both NI and Uganda will also be offered.

8.1 Demographic Characteristics

A summary of the demographic characteristics of informants has already been presented in Table 4, Chapter 6, with a brief biography of each informant provided in Appendix H. In Uganda, all but two were female. Their mean age was 45 years, although one refused to give her age. Fifteen were indigenous Ugandans from a range of ethnic groups, including Buganda, Lugbara, Paddola and Mumasa. Three were Western expatriates, who had made their long-term home in Uganda. Informants often identified their ethnic group:

'I am from Tororo, my tribe is called Adola we are Paddola'. Lynn, Private practice, Uganda

In NI, the majority of informants (19) were female, and one was male. Their mean age was 50 years. Informants described their ethnicity as 'white'. All were indigenous to NI and described themselves as 'Irish' (6), 'British' (5) or 'Northern Irish' (9). These categories tend to equate with membership of either Protestant (British) or Catholic (Irish) communities; individuals who wish to avoid being identified with either group often adopt the term 'Northern Irish'. The NI sample is representative of both Catholic and Protestant communities, and is similar, in this respect, to other qualitative studies of helping professionals working in NI (Campbell & McCrystal, 2005). Issues relating to religious identity were not discussed by the majority of NI informants. Whilst there is a dearth of research into religious identity and counselling in NI, other relevant research has focused on the practice of helping-professionals in the NI context (Campbell & McCrystal, 2005; Pinkerton & Campbell, 2002; Ramon et al., 2006).

Table 7: Informant characteristics

Major Theme	Subsidiary Themes	
	Uganda	Northern Ireland
Motivation in becoming a counsellor	<p>Former nurses, social workers, librarian, teachers; wanted to engage more therapeutically.</p> <p>Personal characteristics: naturally drawn to people.</p> <p>Family and friends who are counsellors.</p>	<p>Former nurses, social workers, teachers; wanted to engage more therapeutically.</p> <p>Personal characteristics: naturally drawn to people.</p> <p>Own personal bereavement.</p>
Goals for counselling	<p>Collectively and individually defined.</p> <p>To engage, educate and support the community and integrate the bereaved individual back into the community.</p> <p>Holistic goals; meeting range of client needs including issues related to poverty.</p>	<p>Individually defined.</p> <p>To empower individuals to move on and to enhance their quality of life.</p> <p>Psychological goals; to help clients deal with the emotional aspects of their loss.</p>
Personal impact	<p>Emotional burden.</p> <p>Difficult working with a family whose circumstances bore similarities to their own.</p> <p>Tended to cope by ‘not feeling’.</p>	<p>Emotional burden.</p> <p>Difficult working with a family whose circumstances bore similarities to their own.</p> <p>Developed coping strategies with clear boundaries.</p>
Model of intervention	<p>Initially did not refer to any specific model. Later referred to Rogers, Egan, CBT and working eclectically.</p> <p>Bereavement counselling models; Worden and an in-service model; TASO.</p> <p>Directive approach common.</p>	<p>Familiar with a range of generic counselling models. Rogers, Egan, CBT and working eclectically.</p> <p>Bereavement counselling models; Worden and an in-service model; Cruse.</p> <p>Person-centred approach common.</p>

For example, Campbell and McCrystal (2005) examined mental health social workers' perceptions of the impact of the Troubles on their practice. They found that practitioners struggled to integrate political, professional and personal roles, and dealt with this dilemma by trying to adopt a neutral approach to their clients. This suggests that the lack of discussion of sectarian or religious issues by the present informants might reflect their perceived needs to present a predominant ethos of neutrality within the counselling relationship.

However, two NI informants, both of whom worked in organisations which offered Troubles-related counselling, did identify a sectarian dynamic in their work. Helen, based in one such organisation describes how clients try to establish if she is Catholic or Protestant:

'I have been tested to a certain degree. When I first go out they try to work out what I am' ... 'I do my best to avoid those, but sometimes you can't'. Helen
Voluntary agency, NI

Several informants in both NI and Uganda had initially qualified in another profession, such as nursing, teaching or social work, before completing counsellor training. Counsellor qualifications in both settings ranged from Further and Higher Education Certificates to Master's Degrees. Two American counsellors in Uganda had Doctorate-level qualifications in counselling. The broader counsellor characteristics listed above will now be considered, with reference to Table 7 which summarises the key similarities and differences between the two settings.

8.2 Motivations for Becoming a Counsellor

Similarities were identified across settings in terms of informants' motivations to practice as bereavement counsellors. For example, informants described a desire to move on from a job which did not facilitate any therapeutic engagement, and identified awareness of personal characteristics which helped them relate well to people. Some Ugandan informants were also motivated through having family members and friends who were already counsellors. Although six Ugandan informants discussed personal bereavements, they did not link personal loss to their motivation in becoming a counsellor. However, eight informants in NI described personal bereavements which had motivated them to do so, three of these relating to suicide.

'Well, I suppose the loss of my own son to suicide seven years ago. After about a year it made me reassess what was important or what I wanted to do with the rest of my life, or I sort of felt that if there was something I could do to help anybody in the situation'. Colin, Voluntary agency, NI

'Because I've had a lot of loss in my own life and one of those losses was a suicide, my brother's suicide' ... 'When the right people helped, I benefitted'. Sharon, Voluntary agency, NI

A significant personal loss has been identified by other authors as a core motivator in decisions to become a bereavement counsellor (Dunphy & Schniering, 2009; Garfield & Jenkins, 1981). However, while both groups of informants had experienced loss, the central importance of personal loss was acknowledged in this study only among NI informants. This may be explained by a greater propensity for self-reflection and psychologising among informants from NI, or it might highlight a normalising response to the prevalence of loss in Uganda.

8.3 Counsellor Goals

There were considerable differences between settings in informants' goals and rationale for counselling. These can be understood in terms of differences in the habitus of bereavement counsellors generated by participation in networks of interdependency of differing complexity. NI informants were concerned to meet the individual psychological needs of their clients. In contrast, Ugandan informants described holistic goals in supporting clients with both psychological and material needs. Ugandan informants also typically described themselves as holding a dual responsibility to support both the individual and the community. Their responsibility to individual clients was seen in terms of the need to integrate clients back into their local community, on the grounds that the community is enhanced when individuals can return to their roles and relationships.

'When you counsel a child, or when a child does something wrong, it is the community's responsibility, when you prosper it is the community's joy, so by

helping this individual, you will be helping the community'. Martha, Private practice, Uganda

'What we intend [is] ... for this client to be in a position to support other family members go through this bereavement. Because for me I have direct access to this particular client, but maybe I may not have access with maybe the grandmother, the real mother to the client and the rest, so I want to go through her for her to be able to support the others'. Jane, Private practice, Uganda

Within NI, informants identified their responsibility as being for the individual client in isolation from their communities. This was consistently described as seeking to 'improve the quality of life' of bereaved individuals. It was most often understood in terms of 'empowering' their clients to 'move on' and develop 'a new life', as their old life had irrevocably changed:

'My goal is to empower the clients to move on, and my goal is to empower all my clients, whether it is grief or whatever to reach their full potential'. Wilma, Independent agency, NI

'To empower, to help them journey, to move on and see a life beyond the grief, to have hope, to help them to see that life will never be the same. To equip them with the tools to move on, to get them back to purposeful life'. Jan, Statutory agency, NI

'Self-empowerment and the ability to move on and to laugh and to just get on with their lives again. It will never be the same but to acknowledge that it will be a new normal, you know'. Maureen, Voluntary agency, NI

'To survive in the new normal'. Cheryl, Voluntary agency, NI

'To have real hope ... to make new meaning in their life'. Patsy, Hospice, NI

Whilst, only one counsellor referred to Klass's continuing bonds theory, references to 'move on' may reflect NI informants' views of the ongoing relationship between the bereaved individual and their deceased loved one. Integration of the dead person into the life of the bereaved has been identified as a key dimension of grief, with the desire to maintain 'continuing bonds' identified within diverse societies (Klass & Walter,

2001). It is not possible from the NI informants' accounts to determine the attitude of their clients towards maintaining these bonds. However, it does appear that, in NI, the counsellors' focus is more on 'letting go' and 'moving on'. This is somewhat surprising as, in contemporary Western society, the dead are said to remain in relationship with the living, though their actions and messages seem restricted to the private sphere (Klass & Goss, 1996). However, Walter (1999) suggests that one of the major components of what he terms the 'clinical lore' – that is, the psychological theory of grief-work – is the 'resolution' of loss. Walter (1999) suggests that clinical lore posits a grief process moving from attachment to autonomy, and encourages bereaved individuals to make temporary relationships with other bereaved people, as opposed to maintaining an ongoing relationship with their dead loved ones. The findings from this study seem to concur with this view. In Uganda, however, informants understood their clients as continuing their relationships with the ancestral dead. Klass and Goss (1999) identify the ubiquitous belief, within 'traditional' societies', of ongoing bonds with the ancestral dead, and the important role these have in maintaining religious belief. They suggest that ancestral bonds are symmetrical, characterised by mutual obligations between the living and the dead and by equal power to help or hurt. This has been identified within anthropological studies in Uganda (Middleton, 1987 [1966]), and was a clear theme among Ugandan informants who viewed bereaved clients as having to negotiate relationships with both the living and the dead.

'You know, people will come in, I hope you don't mind if I use your name: "Oh Lorna, remember my father when you meet him in heaven and remember grandfather also". And it touches the old grief but it helps because you are crying to get over the shock and denial quickly, that stage we go through faster because of that'. Sandra, NGO, Uganda

Seale (1998) suggests that the purpose of bereavement counselling is to enable the bereaved individual to restore ontological security and to promote social inclusion. In Uganda, the goals of the informants were largely collective, in seeking to reintegrate the bereaved individual into the collective order of society. Here, the sense of self was seen to be continuous, defined by authority structures, social norms and stabilising routines. Informants in Uganda made few references to empowering their individual clients to negotiate their loss; rather, they implied that it is through the process of social inclusion

that meaning is restored. In contrast, informants in NI described their goals as enhancing their clients' quality of life by encouraging them to process their grief reflectively and determine their own way of working through it. Here, ontological security was sought through individual negotiation. Social inclusion did not feature highly among stated counsellor goals, although clients were often directed towards segregated but communal support networks.

8.4 Personal Impact

Another major theme, and one identified by the majority of informants in both settings, focused on the emotional cost of working within the context of death and bereavement.

'You are torn in two pieces. In fact, actually at times you leave this place and go with problems on your head'. Joyce, NGO, Uganda

'It really took a big toll on my life'. Priscilla, NGO, Uganda

'It's heavy work, it can be heavy work ... [pause], it's emotionally quite draining'. Ellen, Statutory agency, NI

Informants in both settings also acknowledged the added difficulty of working with a family whose circumstances bore similarities to their own.

'When I had just started with [name of HIV hospital], I would each day, each children's clinic day would be difficult for me because I would see a child suffering and then I would relate, as a mother, I would think if it was your own child suffering'. Rose, Hospice, Uganda

'Sometimes, you are very affected by people's pain, no doubt about it you know. I remember last year talking to someone whose daughter' ... 'had been diagnosed with cancer who had young children and she was the same age as my daughter and it was critically difficult'. Patsy, Hospice, NI

A particular dynamic was identified in NI, where two informants were working directly with clients bereaved through the NI conflict. Here, Helen describes her sense of fear and distress at the risk of being caught up in ongoing sectarian violence during a home-visit to a client.

'I've come out of visits and cried all the way back to the office, so it is hard, some of the stuff. I've a young guy who got shot and he lost his leg, so meeting with him for the first time was horrific' ... 'we were sitting in the very house it happened, the very place it happened and it's almost like it's happening to you. The fear of going into some of the houses. Actually, I've made a point now of not sitting near a window for fear of someone shooting in the window when you're sitting there, so that's always at the back of your mind' Helen, Voluntary agency, NI

Campbell and McCrystal (2005) have explored the personal reactions of social workers during the Troubles, noting high levels of stress and anxiety in an atmosphere of fear and mistrust. Helen's personal account resonates with these findings. Moreover, like the social workers in their study, it appears that Helen is committed to supporting her clients regardless of their background and political preferences. Grace, another counsellor based in this Troubles-related agency, also offers support to clients regardless of their political backgrounds. Grace appears to manage political tensions by imposing strict boundaries on what clients disclose to her:

'The one criteria we have and I personally hold to, they must no longer be involved. They must no longer be perpetrators' ... 'I have a golden rule; I don't want to know any dates or places.' Grace, Voluntary agency, NI

Grace also appears to align herself with one political group, identifying negative features of the 'other':

'If it's terrorism, and I do some work with people on the other side of the divide as well, they on the whole don't always show remorse for the people that have died as a result of their action, but they have huge things about their comrades again'. Grace, Voluntary agency, NI

Ramon et al. (2006) note that when support is offered across politically divided communities, it is easier for most people to treat the victims of one's own social group with respect and care than adopt a similar stance towards members of the opposing social groups. Professional roles are challenged when the 'other' is perceived to be the 'enemy' (Cohen, 2001).

It seems that for those counsellors working specifically with clients bereaved through the NI Troubles, the personal impact of the work includes the development of a sense of fear and anxiety, leading to the need to develop coping strategies of various kinds. However, only these two respondents of the 20 interviewed in NI, raised issues surrounding political conflict and deaths due to terrorist violence.

In Uganda, one counsellor worked specifically with victims of the LRA, offering counselling within the IDP reception centres for abducted children and adults. Her discussion of the personal impact of this work appears more focused on client experiences than her reactions.

'It's a joy, a mixture of joy and a mixture of other emotions. Because other children, yes, they come back, and they were not injured but there are those who came back and you see the future is completely bleak, they have injuries, you know extensive injuries, spinal cord, some are blinded, others, you know, they have been maimed, so of course you also become happy where you see the situation was hopeless and now you see there is a ray of hope'. Sylvia, NGO, Uganda

The process through which informants dealt with the emotional impact of their work differed noticeably across the two settings. Ugandan informants were most likely to minimise their personal reactions to their work, and seek to repress their emotional responses. Informants frequently described a process where they no longer felt emotional: *'I need to get over it', 'I will go home and not feel', 'I learned to adjust', 'I am no longer emotional', 'I have now coped up, I don't feel emotional about it'.* Ugandan informants provided limited evidence of self-reflection or psychologising, responding in ways that appeared largely to repress their emotions. In so doing, they indicate a high level of emotional-involvement, perhaps suggesting an association between involvement and repression.

This was highlighted in my interview with Jane. The pattern of this conversation was repeated in several other Ugandan interviews:

Jane: *'It's quite exhausting, it's quite draining and exhausting and sometimes it leaves you with a lot of emotional burden'.*

Lorna: *'Could you explain that, about the emotional burden Jane?'*

Jane: *'How it impacts me, well naturally as a counsellor I try not to make it my burden because I must meet the next client, and the next and the next'*. Jane, Private practice, Uganda

Ugandan informants who worked with HIV-positive clients emphasised the emotional impact of this work. Here, Martha describes the process she took to prevent herself feeling afraid and upset:

'I personally, when I was training, I had to work in an HIV place and I feared. I could not imagine talking to someone whom I know is not going to be healed'. ... 'These days, with training and experience, I can comfortably catch myself, I can spend the whole day talking with clients and I will go home and not feel'. Martha, Private practice, Uganda

These findings are consistent with other Ugandan studies which highlight the particular difficulties in working with HIV-positive clients. Counsellors' capacity for empathy was seen to originate in the experiences of pain, stigma and multiple losses they shared with their clients (Kaleeba et al., 1997; O'Keefe & Frankham, 2002). This was particularly true when the counsellor was also HIV-positive. (In the present study, informants' HIV status was unknown.)

Counsellors in NI acknowledged similar emotional pressures. However they managed their emotions differently, evidencing a high level of self-reflection and emotional detachment. They described the development of alternative strategies to manage their emotional responses, these included peer support, heightened self-awareness and the maintenance of clear boundaries.

'I think I've got better at letting that go and knowing where that exists and lies, I know whose responsibility this is, and I know it's not mine, so I think that's been one of the valuable aspects of learning this role'. Debra, Statutory Agency, NI

NI informants described techniques in developing their self-awareness.

'When I work with clients, I'm always very aware of my own self-awareness, my own skills, my own knowledge, so I would never allow myself to get complacent'. ... 'I would write a journal entry on, "How have I been with this person?"' Kate, Voluntary Agency, NI

Another NI informant discussed her boundaries, offering the analogy of watching a play. The following quotation highlights a considerable level of self-awareness and reflexivity consistent with strong emotionally-detached responses and psychologising processes:

Patsy: *'I describe it a little bit like being at a play. And you're watching the play, and you're watching it so hard, and you're right at the front, and it's almost as if you are in it, and you're listening and watching everything, and picking up on all the nuances, but actually the critical difference is that you're not on the stage you're, albeit that you're [pause] ...'*

Lorna: *'You're in a different category'*

Patsy: *'You're outside it. But I think, for me, it's really always reminding myself that. And understanding that, once you put a foot on that stage you're no longer able to have the objectivity to help people, plus you will not be able to sustain yourself through the distress ...'*

Lorna: *'Putting a foot on the stage, what would that mean?'*

Patsy: *'Putting a foot on the stage would be becoming embroiled in the family, in the dynamics or, actually, feeling their pain to the extent that you lose any sense of separateness from it'*. Patsy, Hospice, NI

The emotional impact on counsellors engaged in this form of work is widely acknowledged (Worden, 1991). Bereavement counsellors require a simultaneous awareness of their clients' needs, along with an ability to be self-aware during counselling sessions (Puterbaugh, 2008).

It appears that, in keeping with our expectations of differences in habitus between the two national settings, NI informants were more likely to process the personal impact of this work in psychological terms, seeking to remain objective, formulating a detached, rational response, engaging in self-regulation and developing a strategy to cope with their reactions. In contrast, in Uganda, the personal impact of the work tended to be managed at an emotionally-involved level. Ugandan coping strategies appeared to lack the rationalising and psychologising approaches evident in NI, and might be taken to exemplify the Freudian concept of repression as denial (Freud, 1915).

8.5 Models of Intervention

Informants referred to similar counselling and bereavement models; for example, they referred to Egan's helping skills (Egan, 1998), Roger's person-centred theory, CBT, and Worden's Tasks of Mourning (key features of these models were outlined in Chapter 4); these models were taught in counselling training courses in both settings. Informants in NI also identified a more disparate range of models, including the DPM, Bowlby's attachment theory, Parkes's phases of grief and Klass's continuing bonds theory; however, these were each only identified by one informant. No informants in either setting made specific reference to Freudian theory.

Ten Ugandan informants had initially stated that they did not follow a model, or couldn't remember its name. However, as discussion proceeded, Worden's Tasks of Mourning was the most commonly cited model, referred to by five counsellors. In describing their practice, Ugandan informants revealed an eclectic approach, referring to the use of both person-centred and cognitive models in their practice. On balance, it appeared that Ugandan clients are familiar with a more directive style of counselling; consequently a cognitive approach was more often used.

'And actually, at times, we see somebody trying to force you to make a decision for her, which we are not supposed to do. And want to be told, go and do it this way or that way. And when they come, they expect the results to be seen immediately, which is not the case. They don't know they have to work on it'.

Maud, Private practice, Uganda

Informants in NI indicated a much more comprehensive engagement with counselling models, also identifying the use of Egan, Rogers, CBT and Worden's models:

'I'm Rogerian. I would work with person-centred very much, but I use Gestalt when required, CBT when it's appropriate. I have a knowledge and training in all of those but person-centred is my preferred approach'. Grace, Voluntary agency, NI

'When I did my nursing degree, Kubler-Ross was the be all and end all. I worked in [name of HIV hospital], as a district nurse in south London and Colin Murray Parkes worked there. So I have attended some of his stuff and read lots of his stuff and I suppose in the counselling and psychological training that I've

had, Bowlby has become more prominent in my thinking around bereavement, but I'm sure there are lots of others'. Ellen, Statutory agency, NI

It has been alleged that training non-Western counsellors in Western counselling models promotes an ethnocentric approach to counselling (Arulmani, 2007). There are conflicting arguments around the relative effectiveness of particular models which are utilised across different social contexts (Tseng, 1999). A directive approach (Nefale, 2004; Pattison & Corr, 2009) and a client-centred approach have both been positively endorsed in African settings (McGuinness et al., 2001; West, 2007). In this study, in keeping with the findings from other studies (Payne et al., 2002), counsellors in both Uganda and NI tended to be eclectic in their approach. Ugandan informants acknowledged the value of both person-centred and cognitive models, although, on balance, were more likely to use a cognitive approach. For bereavement counsellors in both settings, theoretical issues were not high on their list of priorities and allegiance to a narrowly-defined conceptual framework was not salient. They were pragmatic, eclectic and flexible in their practice. However, they subscribed to, and incorporated in their practice, the three key elements of the legacy of Freud identified in Chapter 4. These comprised a belief in: a conception of the self as shaped by intra-psycho forces; the concept of grief-work as the task facing the bereaved; the therapeutic value of the counsellor-client dyad, shaped by the therapeutic alliance and processes of transference.

Most Ugandan informants did not identify concerns about utilising Western counselling models, although these concerns have been highlighted in the literature (Arulmani, 2007). However, informants who had lived or trained outside Uganda, including expatriate informants, were more likely to comment on these issues.

'I realise that most of the models wouldn't apply so much to our context here. So I try to do what we think will be applicable and more culturally sensitive to our people'. Thelma, Private practice, Uganda,

8.6 Reflective summary: Counsellor characteristics

In terms of counsellor motivations, I shared very similar motivation to the other NI counsellors. I have trained as both a social worker and counsellor, and throughout my career, have felt an aptitude and motivation towards engaging therapeutically with

others. In completing the interview questions, I also reflected on my goals for counselling, considering if, and how, they might differ across settings:

'I realise that I adopted a very individualistic approach to bereavement counselling in NI, and defined my goals in terms of helping the bereaved individual cope with the loss without much reference to the wider community. However, this was also true of my practice in Uganda.' LM: Personal response to interview questions

Thus, although aware of the collective nature of Ugandan society, to a large extent, even in this context, I felt a responsibility towards the client and not towards the wider community.

Like other informants in NI and Uganda, I was aware of the personal impact of dealing with clients' losses. Similar to the NI counsellors, I managed this by adopting deliberate coping strategies such as maintaining clear boundaries and utilising supervision and peer support. I could also concur with the findings from other studies (Campbell, 2007), in determining to present myself as politically neutral (see reflexivity section in the methodology). I have worked therapeutically with bereaved individuals in two main capacities. As a counsellor within a voluntary sector counselling agency, my clients did not present with Troubles-related issues. To some extent, it felt that in this 'counselling role' I was insulated from these events and their consequences. However, this is in contrast to my role as a social worker based within a psychiatric service (Appendix E). In this capacity, I have dealt with Troubles-related issues, for example, dealing with individuals diagnosed with PTSD following sectarian violence or traumatic deaths. Furthermore, as a member of a Trauma Advisory Panel in NI, I gained insights into how communities have sought to deal with the legacy of the Troubles.

As a counsellor in Uganda, I did not offer counselling to victims of the LRA, suggesting that this work was perhaps confined to specialist organisations or to the geographical areas of northern Uganda.

Whilst I have trained in psychodynamic methods, my practice would be defined as eclectic. In Uganda, I was aware that I imported a Western mindset onto my counselling, presuming a reflexive notion of self and Westernised assumptions about families and relationships. For example, I offered bereavement counselling to a

Ugandan family (Family B: Appendix F) following the death of their oldest child. During counselling, the parents described how they favoured their (now deceased) first born son, and that '*the wrong boy was taken*'. In response, I suggested to them that this might be a painful thing for the remaining son to hear. In my journal record at the time, I have identified how these attitudes might be reflective of my own Western values:

I managed this as I would with a Western family, but I was conscious of differences and the imposition of Western values onto this family, such as the rights of the remaining children to be heard, respected and valued. LM: Journal entry: Family B: Appendix F

8.7 Conclusion

Counsellors in NI and Uganda shared similar demographic characteristics, although ethnicity differed within and across settings. In NI, counsellors were representative of both Catholic and Protestant communities. In both settings, counsellors identified similar motivations for engaging in bereavement work, although only informants in NI identified personal loss as a motivating factor. Informants in both settings described an awareness of similar counselling models. These included Egan, CBT, and Worden's Tasks of Mourning; none of the informants identified an awareness of Freudian theory. Eclectic approaches to counselling were most commonly adopted in each setting. Whilst there appeared to be a general lack of focus on theoretical concepts, counsellors clearly subscribed to the deep discourse set out by Freud, as described in previous chapters.

Counsellors in both settings identified the emotional impact of this work, however, they differed in terms of the strategies they chose for managing this. Ugandan counsellors adopted emotional involvement, repression and distance from their clients as their coping strategy, whilst NI counsellors coped by adopting emotionally-detached reflexive reasoning. Counsellor goals also differed, with Ugandan counsellors adopting collectivist goals, whilst the goals of NI counsellors were more individualist. Continuing relationships with deceased loved ones were identified in Uganda and not in NI. In NI, this absence was understood to reflect a 'clinical lore', in which therapists promote the 'resolution' of loss (Walter, 1999).

In NI and Uganda, the large majority of counsellors did not work with clients who were impacted by armed political conflict. In NI, only two informants discussed sectarian or

Troubles-related issues. They each sought to distance themselves from conflict issues through emotional self-discipline. In addition, they avoided letting clients know whether they were Protestant or Catholic. This concurred with my own experience of counselling in NI. In Uganda, only one informant worked in a specialist organisation dealing with the activities of the LRA, although other informants referred to the impact of past conflicts and violence incidents. Thus, in Uganda, perceptions of 'normal' deaths appear to be profoundly influenced by AIDS and the LRA's terrorist activity while, in NI, terrorism did not appear to have impacted on the informants' perceptions of 'normal' deaths, but, rather, had been 'bracketed', or held aside.

The application of Freudian and post-Freudian theories helped to make sense of some of the variations in counsellor characteristics across settings. In particular, reference to Klass's continuing bonds theory would highlight how informants in both settings managed ongoing relationships between bereaved individuals and their deceased loved ones (Klass, 2001). However, this theory cannot not offer a systematic account of the role of social factors in reflexively shaping bereavement responses (Lalande & Bonanno, 2006).

In contrast, the advantage of Elias's figurational theory is that it provides a unified account of the interconnection of social structures and internal psychic processes, so that variations in bereavement responses can be understood within the context of networks of relations between individuals (Dalal, 1998). In explaining the differential responses of counsellors, figurational theory anticipates differences in the habitus of counsellors across settings, and suggests that in Uganda, a lesser degree of foresight would be evidenced in more limited processes of psychologisation and rationalisation, together with a higher threshold of shame. In line with this expectation, Ugandan informants demonstrated a more limited tendency towards mutual identification with clients. They were also more likely to respond to their clients', and their own, emotional pain in an emotive way, with little evidence of reflection. To a large extent, informants in NI offered more reflective accounts of the impact of bereaved individuals on themselves; they appeared cognisant of the dynamics of a causal relationship between their own pain and that of their clients, and they sought to be rational and objective in how they dealt with the emotional cost of their work.

Chapter 9 Findings: Characteristics of Bereaved Clients

This chapter explores the characteristics of bereaved clients as perceived by informants in both settings. It will address similarities and differences in the perceived demographic characteristics of clients, referral careers and reasons for seeking help. Reflective comments of my own observations and past experiences in relation to client characteristics will be offered.

9.1 Informant Perceptions: Demographic Characteristics of Clients

Table 8 highlights similarities and differences in the perceived demographic characteristics of counsellors' clients.

Table 8: Informant perceptions: demographic characteristics of clients

Factor:	Uganda	Northern Ireland
Gender	Mostly female.	Mostly female.
Age	Usually 15-50 years.	All ages.
Socioeconomic grouping	No definite pattern: some informants in NGOs identified 'poor' clients; some informants in private practice identified 'educated' clients.	No definite pattern.
Ethnic origin	Range of ethnic groups.	Large majority white.

In NI, whilst the majority of informants stated that bereaved individuals in their 30s, 40s and 50s were more likely to come for counselling, two informants working specifically in child bereavement services offered counselling to the 'very young' whilst two others described working with 'older people'. In Uganda, a wide age range was also identified, with 50 probably constituting old age within this population. Whilst Ugandan informants identified 15 years as the youngest age of clients, my participant observations have indicated that children as young as seven might be included in group counselling. The gender imbalance in both settings, with more women than men seeking counselling, has been identified in other studies (DHSSPS, 2002). NI counsellors stated that there was no definite pattern evident in the socioeconomic grouping of clients. Ugandan informants based in NGOs thought that it was the 'very needy' or poorer

people who came for counselling, whilst those in private counselling agencies indicated that wealthier individuals came for counselling.

In NI, the majority of clients were white. The perceived low numbers of referrals of ethnic minority clients in NI is in keeping with racial equality studies of health and social care provision within NI (DHSSPS, 2003). However, bereavement care, sensitive to the dynamics of different social settings and value systems is an explicit requirement of regional and national guidelines (DoH, 2005; DHSSPS, 2009b; NHSCT, 2009; NICE, 2004).

Whilst some informants described their organisation as offering counselling to all religious sectors, there was very limited discussion of the religious identity of clients by the majority of NI informants. This was very surprising as national and religious identity remains strong in NI (Ewart & Schubotz, 2004) and sectarianism has been found to persist as a significant problem (Campbell, 2007; Jarman, 2005). Potential explanations for this apparent anomaly will be explored in Chapter 11.

Ugandan informants did not indicate that any particular ethnic group was more or less likely to come for counselling. Expatriate counsellors acknowledged the dynamics of working with different ethnic groups. However, only two indigenous informants identified differences in the ethnic background of client and counsellor as issues in the counselling process.

'Well, one of the things is that the social set up, or the tribal group, that is another factor that one needs to know'. ... 'They have different approaches, one needs to know that. And also religious commitment is another thing that one needs to know'. James, NGO Uganda

'You base your counselling on the systems the client comes from, because if I am counselling a client from northern Uganda I may use a different language, a different approach from the one way in central'. Priscilla, NGO, Uganda

McLeod (2009) reviewed research exploring the relative advantages and disadvantages of ethnic matching of clients and counsellors. Whilst he identified somewhat ambiguous results, it was noted that almost all of these studies had been carried out in the USA. Consequently, little is known about ethnic matching in other countries. Further research is needed to explore this important feature of counselling in NI and Uganda.

It is noteworthy that, in both settings, issues of social difference were rarely acknowledged by informants. Whilst they listed differences in the demographic characteristics of clients, the ways in which these differences impact counselling were not discussed. Thus, clients of different ages, genders or ethnicity were presented to a large degree as homogenous. It is difficult to know if informants failed to recognise these internal differences or chose not to discuss them. Their attitude is consistent with adherence to an intra-psychic discourse derived from Freud.

9.2 Informant Perceptions: Referral Careers of Clients

The perceived referral careers of bereaved individuals are outlined in Table 9.

In NI, informants identified criteria by which potential clients could access counselling services. Although some variation was noted across the voluntary and statutory sectors, referral criteria related to clients' age, the catchment area in which they lived and the nature of their loved ones' illness or death, such as specialist counselling services for cancer-related deaths or suicide.

Informants from two organisations, both within the voluntary sector, stipulated a time-scale within which a bereaved individual should seek counselling; one suggested that a client should wait until four months after a death, the other suggested six months. In the voluntary and independent sectors the majority of clients referred themselves, although some clients in the voluntary sector were referred from other agencies, such as GP practices. In the statutory sector, clients were referred from other statutory agencies or from their GP.

All informants in NI referred clients on to other agencies such as mental health services. No formal referral criteria existed for this process; rather the informants stated that they re-referred when the issues presented were felt to be beyond their level of expertise; this might be done, for example, if a mental health assessment was required.

In NI, whilst statutory and empirically based guidelines stipulate when and in what circumstances bereaved individuals should be offered counselling (NICE, 2004), in practice, informants did not always conform to these guidelines. The reasons for referral for bereavement counselling were similar across voluntary, independent and statutory sectors and referrals happened in a somewhat arbitrary manner. This rather *ad hoc* picture has been identified in other studies where the provision of bereavement

counselling has been found not to conform to statutory or best-practice guidelines (Schut et al., 2001).

Table 9: Informant perceptions: referral careers of bereaved clients

Major Theme	Subsidiary Themes	
	Uganda	Northern Ireland
Referral criteria	None.	Age. Geographical boundaries. Time-scale. Nature of illness or death.
Referral source	Family and friends. Self-referral. Hospice/ HIV centres. When traditional help-seeking structures had failed.	Voluntary agencies: self-referral, referral from other agencies such as GP. Statutory agencies: GP, cross-referral from other departments. Independent agencies: self-referral.
Referral on to other agencies	[Not discussed]	Re-referral when client required specialist interventions, e.g. psychiatric assessment.

Ugandan informants did not stipulate any referral criteria. Clients were most likely to be referred by friends or be self-referred; if bereaved individuals or others in their social networks felt that they needed counselling, this was sufficient reason for them to be accepted for counselling. Thus, the referral process in each setting was shaped by the level of structural differentiation. In Uganda, self, family and community (in addition to international agencies supporting HIV patients) dominate referral channels. In NI, clients come via a network of bureaucratic agencies and organisations. In Uganda, an additional dynamic related to how professional counselling co-existed with traditional help-seeking structures (Senyonyi et al., 2012).

‘Before we go deep into the discussion, it is probable you find out they have visited those shielings and they have failed. Even when they come here

sometimes they go back to the shielings to consult with the spirits, sometimes they share with us that maybe the gods have said this'... 'I have some two ladies, they said they visited a traditional healer and the gods advised them to stop taking the drugs because they can't conceive when they are taking the drugs, so the traditional religion also'. Joyce, NGO, Uganda

Whilst three informants explained that some of their clients sought help from traditional healers concurrently with their counselling, they offered no explanation for why they did so.

9.3 Informant Perceptions: Reasons for Bereaved Clients to Seek Help

The factors which appeared to prompt help-seeking behaviour by clients were broadly similar across the two settings, although different specific issues were highlighted within each setting. Ugandan informants understood death as wholly integrated into day-to-day experiences, within social structures providing sufficient support for bereaved individuals, which included traditional healers. However, they explained that, in this setting, changes in the structure of society and in the mourning process had challenged these support mechanisms and some individuals had therefore turned to professional counselling. In NI, bereaved individuals had limited predetermined or collective channels of support. Bereavement counselling provided a forum in which they could reflectively process their loss. Elias (2001 [1982]) explains these changing attitudes to death by suggesting that, in Western societies, death has become repressed both individually and socially, and is consequently concealed from view.

The secondary literature has identified certain risk factors and coping styles that have an impact on adaptation to loss in a Western context (Hansson & Stroebe, 2007). Similar themes were identified in this study in both Uganda and NI. In Table 10 they have been grouped into three main categories: the nature of the bereavement, intrapersonal factors, and interpersonal or situational factors.

Informants in both settings stated that the nature of the bereavement affects the grieving process and the likelihood of someone seeking professional help, although different aspects were identified across settings.

Table 10: Informant perceptions: why bereaved individuals seek counselling

Major Theme	Subsidiary Themes	
	Uganda	Northern Ireland
Nature of the bereavement	HIV/AIDS.	Cancer, prenatal deaths.
	Multiple deaths.	Multiple deaths.
	Sudden death.	Sudden death.
	Murder.	Suicide.
	Death with no-one to blame.	Perceived untimely death. Death could be avoided, failure to intervene, losing control.
	[No discussion of medical processes.]	Medical processes: inaccurate diagnosis, poor hospital care, difficult death process.
	Lord's Resistance Army.	Troubles-related: recent political events reactivate earlier trauma.
	Recent traumatic incident: 'Junior B' school fire.	
Intrapersonal characteristics	Caring role with a protracted illness.	Caring role with a protracted illness.
	Limited reference to personal characteristics. General focus on roles and responsibilities.	Adults: disabled, ill, history of depression, vulnerable personality, previous negative experience of death and trauma.
	Children: only interpersonal factors discussed.	Children: with more complex attachments to the deceased.
Interpersonal characteristics	[Protective factors: not discussed.]	Protective factors: coping strategies developed from previous experience of death and trauma.
	Family dynamics: Generally described in terms of roles and responsibilities.	Family dynamics: Generally described in terms of relationships.
	Local customs: Levirate system, property grabbing.	Local mourning customs not discussed in this context.
	Loss of breadwinner.	[Economic issues not discussed.]
Interpersonal characteristics	[Factors associated with counsellor not discussed.]	Previous positive contact increased the likelihood of a bereaved individual requesting help.

Ugandan informants referred to multiple deaths. Many stated that, in the recent past, multiple deaths were common in Uganda and contributed to a collective ‘numbing’, in which people became so familiar with death they did not feel the pain associated with it. These comments tended to relate to the legacy of the Amin wars, which would most likely be remembered by the Ugandan informants in this study (Oloka-Onyango, 2004).

‘In Arua we suffered badly from the war in West Nile’... ‘Ida Amin, many of his rebels were from West Nile and stayed and continued to terrorise, even when the war had ended. They left a lot of trauma. There are many orphans and widows as a result’. James, Private practice, Uganda

‘I mean every week you would have five people dying. People that you knew dying. And so it lost meaning. It was like, “Who are you going to cry for and who are you not going to?”’. Sandra, NGO, Uganda

‘And at times we have ... I don’t want to use the word, “getting used to death” ... And when we go to the north of Uganda that’s another thing, then we had the wars of Amin and you would be walking around and you would find a dead body. ... It becomes, I don’t know, it’s part of life and so your heart becomes hardened’. Lynn, Private practice, Uganda

Multiple deaths were also associated with the HIV crisis.

‘I was talking to clients recently. They are both HIV-positive, the husband and wife, and she was talking about death. “Supposing he dies, what will happen to my medical in the bank?” It was just like one of these questions that comes in and out. So I don’t even know how to answer that question’. Roberta, Corporate agency, Uganda

The adaptation of psychodynamic theory offered by Ornstein (2010) may also help explain these client responses. Ornstein suggests that multiple and traumatic loss leads to changes in the mourning process; because of the volume of loss, ‘numbing’ takes place as a defence mechanism until the availability and support of others enables grief-work to begin.

Ugandan informants also referred to murder and other sudden and violent deaths, focusing largely on two topics: a recent school fire and the ‘Kony war’, the LRA

activity in northern Uganda. However, whilst the impact of the LRA was widely acknowledged, it was only discussed in detail by those informants working with individuals directly affected. Sylvia was the only counsellor in this study working specifically in northern Uganda. The international NGO, of which she is a member, offers counselling within the IDP reception centres for abducted children and adults, many of whom will have been forced to kill their own family members (Senyonyi et al., 2012). In addition, two expatriate counsellors, both based in the capital city Kampala, identified LRA victims among their clients. When these expatriate counsellors discussed the impact of the LRA, they described in detail the level of violence. This detail was absent from Ugandan counsellors accounts. Valerie, an expatriate counsellor, provides the following account:

Valerie: *'I had one client in Northern Uganda, English-speaking who had been through seven major traumas, all dealing with grief and loss. Everything from having the father's head bashed and the brains drip out to having the mother's body cut up and put in a pot to boil'.*

Lorna: *'Did he observe that?'*

Valerie: *'He was called and came upon the body when it was still warm. And that was just another one, being called that the rebels had come to a village, his wife's village, and getting on his bicycle and going there and finding the pots still in the middle of the road and people's body parts being cut and put inside. His wife had two relatives who had been killed and ended up like corkwood to be boiled, just heinous, unbelievably shocking things and he had never grieved any of the seven'.* Valerie, Expatriate counsellor, Uganda

Gloria, also an expatriate counsellor, describes her work with a young female victim of the LRA who had been forced to kill other people. Gloria also describes this client's reluctance to address her grief:

Gloria: *'There is a grief around her new self because she has been raped, she has been abducted, and she has been abused, and she has seen many, many shocking things and she has been forced to kill people. The grief, bereavement around who she was before and who she is now I imagine is there amongst the rest of the trauma that she has experienced'*

Lorna: *'Why do you think she is not seeing the bereavement as a core problem for her at the moment?'*

Gloria: *'I think it really depends on how ready she is to access that pain because she initially wanted to come to me for, because her body was shaking, which we have identified as stress and anxiety. ... and she would then say "I don't want to go there"'*. Gloria, Expatriate counsellor, Uganda

The literature suggests that members of African communities are likely to manifest somatic symptoms of grief (Madu et al., 1997; Patel & Sumathipala, 2006). However, this was not identified by the majority of informants in this study. It is noteworthy that Gloria, in her account above, offers the only description of somatic grief. In this case, the expression of stress appears to manifest itself in bodily symptoms, which are not attributed to a physical disease. Often, with somatic symptoms, the underlying psychological distress is denied; in this example it appears that physical symptoms are masking the emotional component of loss.

The impact of the LRA atrocities on its victims has been noted in other Ugandan studies which record high levels of client trauma (Roberts et al., 2008). These accounts clearly take us into the world of traumatic grief (Prigerson & Jacobs, 2001). Individuals bereaved in such circumstances often experience complicated grief reactions which are long-term and debilitating (Higson-Smith, 2014).

Sylvia was the only Ugandan counsellor to identify a 'complicated grief' reaction. She attributes this to the lack of opportunity of bereaved individuals to fulfil the customary death rituals:

'Much of this grief is complicated. It is not normal.' ... *'That is the problem, there is no body, no vigil is kept, the children are uprooted from their ancestral home; the parents are not buried in their ancestral home'*. Sylvia, NGO, Uganda

Holloway's (2007) identification of 'special deaths' might be relevant here. These deaths incur a high level of psychosocial trauma, and appear to be both stigmatising and existentially challenging. However, in Uganda, such deaths have arguably become the norm. Thus, whilst other Ugandan informants identified volatile and violent situations, they seldom identified complicated grief reactions in their clients. It is possible that these reactions have been normalised and are not identified as such, or that many

bereavement counsellors in Uganda have not been trained to distinguish different types of grief reactions.

In Uganda, the timing of death was also presented as an important factor impacting the grieving process. Both sudden death and protracted caring roles were seen to be difficult. In particular, a complexity has arisen with the recent availability of medication for HIV which has changed the predicted lifespan of patients. HIV-positive patients who are receiving anti-retroviral treatment (ART) are living near normal lives (Bikaako-Kajura et al., 2006). Roberta acknowledges the complication this brings to bereavement counselling:

‘And for those who are still living with all the medication that has come in there is a sense of, “Is he going today, tomorrow, two years, ten year?” So there is, “When is this thing going to happen?”. So it does something to the counselling model that we should know, it must affect it somehow’. Roberta, Corporate agency, Uganda

In NI, informants similarly identified the nature of the bereavement as an important factor contributing to a bereaved individual seeking counselling. However, in contrast to Uganda, NI informants conveyed an expectation of longevity. In the example below, Verona highlights her clients’ belief in the right to a long life:

‘Say, if I worked with people who died at eighty or seventy, I think there is an expectation that we don’t live forever, so people and their peers are dying around them. So you find someone who is thirty-five with two young children; I mean that’s abnormal in society’. Verona, Statutory agency, NI

Bereaved individuals in NI indicated a particular concern if they felt the death of their loved one could have been avoided. Thus *‘death out of the natural order’* or where *‘their life could have been saved’* was seen as particularly difficult, with examples given of a car accident, suicide, stillbirth or termination, and sudden or complicated cancer death. A *‘complicated trajectory of the disease’* and *‘perceived medical failures’* were also deemed to be particularly difficult. Two informants, both working within cancer services, described some of their bereaved clients as experiencing multiple deaths. Suicide was also noted as being particularly difficult:

'It is a completely different death because of the trauma of how your loved one died at their own hands. So you have the blame, the guilt and the whole trauma you know to start with, and the "Why?"' Maureen, Voluntary agency, NI

Informants' perceptions of their client's responses to suicide concur with the concept of disenfranchised grief, which, due to the nature of the loss, cannot be honestly acknowledged, overtly mourned or socially supported (Doka, 1999).

This focus on 'the right time to die' was evident in other respects also. For example, informants explained that clients had become preoccupied with their perceived failure to intervene: *'Could I have done something else?'* or *'Why didn't I notice?'* Clients were also concerned about losing control:

'It's gradually slipping out of their hands and they feel they have no control and quite often that's what it is. It's the control thing. Somebody else is in charge and "I feel I'm handing my life over", as it were'. Debra, Statutory agency, NI

This concurs with Parkes's (2001) suggestion that, in the West, death is often seen as a medical failure. Three informants explained that their clients expected death to be peaceful and gentle and were upset when it was not. Informants stated that a *'difficult or a distressing death process'*, which included *'distressing death scenarios'*, *'bad bleed'*, *'terminal restlessness'* or *'personality change'*, all impacted their subsequent grieving process. The role of the media was also highlighted, as in other studies (Howarth, 2007a; Walter, 2007). Tanya describes a client whose expectations of the dying process came from watching TV, and how the reality of her mother's long and painful death came as a shock to her:

'Someone dies and it's very peaceful and everybody, family all-round the bed and that's it. Whereas, just yesterday in fact, I was with a girl who' ... 'had a very difficult death with her mother, and her mother dies and she is still, after several months, needing a lot of help.'

Lorna: *'And was the difficulty around the death process?'*

Tanya: *'Yes, yes' ... "No-one told me that she would close down and an elongated thing".'* Tanya, Voluntary agency, NI

Like the Ugandan informants, NI informants discussed the difficulty caused by a longer dying phase brought about by improvements in medication and medical care; advances in medical science had changed the trajectory of illness and left terminally-ill people and their families confused.

'I think, in the cancer service, the whole activity of the diagnosis and the death can be quite destructive to families. You know it can be a long process, ... people die for longer and' ... 'it brings people right to the edge of their coping, emotionally, physically, lots of exhaustion.. Ellen, Statutory agency, NI

Finally, in NI, only those informants working within specialist, Troubles-related counselling organisations identified the impact of the Troubles as a reason why clients might seek counselling. Here reference was also made to recent paramilitary activities:

'Well, here, what I provide is trauma counselling, because it's for people who have been traumatised by the conflict in NI'. ... 'I think recent events, like the activities of the dissident Republicans that takes people back into the trauma. I see people coming for the first time because of that'. Grace, Voluntary agency, NI

Within NI, the continued need for counselling support following terrorist activities has been identified (DHSSPS, 2002). The fact that Troubles-related deaths were not discussed by participants outside Troubles-related organisations is surprising, as the Troubles have arguably had a significant impact on current bereavement provision in NI (Campbell, 2007). Pointon (2003) identified the legacy of the Troubles as a central issue in post-ceasefire counselling, whilst McNally (2009) and Dillenberger et al. (2008) highlight the trauma associated with Troubles-related bereavement.

There are a number of potential explanations for this anomaly. It is possible that most NI counsellors do not encounter sectarian issues because those clients with strong religious and community ties are supported by relatives and friends. Bereavement counsellors get to see those with weak social networks (Wimpenny et al., 2007); in NI, such clients would potentially have relatively weak sectarian identities. Clients with strong religious convictions may well prefer to use services that they might see as most sympathetic to their beliefs. Gibson and Iwaniec (2003) and Hendron et al. (2012) identify NI clergy as an importance source of support for those who have been victims

of the Troubles. In addition, O'Kane and Millar (2001) researched the counselling support offered by Catholic priests in one diocese in NI. They found that a wide variety of problems were encountered by priests, but the most common was bereavement; however, problems relating to the Troubles identified as 'rarely' addressed issues. This would suggest that individuals who have been deeply traumatised by Troubles-related violence would be referred to, or would seek out, specialist rather than generalist agencies. In recent years, there have been new policy initiatives, designed to deal with unmet need caused by the Troubles. Since the Peace Agreement of 1994, a Victims Strategy (DHSSPS, 2009), and a Victims and Survivors Service (VSS) have been established. A recent report for the Commissioner for Victims and Survivors (CVS) revealed '*the pervasive and protracted toxicity of psychological trauma on the health of the Northern Irish community*' (CVS, 2011:1), recommending the further development of specialist services offering therapeutic interventions for Troubles-related trauma.

The second reason for seeking counselling related to intrapersonal factors. In Uganda, there was only one reference to the intrapersonal characteristics of clients. However, even in that case, the focus moved quickly to interpersonal factors, such as the role and responsibilities of bereaved individuals:

"Maybe the personality, maybe the coping mechanism of the individual, for example their responsibilities left behind or' ... 'unfinished business that you may be having with the deceased. Those are some of the things. Plus the economic status, the social status this individual, the deceased has with the person grieving." Joyce, NGO, Uganda

In NI, however, greater emphasis was placed on intrapersonal factors. Coping strategies, developed through experience of previous losses, were seen as protective, whilst adults with a disability, mental health history or 'vulnerable personality' were deemed more likely to need help:

'Also, for people themselves who may be disabled or ill themselves or may have a history of depression, things that you would probably be aware of. The other group would be, I suppose, people who you might consider vulnerable by virtue of their personality, their past experiences. And people for whom the person who died had particular, very strong meaning'. Patsy, Hospice, NI

NI informants based in the statutory sector suggested that a previous positive relationship with staff in statutory organisations was also an indicator that an individual would seek professional help following his or her loss.

The third reason for seeking professional help, and the most common in both settings, related to interpersonal factors, in particular, the availability of family support. Informants in both settings claimed that individuals who have the support of their family do not need counselling.

'The more support they have, the more they really don't need the one-to-one that I provide because it has already been provided by the family out there'. Roberta, Corporate agency, Uganda

'People who have a lot of family support don't need professional help'. Patsy, Hospice, NI

However, in Uganda, informants talked of support in terms of the roles and responsibilities within a family, whilst NI informants focused on the emotional support provided by family members.

In Uganda, the loss of an individual was defined in terms of the loss of the contribution of that individual to the family's survival. The death of the breadwinner was consistently noted as being most difficult.

'Sometimes you find that, most of the people who die, they are bread winners and the most issues are how they're going to live on, how are they going to continue, you know, a life without the deceased. The fact that he or she has been the breadwinner, and usually it will come into financial concerns. But sometimes it is how to live with the losses of that person within the home'. Clarissa, Hospice, Uganda

'I was thinking about a case where the deceased person is the sole provider ... there is a wife and children and probably extended family who have been totally dependent on one person. So that grief takes another level'. Jane, Private practice, Uganda

'Maybe the breadwinner is gone, the husband is gone, the father is gone, who is going to take over the family?'... 'There is no one to care for them'. Moses, NGO, Uganda

Studies have confirmed that in Uganda, death is likely to bring practical and economic problems (Grant et al., 2011). However, despite the greater concern for economic survival, bereaved individuals in Uganda also sought counselling in order to deal with the psychological and relational aspects of their loss. An understanding of the impact of death in Uganda therefore needs to acknowledge the interplay of emotional and economic factors (Nordanger, 2007).

'And if somebody's relationship actually breaks, you have lost a lot. You would rather lose in terms of goods than lose a relationship, and I think that's why it's so important' 'It's important enough to seek counselling to be at peace with those around you and also to be at peace with yourself. Because, when you are not, then you can't fit, you can't fit in the society, you can't fit in the family, so I think that is very crucial. Yes, here there is poverty and all diseases and those things, and I think the value of those relationships which are still of great value'.

Thelma, Private practice, Uganda

There were also frequent references by Ugandan informants to the role of the bereaved individual within a family. When the heads of the families were personally bereaved, their responsibilities to manage the burials and care for their families inhibited grieving.

'You are allowed to cry and you don't cry. Or you are aware you are the head of the family and the children are looking up to you, or so everybody is looking up to you, and you have to arrange the burial and everybody is looking to you. Then you have to postpone grief for up to a month and such people come for counselling'. Martha, Private practice, Uganda

In particular, the practice of polygamy and the role of wives in the leviratic inheritance system impacted the grieving process.

'Especially if it's a wife, she gets many surprises. The in-laws who seem to care initially turn against her at times. The husband, whom she thought had her own children, other children now surface'. ... 'So many challenges now do happen,

she is told that property “was not for your husband it was for the family and you are not part of the family”’. Jane, Private practice, Uganda

‘But usually that one depresses more the women, the men get along easily. You lose a wife, “What about it?” You marry another one. At times, you’ve lost a wife and you already have another one as a co-wife.’ ... ‘Then they come and tell you, “My husband, his brother comes at night and he is always disturbing me, I’m still grieving the death of my husband, I can’t run away. They told me that’s cultural.”’. Joyce, NGO, Uganda

Informants also discussed the particular dynamics for grieving children. In keeping with other Ugandan-based studies, an embargo on children expressing emotions was identified (Fjermestad et al., 2008; Sharpe, 1999).

‘African culture puts children in a very negative position. The child cannot talk, cannot express feelings. The adult forgets that the child is grieving.’... ‘With the children we work with, the parents have been killed at the hands of rebels or died of HIV AIDS and so grieving is complicated’. Lynn, Private practice, Uganda

Ugandan informants focused on their domestic interdependency networks: the expectations, roles and responsibilities of husbands, wives and children and how these impacted the grieving process. Given the collective goal of survival, the loss was identified, in part, as a ‘loss of asset’ to the community (Nwoye, 2000). As such, there were prescribed roles and behaviours for men, women and children in order to deal with this loss in a way which minimised disruption to the community.

NI informants also focused on the network of interdependencies and the interaction of the bereaved individual with his or her family. However, the interest here lay in the emotional support and dynamics of familial relationships. In keeping with the findings of other studies, the psychological support offered by family members in NI was a key factor in determining whether or not a bereaved individual sought counselling (Benkel et al., 2009). Familial factors were identified in relational, not economic, terms. In particular, pre-existing relationship difficulties impacted loss:

‘I suppose, if relationships haven’t been good with the deceased person, whoever that is, and there’s a lot of issues come up afterwards, you know,

unresolved stuff, and there's a lot of baggage from that'. ... 'And that loved one has died and "What do I do now with all this I'm left with?"'. Debra, Statutory agency, NI

'You can be sometimes dealing with a lot of regret, unfinished business in relationships'. Jan, Statutory agency, NI

'Often you tend to find that, if there are fault lines in a family, they get opened up though the experience of illness and death, and, of course, wills and how people behave around funerals and all that'. Patsy, Hospice, NI

In addition, many informants reported that families become conflicted following a death which could lead to an inability to offer support.

'Often you'll find families who maybe have always been a bit conflicted, maybe become more so. And people don't have their resources to deal with that. You get factions and then that takes away a layer of support for people'. Patsy, Hospice, NI

NI informants noted that tensions could arise in families because men dealt differently with the loss to women. Positions in a family may also change, and historically difficult relationships may be compounded when the family is grieving the loss of one of its members.

'Often, when death happens, the whole dynamic of the family changes. It's as if everything has been thrown up in the air and nothing has landed in the same spot'. Verona, Statutory agency, NI

'But, quite often, the kind of referrals we would get is because maybe there is a reasonably dysfunctional family and there aren't a lot of supports or there are other problems in the family'. Jan, Statutory agency, NI

The consistent message was that people with fused, enmeshed or poor relationships, or with unresolved issues with the deceased, were more likely to seek help. These findings are consistent with other studies of family coping (Wimpenny et al., 2007).

In both settings, then, the presence of a supportive family or community made it less likely that a bereaved individual would seek counselling. However, difficulties within these support structures contributed to individuals seeking help. In Uganda, eight

informants discussed difficulties which were related to external factors, such as poverty, social practices which disempowered particular sections of the community such as women, and roles and responsibilities within the family. In NI, interpersonal dynamics were most often cited as the problem. This distinction between the relational and functional aspects of family life highlights a fundamental difference in the nature of the loss between the two settings. In contemporary Western societies, material prospects are more dependent on educational achievements than the status and support provided by family. Thus *'bereavement becomes less a loss of status or of income, more the loss of a deeply personal attachment'* (Walter, 1999: xvi).

9.4 Reflective summary: Client characteristics

In Uganda, I personally counselled clients from a range of ethnic groups. Often, clients discussed their ethnicity: for example, *'I am Mugwere, my mother tongue is Lugwere'*. In NI, my clients came from both Catholic and Protestant communities. Whilst I would not routinely have asked clients about their religious identity, I would often be aware of this through their names.

As noted earlier, it was only whilst working in NI as a social worker in a statutory-sector psychiatric service that my clients presented with Troubles-related losses. This might suggest that individuals dealing with Troubles-related issues only sought help from the professional statutory sector or that such clients only sought help when their issues had reached the stage of requiring professional psychiatric interventions.

In both settings, my clients sought help because of issues relating to the nature of their bereavement, and also intrapersonal or interpersonal factors. In NI, unresolved personal issues with the deceased, and going conflict with family following the death of a loved one, appeared to be a key reason why people came for counselling. In Uganda, I have reflected on work with two indigenous clients both of whom had moved away from their extended family networks and had limited opportunity for community support. Each of these families presented following the death of a child, and the frustration of being unable to 'save' the child (Appendix F). Family A's infant daughter had died from a snake-bite whilst her parents were at work. Family B's first-born son was diagnosed with cancer. This family did not have the resources to seek high quality medical treatment and the boy subsequently died.

9.5 Conclusion

This chapter explored informants' perceptions of the characteristics of bereaved individuals seeking counselling. These centred on demographic factors, clients' referral careers and their reasons for seeking help. Similarities and differences were identified between the two settings.

The perceived demographic characteristics of clients were similar across settings, with an over-representation of women in both. Referral processes were more bureaucratic and formal in NI than in Uganda. Informants' perceptions of why bereaved individuals sought counselling highlighted the nature of the bereavement, intrapersonal features and interpersonal factors as important contributors to help-seeking behaviour.

In relation to the nature of the death, in Uganda, informants highlighted the large number of deaths over the last 20 years, resulting from the AIDS pandemic and LRA activity, suggesting that, at times, the grieving process had been interrupted and people had become numb. In NI, informants described clients' expectations of longevity, their shock at sudden death and their anxiety over a failure to prevent the perceived untimely death of a loved one. Expressions of distress around the dying process appeared to indicate repugnance associated with death. NI informants identified a concern that death could have been avoided, suggesting a fundamental belief in the right to a long life, which was absent in Uganda. In NI, only those counsellors directly working with Troubles-related organisations made references to the impact of deaths related to terrorist activities.

Interpersonal factors were understood within the framework of informant's figurational locations; the availability and nature of family support was the most significant factor influencing help-seeking behaviour in both settings. Intrapersonal factors, such as predisposing vulnerabilities, were noted by informants in NI, but limited reference was made to these in Uganda.

The psychological theories offered by Freud, and Prigerson and Jacobs, help to highlight issues presented here relating to traumatic loss. However, since these theories tend to focus on intra-psychic, as opposed to social, mourning processes, they cannot explain differential responses across settings. As noted, Elias's figurational theory can explain such differences. For example, in accordance with his theory, Uganda, informants identified death as more open and visible, whilst apparently indicating a

higher threshold for shame and repugnance associated with death, compared to NI. In a setting where violent deaths are frequent, only the expatriate informants tended to describe the more 'repugnant' features of death, describing what, in a Western society, would seem macabre, such as body parts being burned. These were not mentioned by any of the indigenous Ugandan counsellors. These differences were understood according to how the civilising processes of different societies differentially influence reactions to loss and in particular, the advance of thresholds of shame and embarrassment.

This chapter focused on the characteristics of bereaved clients and the factors which contributed to help-seeking behaviour, as perceived by informants in both settings. Many of these are similar to a range of factors identified by other writers (Hansson & Stroebe, 2007). However, whilst factors were broadly similar in Uganda and NI, different specific issues were highlighted in either setting. Nevertheless, it seemed that, in each setting, the availability and nature of family support was a central factor in determining if a bereaved individual would seek professional intervention.

Chapter 10 Findings: Counselling Practice

This chapter considers the nature of bereavement counselling practice in NI and Uganda, as described by informants. It explores the routines and activities which constitute bereavement counselling; the presenting problems brought by clients, together with consequent counsellor interventions; and the dynamic aspects of the counselling relationship. These findings are supported by participant and non-participant observations, along with a reflective summary of my own personal observations and experiences of counselling practice.

10.1 Counselling Routines

Many counselling routines were similar in NI and Uganda, as highlighted in Table 11. In both settings, clients were seen in the counsellor's office. A fee was charged by counsellors in private practice but no fee was charged by counsellors working within NGO, voluntary or statutory sectors. It was anticipated that fee-paying would add a dynamic to the counselling process (McLeod, 2009). For example, the payment of a small fee by clients is seen to motivate them to attend, or conversely, may also influence the number of sessions offered where fee paying clients may be more likely to attend for fewer sessions than those receiving a free service. However, informants made limited references to differences between the fee-paying or complementary status of counselling services. In Uganda, seven informants offered counselling on a private basis. Of these seven, some suggested that wealthier Ugandans sought their services; others noted no difference in the socioeconomic status of their clients, whilst one informant suggested that 'poorer clients' will pay for counselling if they need help to restore relationships. Only one informant in private practice suggested that the number of sessions offered may be limited by the client's ability to pay. In NI, two informants described themselves as private or independent; only one of these indicated that the need to pay for counselling services limited the number of sessions offered.

In Uganda, counselling typically lasted between two and six sessions. In NI, whilst many clients were seen for up to six weeks, there was greater variation and some clients were still receiving counselling after one year. Informants in both settings differentiated between pre-bereavement counselling, where the counsellor sought to assist the patient

and their families to prepare for death, and bereavement counselling, offered to an individual following the death of a loved one.

Table 11: Informant perceptions: counselling routines

Major Theme	Subsidiary Themes	
	Uganda	Northern Ireland
Venue	Counselling office.	Counselling office.
Fees	NGO: free.	Statutory, voluntary sector: free.
	Independent: fee.	Independent: fee.
Number of sessions	Depending on need.	Depending on need.
	Most likely 2-6 sessions, More sessions uncommon.	Varied: 6 sessions common but long-term (6-12 months and over) possible.
Pre-bereavement Practices	Preparing others: how to tell children, devising memory boxes.	Preparing others: how to tell children, devising memory boxes.
	Helping people get their affairs in order.	Helping people get their affairs in order.
Bereavement Practices	Talking therapy with some examples of practical help.	Talking therapy.
	Early focus on assessment and telling the story.	Early focus on assessment and telling the story.
	Counselling sessions may include others.	Counselling sessions usually one-to-one.
	Most valued: being understood, being listened to and not judged.	Most valued: being understood, being listened to and not judged.
	Limited group work.	Limited group work.
	Mismatch in expectations around payment.	Mismatch in expectations around number of sessions.

Informants in both settings described a traditional talking therapy, in which sessions typically lasted about one hour and utilised specific strategies such as enabling clients to tell their stories, active listening, and developing supportive therapeutic relationships.

Similar interventions have been identified in other, Western-based, studies (Allumbaugh & Hoyt, 1999; Forte et al., 2004; Payne et al., 2002).

Informants in NI indicated that earlier counselling sessions focused on encouraging clients to tell their story and also on assessing their, predominantly psychological, needs; however, only two informants described the use of a formal assessment model at this stage. Later sessions focused on addressing issues associated with the loss. Ugandan informants conveyed a similar pattern, but none used a formal assessment model. Rubin and Malkinson's (Rubin et al., 2012) twin-track model, although not explicitly identified by any informant, identifies these two processes as key features of bereavement. Thus, informants dealt with both the bereaved's functioning and with their emotional attachment to the deceased.

NI informants identified a mismatch in client and counsellor expectations of session number, with clients wanting to remain in counselling longer than was deemed necessary by the counsellor. Ugandan informants described a mismatch in client and counsellor expectations in the sense that clients did not expect to pay for counselling, as traditionally support has been freely available through community structures. Informants in both settings stated that clients valued a safe environment, in which they could feel they were being understood, listened to and not judged.

One Ugandan informant explained that she also offered practical assistance to her clients, in the form of advocating for resources or helping them to manage their finances:

'I love it when I have a solution to their problems but I have run away from only offering psychological support. I also want to support the client get a source of income'. Joyce, NGO, Uganda

Two other informants suggested that clients have an expectation of financial or practical assistance. In NI, these wider work roles are more likely to be carried out by a range of other professionals, such as social workers.

Other African-based studies have also demonstrated that counselling activities included advice and practical assistance (Alao, 2004; Ochieng, 2010; Oyewumi, 1986; Pattison & Corr, 2003). The DPM conceptualises differences in the presenting problems of bereaved clients as associated with the variable presence of loss-orientated and

restoration-orientated stressors (Stroebe & Schut, 1999). The balance of loss-orientated and restoration-orientated behaviours is deemed to vary according to the demands of particular social practices and belief systems. In keeping with the economic pressures in Uganda, where bereaved individuals must quickly re-engage with their responsibilities, it appears that restoration-orientated features of grief are more prominent (Maasdorp & Martin, 2009).

Perhaps the most significant difference between the two settings was the degree to which the focus of counselling was individual or collective. A consistent message from the Ugandan counsellors was that clients' connection to their community was a central and prominent feature of their practice. Seven Ugandan informants confirmed that counselling was not seen as a one-to-one activity, but as one that should always involve others, in particular, the extended family.

'Counselling the individual alone without, it's like cleaning the person and then putting them back in a dirty environment'. Lynn, Private practice, Uganda

'Even when I am teaching my counsellors, I say there's a context, a big wide context, you can't work with the individual alone. I don't know whether that's cultural or not but there are people who connect with this person. So, if I'm dealing with a seventeen-year-old, like I was today, she has a mother, she has a father, these two are separated, that has an effect on her. She cannot, even if she is eighteen, cannot make up her own mind. You have to take in consideration all the people around her and the influence that they have on her, and sometimes you actually have to bring them into counselling, to get them on board in order for this person to do that which you feel needs to be done'. Roberta, Corporate agency, Uganda

A justification for including others was that the family, and not the counsellor, had ultimate responsibility for the client.

'Family support system - we always make sure that the client doesn't depend on us. We remove that dependency by making sure this client is linked more to the sisters, more to the friends, and for other organisations surrounding'. Rose, NGO, Uganda

A clear example of the collective nature of Ugandan counselling is seen in the therapeutic response to a fatal school fire. The psychological debriefing sessions took the form of group counselling, and were open to anyone who considered themselves to be affected by the deaths. A wide range of disparate groups of people sought help:

'The group, we have divided ourselves in groups and we are looking in particular categories. There are those parents who have lost children, there are those parents who have children who were staying in the same dormitory, there are those parents who have children who are staying in the same school who have witnessed. Then the others, the teachers, the relatives like the siblings and the children themselves, who are the survivors. We shall put them in groups and talk to them and try to debrief them. We cannot actually counsel them individually'. Jane, Private practice, Uganda

In each of these sessions, parents were welcome to attend with their children. (I was also involved in the Junior B initiative and noted the wide range of people who came for help – see Appendix F.)

Ugandan life is characterised by lack of freedom of choice, and the locus of control is external. Consequently, it is deemed necessary that decisions are made with the explicit involvement of other significant people in the life of the client. Here, networks of interdependent relationships were explicitly acknowledged; the goal of Ugandan informants was to reintegrate clients into the collective order and to restore their relationships, through a counselling process which was shared with others. The maintenance of these core traditional values are reflected by Eisenbruch (1984b), who, in exploring the impact of modern technologies on 'traditional' societies, suggests that whilst Western technologies may be incorporated into procedures, the deep value systems and belief systems remain intact.

In NI, however, informants had a very different view of who should be included in a counselling session. Here, counselling was almost exclusively offered to individuals in isolation from their families. Where other people in a family were impacted by the death, they were most often referred on to another organisation or counsellor.

'Quite often, if there have been children involved, we would have referred them to the Family Support Worker in the [name of organisation] so she will follow

up with the children, whereas we will work with the adults. No, generally (I work) with the individual who I've been seeing or has referred themselves. We wouldn't bring in other family members at that stage'. Debra, Statutory agency, NI

'I suppose if there were other people struggling that the person felt they might benefit, I would say to them would they apply for counselling and let them see a different counsellor. Just because sometimes I think that's better that the person I'm dealing with has that space on their own. I haven't had a reason to do otherwise up to this point'. Sarah, Voluntary agency, NI

An informant in NI stated that it would be unacceptable in her organisation to work with members of the same family together:

'I don't think I'm supposed to work with a family as such, as in family intervention, because the manager here would say that if a child sees me working with the mum then I'll lose the trust of the child'. Helen, Voluntary agency, NI

There were, however, exceptions to this; four NI informants described working with more than one individual in a session. However these informants acknowledged that this was the exception within their own practice and agency.

The individualised nature of counselling in NI is, ironically, best seen in the descriptions NI informants offered of group-work; here, bereavement support groups for parents and children were provided separately:

'We also run bereavement groups for children with a concurrent group for the parent or the grandparent who's caring for all that. So the children's' group is around issues of their bereavement, the parent or guardian group is really around what it's like to be parenting bereaved children'. Patsy, Hospice, NI

This dynamic has been reflected in my own counselling practice in NI and Uganda. In the former, the tendency has been to see individual clients on their own; in the latter, family members were often included in the counselling sessions (Appendices F and G). In NI, intrapersonal concerns predominate in counselling sessions and, although relational issues are addressed, individual clients are coached to negotiate these relationships outside the counselling room. The informants perceived their clients as

autonomous individuals and consequently counselled individuals in isolation from others. They did not appear to engage the interdependency networks of which their clients were a part.

10.2 Counselling Practice: Presenting Problems and Counsellor Interventions

In both settings, informants were asked if their clients presented with spiritual, emotional, financial, and relational issues. Whilst identifying these factors, informants suggested that clients also presented with behavioural and physical issues (Table 12).

Table 12: Informant perceptions: presenting problems brought by clients

Major Theme	Subsidiary Themes	
	Uganda	Northern Ireland
Financial	Prominent issue.	Limited reference.
Behavioural	Limited reference to behavioural issues.	Drinking, disengaging, not sleeping or eating; no routine; not fitting in any more.
Physical	Limited reference. One somatic reaction identified.	Symptoms of anxiety, headaches and backache.
Relational	Importance of relationships emphasised. Strong sense of needing to belong.	Importance of relationships emphasised. Problems related to enmeshed relationships, or unresolved conflicts.
Emotional	Social practices limit emotional expression. Counsellors encourage emotional expression. Anger, shame identified.	Repression of emotions outside counselling. Counsellors contain emotional expression. Anger, guilt identified.
Spiritual: making sense of the loss	‘Why’ question common; need to apportion blame. Collective, syncretistic belief system which includes witchcraft.	‘Why’ question common. Christian belief system, individually determined.

Considerable variation was identified in the perceived importance of these problems, although emotional and spiritual issues were emphasised in both settings. Such variation is in line with the DPM, which predicts that patterns of adjustment, and the extent of changed life circumstances, will vary across social contexts (Stroebe & Schut, 1998).

10.2.1 Financial Issues

Counselling theorists with Western backgrounds have typically focused on emotional issues, and not taken into account the secondary adjustments that need to be made following a loss (Hansson & Stroebe, 2007; Stroebe & Schut, 1999).

In the present study, NI informants seldom mentioned secondary losses. However, in Uganda, secondary losses and, in particular, financial losses were commonly seen as a fundamental problem.

‘At [name of AIDS hospital], those who have money hide the pain. The poverty sometimes lets the pain show. If they have this and this then the only remaining problem is fighting the disease. In Uganda, if you wake up sick and have money to go to hospital, and you call your friend Mary and you chat. You rarely find a man in depression. But if you wake up and have no money to go to the hospital, and no one to talk to, then everything becomes worse. That’s the way our culture is’. Martha, Private practice, Uganda

Sylvia’s account, of children bereaved through the activities of the LRA, is particularly poignant:

‘In northern Uganda, grief counselling tends to focus on the financial problems, a child might say, “If my mother had been alive then I would have had my school fees” at other times the sadness can be the focus’. Sylvia, NGO, Uganda

10.2.2 Behavioural Issues

In NI, informants suggested that some clients sought counselling because they were no longer able to complete their normal routines, were drinking too much, or isolating themselves. A typical scenario is that the bereaved individual is:

‘Barely functioning, struggling to get up, to get washed and dressed, experiencing a lot of emotional distress, and just struggling to do ordinary basic things’ ... ‘or feeling that they are going mad’. Verona, Statutory agency, NI

However, Ugandan informants seldom discussed behavioural issues, and made very limited references to how grief impacted daily functioning. It is possible that, despite their loss, bereaved individuals in Uganda may have no alternative but to remain economically active to ensure their own survival.

10.2.3 Physical Symptoms

Three NI informants identified physical symptoms in their clients, including anxiety, headaches and backache. Here, Maureen is equating the physical responses in someone bereaved by suicide to the physical trauma caused by a car accident:

‘Look, if you had been in a car crash and had severe physical trauma to your physical body’ ‘You need to learn to walk again, you need to learn to work again, you need to learn to live again. This bereavement is the same, but only you can see it’. Maureen, Voluntary agency, NI

Only one informant in Uganda, an expatriate, identified physical symptoms; this was understood as a somatic reaction to loss.

10.2.4 Relational Issues

Informants in both settings indicated that clients presented with relational issues.

‘I would say because most of our cultural is relational. In most of the cultures here, relationships are so, so vital and, even when you are poor, the relationships are very strong’. Thelma, Private practice, Uganda

‘Always relational issues, I’ve never had a case, grief-centered or bereavement without relational issues’. Wilma, Independent agency, NI

In Uganda, the focus was on needing to be accepted, and acceptable, within the community. However, informants in NI were more likely to describe conflicts and difficulties within their relationships, and to discuss how these impacted the grieving process. (This finding is addressed more fully in Chapter 9, Section 9.3).

10.2.5 Emotional Issues

In both settings, emotional issues were identified as a common presenting problem and as a key focus of counselling intervention, with informants describing the opportunity for emotional expression as a core therapeutic benefit. Ugandan informants suggested

that bereavement counselling offered clients a unique opportunity to express emotion which was otherwise socially unacceptable. A central theme in Ugandan bereavement studies is that the expression of emotion is prohibited outside the mandatory grieving period (Fjermestad et al., 2008; Oleke et al., 2007; Sharpe, 1999; Withell, 2009). Ugandan informants in this study consistently referred to highly sanctioned rules around emotional expression, identifying a prevailing attitude among bereaved individuals that they should hide their emotions. Thus, people needed to be resilient following a death, and assume that they would learn to cope so that, eventually, they would get over it.

'That's not so easy for this culture, you know, when they are in pain, when they are hurting, their culture is to swallow the pains. We don't talk about it, we don't openly share'. Lucy, Expatriate counsellor, Uganda

'They [Ugandans] don't even know they have emotional needs. "If I am depressed and I am over-sleeping, that means that I am lazy"'. Sandra, NGO, Uganda

There is no place to express emotion outside restricted and time-limited rituals where intense public expression is promoted and then denied.

'Before coming for counselling, people will not have been listened to, allowed to be themselves, to express any emotion'. Thelma, Private practice, Uganda

Thelma, an informant who had lived outside Uganda, goes on to suggest that Western models of counselling do not fit Ugandan norms and mores because of the embargo on emotional expression.

'Grief is not easily expressed the way I think it is done in the West, where it is normal to grieve, where it is more acceptable. But, in most of our cultures, there are some people who are, "You shouldn't grieve. You shouldn't show, like you are not strong"'. Thelma, Private practice, Uganda

Seven Ugandan informants stated that clients did express emotion in the counselling session but did not feel they had the right to; they felt embarrassed by their grief and apologised for it.

'When they begin to talk about their grief, the bereaved, they become emotional. Then they apologise as though it is something that shouldn't be happening. For

me, I say it is just to make them comfortable, to let them know that it is very OK, it is very alright to grieve, it is very all right to cry for a loved one who has left you. It is not pretence. It is also what you are feeling. So it is to be genuine with yourself, and to be genuine with what you are feeling inside. When you do that you see people begin to say: "Are you sure, is that OK? No-one has told me this that it is OK"'. Priscilla, NGO, Uganda

Four other informants stated that clients found it difficult to express emotion in the counselling session, and were more likely to become silent when upset.

'Those who like get to know their (HIV) status and they are surprised, and you are in a session and you can see a person expressing anger on the face. Some go to the extent of talking. Some even cry. Then some of them even stop to communicate with you until when? After some time they can resume'. Clarissa, Hospice, Uganda

Clients may feel relieved to be allowed to express emotions.

"Already I feel a relief. I don't know why they stopped me from being myself but now I can be myself now"'. Thelma, Private practice, Uganda

There was also evidence of a surge of emotional expression, when this was permitted.

'When the man went out' ... 'in our culture the wives are not free when they are there. So I said: "Madam, excuse me if you have anything to say". She cried, she shouted saying anything you can think of, crying, crying, holding me'. Martha, Private practice, Uganda

Ugandan informants in this study, perhaps drawing on a Western imported model of the psyche, encouraged their clients to express their individual feelings. Some clients resisted whilst others did express emotions freely or gave in to their counsellor's encouragements to express emotion. Consequently, there was evidence of a flood of unprocessed feeling. This appeared to overwhelm the counsellor in some cases. The counsellors then appealed to the duties of the collective life and clients' responsibilities of role and position within their community. Thus, the external repression of strong impulsive emotions appears to be temporarily reversed within the counselling process.

In addition to the general expression of sadness, the most common emotion discussed was that of anger, noted by the majority of Ugandan informants. Anger was particularly associated with multiple losses:

'I think it reaches a stage when all those stages are replaced with one, anger, anger'. ... 'You could image this person is going through all the processes but then it becomes frequent, and those who are dying becomes more and more over distant relatives, I think that is replaced by anger, a lot of it'. Lynn, Private practice, Uganda

The expression of anger was also prohibited in day-to-day life.

'I mean you are not allowed to be angry with God, you are not allowed to be angry with the person who has infected you with HIV AIDS and then died. No one gives you that permission in the community to even say, to even think it'. Roberta, Corporate agency, Uganda

Roberta suggested that anger is given expression in counselling.

'You are allowed to cry, you are allowed to feel angry. "I am angry because my husband was a full supporter and now he is dead. I am angry with him, I am angry with God". So in the counselling room, in the end, they are allowed to do that'. Roberta, Corporate agency, Uganda

The predominance of anger has been highlighted in other Ugandan-based studies (Sharpe, 1999). Within the staged models of grief, anger is presented as an inevitable and healthy stage of the grieving process. However, the need for repression that comes with multiple deaths and the interruption to normal grieving processes may lead bereaved individuals to remain at the stages of denial and anger (Ornstein, 2010). This dynamic has been particularly identified with HIV-related deaths (Demmer, 2007).

Several informants also noted their clients' expression of fear and shame. Most often this related to the fear of dying as a result of AIDS, along with a sense of shame associated with the illness.

'Children who are saying: "Imagine I am infected and I am innocent". We are getting a number who are born with it. "What did I do? I have this deadly

disease, there is a lot of stigma attached, why should I go through all this?’’

Thelma, Private practice, Uganda

‘They would fear being associated with people having AIDS’ ... ‘even the being associated with that family because they thought it was like a sin. Having HIV was a sin and you are a sinner and you are immoral’. Rose, Hospice, Uganda

Shame can be understood as the fear of social degradation, in which one’s perceived inappropriate behaviour will cause others to disapprove (Giddens, 1991). In structurally simple settings, where the locus of control is external, shame is likely to be a more common emotion than guilt as the inappropriate behaviour violates an external rule. As a structurally undifferentiated society, a higher threshold of shame was anticipated in Uganda. However, feelings of shame were evident, particularly associated with HIV. These were strongly associated with the apparent violation of Christian moral standards around sexual behaviour.

Within NI, dealing with emotional expression was also identified as a central issue for many clients. NI informants also perceived that their clients’ belief systems and emotional dispositions prevented the free expression of emotion, although the reasons given for this were different to those in Uganda:

‘I suppose the key thing, a listening ear, and just somewhere safe to come and just vent whatever emotions. Strong emotions quite often are there, that they just haven’t anywhere else to release’. Debra, Statutory agency, NI

‘So I think having a place where you can talk, where that’s not hurting anyone. If you have a complex situation, it’s very difficult for a person to express how they really feel if they are in the role of carer still, or mother to children or whatever. It’s really important to have that space’. Niamh, Voluntary agency, NI

In NI, a range of emotions was noted, including feeling ‘*depressed*’, ‘*frightened*’, ‘*lost*’, ‘*disorientated*’ and experiencing ‘*deep sadness*’. Thus, the bereaved individual was said to be:

‘Thrown into a wilderness of overwhelming emotions and pain’. Orla, Independent sector, NI

The opportunity to express these emotions in a counselling session was seen as a key benefit of counselling as such opportunities were limited in day-to-day life.

'Quite often, the first session is purely them just getting that all out, a lot of tears and frustrations. And then helping them look at ways of coping with that, and turning that into something positive or productive rather than just inwards on themselves quite a lot of the time'. Debra, Statutory agency, NI

Here the role of the counsellor was to contain emotions which were freely expressed:

'Showing the client "I'm not shocked, I'm not overwhelmed, I can contain it."'
Jan, Statutory agency, NI

'There is definitely something, containment about holding, and almost this work or this process being a transitional object'. Ellen, Statutory agency, NI

Whilst the positive therapeutic effects of emotional expression have been challenged (Stroebe et al., 2005), bereavement counselling is widely seen as providing an opportunity to express feelings and to facilitate the alteration of client's accounts of their loss into a discourse of feelings (Árnason et al., 2004; Hockey, 1990; Walter, 1996). Contemporary Western society offers conflicting messages around emotional expression, which is required to be both expressed privately and restrained publically (Walter, 1999). Thus, the counselling context may provide a necessary space in which clients are free to express emotion. Elias & Dunning (1986) present the concept of the 'controlled decontrolling' of emotions, which might explain the Western counsellor's practice in facilitating emotional expression in the counselling session. Unlike Ugandan informants, NI informants did not seek to re-impose collective controls over their clients' grief, as a collectively imposed moral order is more limited in this society. Rather, public restraint resulted from internalised mechanisms to contain the display of emotions. Here, in keeping with other aspects of life, 'self-regulation' is common (Walter, 1999). Counsellors supported clients to process their grief reflectively and individually, in ways which were familiar to them.

Within NI, the majority of informants identified anger and guilt as the predominant emotions in their clients. Anger could be directed at God, at the family, nursing or medical staff, clergy, undertakers, or the deceased themselves.

'That is probably very, very normal for anybody who has had a loss or a death, to have the feelings of anger, guilt and regret'. Jan, Statutory agency, NI

Guilt was often associated with a concern felt by the client that they had failed the deceased.

'Guilt perhaps as well "Could I have done something else?", "Why didn't I notice?"'. Debra, Statutory agency, NI

'When people do come with grief, sometimes they're there because they can't grieve, and they feel guilty because the grief is overwhelming, and they feel guilt about that'. Wilma, Independent agency, NI

Guilt was associated with the termination of pregnancy, relief following a protracted illness prior to death and, in particular, suicide.

'Because it leaves behind a lot of guilt, anger, because people can't understand it'....'But suicide is one that there's no answers to, and it leaves so many unanswered questions of "Why?"....'For guilt is a big part of loss, of any bereavement'. Orla, Independent agency, NI

Bereaved individuals demonstrated a sense of responsibility for the well-being of their loved ones and felt a sense of guilt and failure in not having protected them from death. Guilt is perhaps a more common emotion in structurally complex settings, as an internalised and individual code has been violated (Elias, 1994a [1939]). It is important to note that how emotions are felt, expressed and understood varies across social configurations (Rosenblatt, 1997). Elias (1987b) suggests that the expression of emotions can only be understood within the context of an individual's connection to other people.

Within these interviews there was a significant focus on the emotional aspects of the loss. The common perceptions of a simple contrast between uninhibited emotional expression in African settings and repressed emotions in Westerns settings have not been borne out by these findings. Emotional expression is inhibited in both settings, with considerable differences in the forces and processes of inhibition. Ugandan informants confirmed that an intense expression of grief was exhibited by bereaved individuals; however, they also suggested that the expression of grief was subject to an externally validated grief process, in which a prescribed set of rules required emotional

expression and then prohibited it outside tight time-limited boundaries. Thus, in Uganda, it is the external forces of the social order that require intense but brief grieving, followed quickly by shutdown of emotional expression and resumption of prescribed roles. The driving forces of these processes are external to the individual. The time and space for grief-work is brief and externally disciplined. In Uganda, then, in line with Elias's (1987b) argument, emotional expression is motivated primarily by the requirements of social interdependence. However, this may appear to contradict a commonly held interpretation of figurational theory (Mennell, 1989), and will be addressed more fully in Chapter 11.

In NI, whilst emotional expression is also inhibited, the processes of inhibition differ from those in Uganda. Here, the 'conscience collective' is eroded, and there are few external, socially prescribed ceremonies through which grief-work can be channelled. The control of emotional expression is internalised, although this internalised self-control must adapt to a societal expectation of private grief and public control (Walter, 1999). Thus, bereaved individuals appear to be left adrift, with highly developed individualised reflective processes but with limited sources of public or private guidance in dealing with their emotional crisis, and limited time or space for grief-work, hence their need for professional counselling.

10.2.6 Spiritual Issues; Making Sense of the Loss

Finally, informants identified their clients' need to find a reason for the death of their loved ones. In both settings, in keeping with the findings of other studies (Davis et al., 2000), this need was expressed within a spiritual framework. However, informants' spiritual paradigms differed across settings, as did their responses to their clients' reflections. Neimeyer (1998) suggests that spirituality and religion play an important part in making sense of a loss. These spiritual narratives are based on pre-established and socially sanctioned meaning and as such will vary across belief systems, communities and families.

In Uganda, it was those deaths for which no-one could be found to blame which were seen as most difficult for clients to deal with:

'There are all kinds of griefs, most of the griefs we have handled are from HIV victims, or from accidents where you don't have anybody to blame, or from

these front-line in the Kony war, where you know that he was a soldier, he's at the front line, it was unfortunate. But this one, where your kid dies, she is young, innocent and you don't know the person who has done it and for what reason, really it's very hard, it's different'. Martha, Private practice, Uganda

Other research studies of Uganda, tell us that death must always be somebody's fault and is often associated with human malice (Seeley & Kajura, 1995). Most often, blame is associated with a belief in witchcraft where a neighbour or family member is said to have bewitched the deceased (Hooper, 1987). Witchcraft was also identified by eight Ugandan informants:

'Yes, witchcraft. Yes, in Africa most death is touched with that'. Martha, Private practice, Uganda

'We are groomed as wives to listen to your husband and not to go beyond him. So if your husband says, "I've been bewitched", even if your common sense you realise it is HIV, you won't come up because he will even tell you to leave his home and where will you go next'. Joyce, NGO, Uganda

Priscilla relates her work with an HIV positive client who stopped taking medication because of his belief in witchcraft:

'But, you know, during that time of sickness when he was bedridden ... Then he started saying that, this time, it is not HIV, it is witchcraft. And you know, I visited this guy and he said "So and so is bewitching me", and he got off the drugs and started using herbs. I talked and we discussed but you know he had already made up his mind'. Priscilla, NGO, Uganda

Priscilla then continued this story by describing the client's death from AIDS and the subsequent response of his widow.

'This woman started saying, "If it hadn't been for that neighbour, my husband would still be alive," although he had HIV. "It was the neighbour who bewitched him, this man". So problems started between the neighbour, and the neighbour was the immediate neighbour. She had to sell part of the land because it was so near the? The witch'. Priscilla, NGO, Uganda

Additionally, Ugandan clients believed in the influence of dead ancestors and evil spirits.

'Someone has cancer but they will think there are things they haven't done within the family, as in the culture to make them right, so that this person could live longer'. Clarissa, Hospice, Uganda

Informants also described their clients as having a core Christian belief, a belief which some of the informants also identified with.

'My experience with HIV people made me realise that someone who doesn't know that there is life after is very hard to deal with, or that there is a super being, a supernatural being that can take control of one's life, is not easy to counsel'. Priscilla, NGO, Uganda

Thus, a syncretistic belief system was identified in Uganda which integrated a belief in witchcraft and traditional religions with Christianity. This was also evident in my own counselling in Uganda (Appendix F) and is consistent with the findings of other Ugandan-based research in which bereaved children (Sharpe, 1999) and bereaved adults (Seeley & Kajura, 1995) knew that death resulted from an illness, understood in medical terms, but nonetheless suspected that the illness was initiated by the bewitching process. Similarly, in NI, clients' need to make sense of their loss was perceived as a key presenting problem. This was most often processed in religious terms; a strong spiritual element was evident here, with most clients described as having a loss of faith, or anger at God.

'If people come with a faith and a God, or Christianity, yeah they can come and sort of question that and be angry with God and find it difficult to even have a faith, or even lose their faith'. Colin, Voluntary agency, NI

'I think (people) are much more spiritually aware at the time of bereavement'.
Tanya, Independent agency, NI

In the following example, Debra is quoting a client who is questioning God:

“‘Why, God? Why me? If I had lived better for you, well maybe you wouldn't have let this happen.’” Debra, Statutory agency, NI

In NI, informants were somewhat speculative, encouraging their clients to accommodate the loss in their own terms, as opposed to the more prescriptive response in Uganda. NI informants did not identify any differences in the ways in which Catholic or Protestant clients made sense of their loss.

'Spiritual issues' ... 'it's a really big thing'. ... 'Because, at the end of the day, our role is very much about enabling people to find answers for themselves. We don't have answers anyway and it would be inappropriate to provide them. Actually, in my teaching that's the message I'm always giving to people. None of us have the answers'. Patsy, Hospice, NI

As suggested in the literature, some informants identified a broader concept of the 'spiritual' than the established Christian belief system (Draper et al., 2013; Holloway, 2007; Howarth, 2007a, 2007c; Neimeyer, 2001).

'They do try to make sense of it. I believe that all people have a spiritual base, not necessarily packaged in church and all that sort of thing. So I believe that all people have a spiritual base, a divine centre if you like and it's trying, for me sometimes, to source that and to work with that'. Kate, Voluntary agency, NI

NI informants identified the lack of a collective script within which to understand death alongside a spiritual belief system, thus suggesting that spiritual belief was individually negotiated. This concurs with Seale (1998), who suggests that counselling facilitates the development of a cultural script for managing grief.

To conclude, informants in both settings perceived that spiritual belief was an important factor in assisting their clients to adjust. Despite the secularisation of death and bereavement in increasingly humanistic societies, empirical findings suggest that faith remains an important factor in bereavement reactions (Agnew et al., 2008; Draper et al., 2013; Neimeyer, 2001; Walter, 1994). In both settings, many bereaved clients asked, "Why me?" in response to a loss, seeking answers to this question in the realm of the spiritual and expressing anger at God for failing to protect. In NI, clients addressed a personal God; in Uganda, clients also sought answers in witchcraft and animism.

Neimeyer's (1998) theory helps to explain why the counsellor's focus becomes that of restoring a sense of coherence in the life narratives of clients. However, Elias's (2001[1982]) figurational theory also offers a means of understanding the process of

how meaning making differs across settings. Understood within a figurational framework, the increasing structural complexity of societies has led to a rise in emotional-detachment, with increasing self-control; individuals increasingly detach themselves from death and ultimately formulate a theory or model to explain it. However, Elias also postulates a more nuanced version of meaning making. Thus, although Western societies often describe phenomena in scientific and objective terms, Elias maintains that magical thinking is still present as the fundamental condition of human experience. In complex societies, this magical thinking becomes submerged into the personality, arguably as evidenced in NI in the identification of guilt, blame and punishment from God. In Uganda, syncretistic belief systems might be assumed to reflect the continued vulnerability of individuals, as well as the more collective nature of this society. However, in a deviation from established communal practices, Ugandan informants referred to their attempts to promote a more rational response to the magical belief system of their clients.

10.3 Counselling Dynamics

Informants described the dynamics of the counselling relationship (Table 13). Counselling dynamics focused on the therapeutic relationship, confidentiality, transference and the extent to which the counsellor directed the client.

Table 13: Informant perceptions: dynamics of the counselling relationship

Major Theme	Subsidiary Themes	
	Uganda	Northern Ireland
Therapeutic relationship	Important factor.	Central factor.
Confidentiality	Not highly valued.	Key feature of counselling relationship.
Transference	Identified by informants. Observed in their descriptions of practice.	Identified by informants. Observed in their descriptions of practice.
The directive nature of counselling	Informants are directive in guiding clients.	Self-reflection is encouraged.

In both settings, the therapeutic relationship was identified as important.

'Nothing works unless you've built up a good relationship with that person'.

Averill, Statutory agency, NI

'The closer or warmer the relationship, the easier it becomes to see through the recovery'. Joyce, NGO, Uganda

The pivotal role of the therapeutic relationship in the counselling process, including bereavement interventions, has been identified in many other Western studies (Beresford, et al., 2008; Elliot & James, 1989). This supports Freud's (1905) emphasis on the central importance of creating a positive therapeutic relationship. However, in Uganda, only three informants described this as their first priority, perhaps reflecting the Ugandan counsellors' prioritising of guidance and direction. In NI, the majority of informants stated that the therapeutic relationship established between client and counsellor was the most important aspect of the bereavement support offered.

'I think the therapeutic relationship is one hundred percent important. I think all the knowledge goes out the window, if you don't have the ability to empathise'.

Wilma, Independent agency, NI

Two informants in NI noted that therapeutic relationships were not always easily developed, although they did not say why this was so.

'Sometimes you connect with people and sometimes you don't get it right, for whatever reason, you know'. Kate, Voluntary agency, NI

In Uganda, consistent with other African studies (Nwoye, 2000), informants noted boundary issues with clients, with difficulties incurred in seeking to impose professional boundaries. The UCA acknowledges similar issues; for example, clients' relatives and friends often approach counsellors informally and it is difficult to refuse to talk to them (Ochieng, 2006).

'Because here we maintain that professional relationship, we wouldn't like to get so close to the client that they are so familiar to us that will compromise on the service that we offer'. Priscilla, NGO, Uganda

Whilst informants in NI made limited reference to boundaries, the need to ensure confidentiality was frequently identified. However, Ugandan counsellors seldom

mentioned confidentiality. My experience was that the Ugandan research interviews were seldom private (Appendix F). This lack of confidentiality and privacy was also evident in my participant observation; for example, in the group counselling offered to victim's families following the school fire, television cameras were invited to record the introduction and plenary sessions (Appendix F). Roberta, a Ugandan informant, who had worked in America, suggested that a significant difference in counselling between America and Uganda was in the differential interpretations of confidentiality:

'You talk to one person at a time in America; in Uganda you can talk to several people at a go. Even here, when I am doing counselling, people come in and out and they don't even think about it. I am talking to someone, they are not supposed to be barging in like that, but that's Uganda. Or I am talking to Lorna right now and I am concentrating with her and someone says, "Roberta, Roberta, Roberta", so you take your eyes off Lorna and speak to this one and it is perfectly fine here, and it's not fine in America'. Roberta, Corporate agency, Uganda

Differences in how the self is conceived may explain the discrepancy between settings in terms of confidentiality. In Uganda, the concept of an individual self is limited and the locus of control is external; people tend to act and think alike, possessing a shared or collective consciousness. With a shared identity, there is arguably much less need for privacy and consequently less need to impose tight boundaries around engaging with one person at a time. In complex Western societies, people tend to see themselves as fundamentally independent and life is divided between private and public spheres; there is a stronger sense of an individual self and a much greater desire for a private life. In NI, like other Western societies, the right to a private family life is guarded in legislation (HMSO, 1998b).

Freud's (1923) core psychodynamic concepts of transference and countertransference were also identified by informants. In the following example, Rose, a Ugandan informant working in a hospice, highlights a potential transference and countertransference dynamic between herself and a child who had been bereaved:

Rose: 'So that's the child I've worked with on some close relationship although we try to detach ourselves not to be very close to them'.

Lorna: *'Why do you try to detach yourself?'*

Rose: *'It's too weary as a counsellor. As a counsellor, you can be burdened, you may get too close and take that child on the time of death or, if anything happened to him, you may get that emotional pain. That's one part; another one is the child may develop some transference like you are now the mother and so he will be always looking up to you'.* Rose, Hospice, Uganda

In the present study, the HIV status of informants was unknown, but other studies have shown that, in Uganda, a shared HIV status between counsellor and client contributes to countertransference (Crowley, 1995; Nefale, 2004).

Informants in NI also noted the possibility of transference and countertransference. At times, these were explicitly acknowledged and at other times implied. Patsy described her own response to a young bereaved woman for whom life now seemed pointless:

'There's real despair and real hopelessness and actually it's really something I have to work hard against because you know how that communicates itself to you as a worker'. Patsy, Hospice, NI

Another example was given by Orla who described a similar case, where a client was *'stuck'*. Orla was perhaps less conscious of the dynamics of countertransference but it seemed to come through in her own sense of being stuck.

'She could not let go of that, so no matter how much we talked around it ... She just could not get away from the stuckness that she was not with him when he died'. ... 'I just felt completely and utterly helpless and hopeless. I think that was how she felt'. ... 'I just felt stuck with that client'. Orla, Independent agency, NI

Finally, differences were evident in the ways in which informants in either setting sought to help their clients. In NI, informants talked about promoting their clients' reflection and autonomy; however, Ugandan counsellors were more directive.

Ugandan informants talked about attempting to influence the belief system of their clients. Three informants described their role as one of *'demystifying the death'*, in effect, offering a rational response to irrational beliefs.

'Now, in cognitive, you are actually trying to help them to understand the facts surrounding the sickness, so that they outgrow that belief that it could be

witchcraft. I think you can reach those levels and shake the belief'. Jane, Private practice, Uganda

'Sometimes, during the counselling ... they would think you remove the myth in-between the death. What people believed probably may not be true and happened to lead to this death, you help them to come out of that and they cope'.

Clarissa, Hospice, Uganda

Arguably in keeping with a Westernised philosophy, some Ugandan informants encouraged clients to interpret sickness and death in scientific terms. Parkes (1996) suggests that a key task of mourning is for bereaved individuals to adjust their 'assumptive models' in light of their loss. Informants in both settings identified a disruption of clients' assumptive world views, affecting fundamental belief systems. In Uganda, it appears that the assumptive world views of clients are not shared by counsellors. Ugandan counsellors, trained in Western scientific models, appear to impose Westernised, scientific assumptive models on their client's magico-mythical belief systems.

Ugandan informants also presented a judgemental or moralistic response to clients, articulating a sense of responsibility for ensuring clients were thinking and behaving in socially appropriate ways.

'The suggestions help her as an individual to say, "No, this is not the right thing" or "This is a right thing". James, Private practice, Uganda

'But then he came back after some years and he told me, "Counsellor, you know I feel like killing myself, the woman is sick, the children are now also sick, I don't have a job, the little money I get I have to spend it on these people, I am also sick, what am I going to do?"'. They were all positive. I told him that, "You know we discussed all that. Now, how do you feel after seeing all those people, those four people are all suffering because of you, because you knew very well that you were HIV-positive"'. Priscilla, NGO, Uganda

Ugandan informants also sought to influence various aspects of their clients' lives. Joyce describes how she challenged a young widow to make the most of her resources, suggesting that she sell her mobile phone and buy a 'phone booth', which could be used as a business.

“Have you ever thought of selling off that phone and get some capital and do something which earns you an income?” “But I have to get in touch with some people”. I said, “People like who? Can’t you use a phone booth and ring somebody.” “I will see, but.” Then I told her, “What if we have this idea you sell off this phone and buy this phone booth.”’ Joyce, NGO, Uganda

In another example, Martha persuades her client to stick with her marriage vows following the client’s discovery that her husband was HIV-positive:

‘So I said “Madam, were you wedded in the church?” and she said “Yes”. “Me, I am also wedded in the church, you can see my ring”. I said, “Do you know, when you stand at the altar, those vows that you make; in poverty and riches, in sickness and health, in death do us part?”. I said, “Mama, this is the time”. She stopped crying and looked me in the face, you know those expressions we see in the counselling rooms. She said “My daughter, you have counselled me today, let me go and make a home”. That cleansed all her anger and it was not pretence. After one week, they were coming back to see if the drugs are OK. The man came into the room and said, “Oh my daughter, what did you do to your mother? She came home a different woman”’. Martha, Private practice, Uganda

This last account also highlights how both the client and the counsellor are prescribed positions and labels in society. The younger woman, the counsellor, is referred to as the daughter, the older woman is referred to as the mother, despite the absence of any familial relationship. Kohn (1977) suggests that families and societies can be categorised according to whether the patterns of social arrangements are person-oriented or position-oriented. In the former, boundaries are flexible, and communication is based on a person’s needs rather than their position in the family, as in NI. In the latter, there are clearly defined boundaries, which designate family roles based on status, social identities, age and sex, as in Uganda. Littlejohn (2002) identifies differences between a closed-role system and an open-role system. In the former, roles are set and people act according to these roles, as in Uganda; in this study, Ugandan informants appeared to direct people to behave in socially prescribed ways, according to their roles and responsibilities. In an open-role society, roles are more fluid and flexible, as in NI.

Several Ugandan informants described their clients as being under a wider system of community control. Here, Martha is discussing the concerns of clients who are HIV-positive, and the authoritative role that the community elders will take in response to this diagnosis:

'Maybe social stigma, that also is a concern of our clients. "Maybe they will see me with a skin rash, they will see me losing weight. How am I going to take these drugs? Maybe my elders will question me. Why I am not breast-feeding this child?" All those concerns are there'. Martha, Private practice, Uganda

Ugandan informants also referred to themselves as part of a system of accountability and control in which they did not have autonomy to make independent decisions about their clients.

'I still need to consult, I can't make my decision as, compared to the West, you work with that person, they know what they want, they make their own decision, life goes on'. Roberta, Corporate agency, Uganda

Thus, to a large degree, Ugandan bereavement counsellors described a directive and somewhat controlling style in their counselling interactions. In contrast, NI bereavement counsellors presented a much less directive approach, talking about empowering their clients to work out their issues according to their own sets of beliefs and values. They described their role as facilitating a reflexive narrative, by providing tools in which clients can work through their own problems without reference to an external standard. In this context, bereavement counselling sought to protect and develop individualised biographical narratives.

'I suppose everybody's bereavement is very unique to them and how they cope with it'. Averill, Statutory agency, NI

'It's not always black and white but it is often what they feel, and we do that in their psycho-education bit, "This is about your journey and your journey will be individual to you"'. Wilma, Independent agency, NI

'The goal, I suppose, is to be there for them as a means of support in the early days, and to equip them maybe with the tools to move on, and as best they can maybe to deal with difficult emotions they've had, like anger, regret, guilt — to

deal with that effectively, to enable them to move, not to be stuck'. Debra,
Statutory agency, NI

However, it should be noted that, the degree to which bereavement counsellors contribute to the development of such narratives in an interactive way is subject to debate (Hockey, 1990). Bereavement counselling arguably remains in some respects a device for meaning production (Árnason & Hafsteinsson, 2003). Nevertheless, in NI, relative to Uganda, there is clearly much less direction, and an attempt to transfer power to the client. These differences between NI and Uganda could be associated with differences in the level of psychologising that were evident when informants discussed the personal impact of their work (Chapter 8, Section 8.4). Mennell (1992) suggests that psychologising is less a matter of judging or censuring, and more one of considering a situation from all angles; it can be contrasted with a moralising response, which, in fact, was observed among Ugandan informants. A greater tendency towards psychologisation, as in NI, is deemed to lead to greater mutual identification. Ugandan informants were more likely to respond to their clients in unqualified terms; clients' behaviours were seen as good or bad, and their expressed responses to clients appeared at times to be unrestrained and judgmental.

By comparison, in NI, informants offered much more reflective, nuanced responses, in which they talked about 'empowering' individuals to adjust to a new life by addressing emotional issues relating to loss.

10.4 Reflective summary: Bereavement Counselling

Perhaps the key difference in my personal counselling practice in NI and Uganda related to the extent to which I adopted an individualistic or collectivist approach to counselling. In NI, I offered bereavement counselling only to individuals on a one-to-one basis, whilst in Uganda I seldom counselled an individual in isolation from his or her family. This is highlighted in my journal account of counselling Family B:

'The parents attended with their five remaining children aged 11, 10, 6, 5 and 2. The family expected to be seen together, but during sessions I would also ask to see subgroups of the family: parents together, older children together'. LM:
Journal entry: Family B: Appendix F

In NI, in my voluntary sector counselling role, I found that clients did not present with Troubles-related issues, nor did my counselling clients in Uganda include victims of armed conflict. In NI, clients often presented with a predominant focus on relational issues, referring to enmeshed relationships, or unresolved conflicts with the deceased. Secondary losses, such as dealing with financial difficulties were not prominent. In NI, my clients tended to express emotions freely and I was conscious of a need to contain these emotions. In Uganda, clients appeared to repress their emotions; as noted in my interview responses:

'One thing that struck me very forcefully in Uganda was what appears to be, a lack of emotional expression. Often, I knew people were very upset, both in counselling and in other contexts, and they just did not show it. Blank faces; perhaps I would use the words 'emotionally blunted'. LM: Personal response to interview questions

This lack of emotional expression was identified in my journal accounts of Family A:

Mrs A spoke little; she appeared to express her sadness through silence. She did not cry but, when pushed described deep sadness at the loss of her daughter and regret at having left her baby with a girl who did not seek help when needed. LM: Journal entry: Family A: Appendix F

In both NI and Uganda, a key aspect of counselling related to clients' need to find a reason for the death of their loved one. In NI, clients often tried to make sense of the death within a spiritual paradigm. In Uganda, this was often understood through a dual belief in Christian faith and magical thinking. For example, whilst Family A described an overt Christian faith, the fear of being seen to be cursed was a major difficulty.

She stated that the worst thing for her was the perception of the village that the death was the result of a curse on her family and that she did not do enough to save her daughter. LM: Journal entry: Family A: Appendix F

Reflecting on the dynamics of the counselling relationship, I was aware that the nature of the relationship differed in NI and Uganda. In both settings, I established boundaries around confidentiality, adopting a Western approach to maintaining a strictly private and confidential environment. However, in my reflective journal, I have noted a very

different boundary for the psychological debriefing session which followed the school fire:

No privacy for parents: given label, placed in categories, which were visible from their label. Paraded in front of the media. LM: Journal entry: Psychological debrief: Appendix F

Whilst I remained largely non-directive in my counselling across both settings, I also noted a strong directive response from Ugandan counsellors during the psychological debrief.

Judgemental attitudes were expressed by my co-facilitator. For example, in relation to anxieties expressed by a parent about the school my co-facilitator responded: 'Why didn't you take the children out'. LM: Journal entry: Psychological debrief: Appendix F

This conflicted with my own counselling style which was non-directive and sought to be non-judgemental.

10.5 Conclusion

Similarities and differences have been identified between NI and Uganda in the informants' perceptions of their counselling practice. These have been presented in this chapter in relation to three overlapping themes: the counselling routines, the presenting problems and counsellor interventions, and the dynamic aspects of the counselling process.

Many similarities in counselling routines were noted. These may be explained as a consequence of Ugandan counsellors using imported individualistic Western counselling models.

Similarities and differences in the presenting problems and counsellor interventions highlighted a number of issues which have been evident throughout this study. In each setting, clients appeared to seek specialist help for terrorist-related deaths.

Ugandan informants highlighted the collective nature of Ugandan life, which requires that the processing of loss must be done in ways that maintain the stability of external social structures. In NI, intrapersonal issues predominate and counselling is offered in

ways that support the negotiation of an individualised narrative of loss (Seale, 1998). In each setting, the balance between loss-orientated and restoration-orientated stressors varied according to the demands of particular social practices and belief systems (Stroebe & Schut, 2010). Thus, in Uganda, where bereaved individuals must quickly re-engage with their responsibilities (Maasdorp & Martin, 2009), it appears that restoration-orientated features of grief, such as re-establishing the role of the breadwinner, were more prominent.

Differences were also identified between the two societies in emotional expression. It was arguably anticipated that bereaved individuals in Uganda would experience freedom in emotional expression, while emotional repression would be evident in NI. However, this expectation was not supported by the findings of this study, since informants in both settings acknowledged inhibition of emotional expression. However, striking differences were identified in the nature of this inhibition. In Uganda, powerful normative expectations and social forces require intense, brief and highly emotional grieving, followed by emotional repression and resumption of roles. This process is externally disciplined. In NI, whilst emotional expression is also inhibited, this is achieved through internalised self-control; there are limited sources of external guidance for dealing with loss and limited social space or time for grief-work. In figurational terms, emotional expression in either setting appears to be shaped by the requirements of individuals' social interdependency networks.

Similarities and differences were also noted in the counselling dynamics, with differences noted in the level of direction offered by counsellors to clients. In Uganda, informants sought to guide clients in the 'right' way of doing things. In contrast, NI informants facilitated a reflective narrative to enable clients to work through their own problems. Elias's theory would associate these different levels of psychologising with the structural complexity of each setting. Finally, Freud's (1923) psychodynamic theory was employed to identify and explore the transference dynamic identified in both settings.

Whilst Elias's theory does not necessarily address the full range of similarities and differences found between NI and Uganda in relation to the practice of bereavement counselling, its emphasis on both the relational nature of social life, and its processual character, offer a foundational framework for interpreting the identified national

variations in death and bereavement practices. The comparative suitability of Eliasian, and Freudian and post-Freudian, theory to account for the findings of this study will be discussed more fully in the following chapter.

Chapter 11 Discussion and Conclusions

This final chapter returns to the key aim of the study. It begins with a summary of the research findings. Similarities and differences in the two settings are presented as responses to the four research sub-questions posed at the outset of the project. Following this, the contrasting ideal-type dimensions of death and dying outlined in Chapter 3 are revisited, and the ways in which counsellors' perceptions confirm or challenge these will be identified. Some reflections are then offered on how these findings, and their conceptual analysis, contribute to an understanding of Freudian and Eliasian theory. From this discussion a contribution will be made to enrich the counselling practises in Uganda and NI, and within pluralistic societies. The chapter will conclude with a discussion of limitations of the study and suggestions for further research.

11.1 The Research Questions

This study's overarching research question asked: 'What are the similarities and differences in the practice of bereavement counselling in NI and Uganda, as perceived by the counsellors in both settings?'. The four subsidiary research questions were:

1. What are the similarities and differences in the context of bereavement counselling in NI and in Uganda?
2. What are the similarities and differences in the characteristics of counsellors as represented by the informants in both settings?
3. What are the similarities and differences in the bereaved individuals who seek counselling in NI and Uganda, as perceived by the informants in both settings?
4. What constitutes the practice of bereavement counselling in NI and Uganda, as perceived by the informants in both settings?

A summary of the findings in relation to these subsidiary questions is presented below.

11.2 The Context of Bereavement Counselling: An Overview of Findings

Similarities and differences were identified in the wider societal context (see chapter section 7.1) and in the local community contexts (7.2) of counselling practice; these were interpreted in terms of the differences in the complexity of global, local and domestic figurations. In terms of the wider societal context, it was found that counselling in both settings had evolved from supportive networks within families and communities, to become a distinct occupation with a claim to professional status. There were observable differences between settings in the organisation of bereavement counselling provision. Counselling services in NI are offered from within a highly differentiated workforce, subject to an extensive policy framework, with many bureaucratic structures, and an ethos of accountability and governance. In contrast, Ugandan counselling organisations are much less differentiated, with few specialisms and fewer bureaucratic structures.

Informants in both settings commented on some of their countries' macro-societal characteristics. References were made to the legacy of religious war in each setting, although these references were limited in NI (9.1 & 10.2). Religious belief was discussed in both settings, although in NI discussion of the impact of the religious divide was surprisingly minimal (10.2).

Informants also discussed local domestic figurations, with a particular focus on the family or community response to bereaved individuals (7.2). In Uganda, emphasis was placed on the collective nature of life, with continual declarations by informants that people '*belong*' to their communities, that you cannot be '*whole*' unless in relationship with others. Individuals' connections to family, clan and community were pivotal. Death was integrated into day-to-day life. The community made provision for supporting its bereaved families, with strictly imposed rituals establishing the appropriate behaviour following a death. However, Uganda was presented as a society in transition, in which communities increasingly did not have the time or resources to offer support. Informants claimed that modern ways of life were failing its people and, as community support declined, the need for professional interventions was becoming established (7.2).

In NI, informants described a more individualistic society than Uganda. Here, families often found it difficult to support their bereaved loved ones as grief was seen as unique

to the individual, processed through individualised responses (7.2). Counsellors provided the space and support to enable their bereaved clients to process this grief.

These core differences, in which the individualism of NI contrasts with the collectivism of Uganda, appeared to underpin many of the other findings.

11.3 Characteristics of Bereavement Counsellors: An Overview of Findings

Differences and similarities in the habitus of bereavement counsellors were identified in NI and Uganda. Many demographic characteristics of bereavement counsellors were similar (8.1) and they identified similar motivations for engaging in bereavement work (8.2). Similarities were also identified in the personal impact of working with bereaved individuals, although strategies for managing this impact varied across settings; NI counsellors were more reflective, displaying much higher levels of emotional detachment, while Ugandan counsellors appeared to have a more subjective and involved emotional response.

Informants in both settings were aware of similar counselling models, as these were taught in counselling courses in both NI and Uganda (8.5). In keeping with findings from other studies (Payne et al., 2002), eclectic approaches to counselling were most commonly adopted. The majority of Ugandan informants did not identify any concerns around the use of Western counselling models, although such concerns have been highlighted in the literature (Arulmani, 2007). Theoretical rigour and conceptual purity were not high on the professional agendas of counsellors in either setting. Informants adopted a pragmatic, eclectic and practical approach in coping with the pressing challenges presented by their clients. They relied upon a body of underlying beliefs which were derived from the discourse originally generated by Freud, but they did not make reference to Freud in interviews. The intellectual roots of their professional practices appeared to be of limited concern to them. They worked with concepts of the self that highlighted intra-psychic factors, a generalised notion of grief work and a belief in the therapeutic value of the counsellor-client dyad.

Contrasting counselling goals were identified across settings (8.3). Ugandan informants often described themselves as holding a dual responsibility to support both the individual and the community; difficulties were interpreted as '*the community's responsibility*', success as '*the community's joy*'. In contrast, in NI, counsellors' goals

were always presented as meeting the needs of individual clients. This was often described as improving clients' quality of life through '*empowering*' them to '*move on*'. There were few references to the individual re-negotiation of self by Ugandan informants, and no references to supporting the community by NI informants.

11.4 Characteristics of Clients: An Overview of Findings

In both settings, informants identified similarities and differences in the perceived habitus of bereaved clients. Clients were mostly women from a range of socioeconomic settings (9.1). Ugandan clients were representative of the large number of ethnic groups in that country. In NI, the majority of informants did not discuss the religious background of their clients, although a small minority noted that their services were offered to all individuals regardless of religious, cultural or political beliefs. A potential sectarian dynamic was identified only by the two informants who worked specifically with Troubles-related issues (9.1).

In both settings, in addition to the influence of the wider societal context (7.1), informants identified three broad factors which impacted the help-seeking behaviour of their clients: the nature of the bereavement; interpersonal or situational factors, such as family dynamics and material resources; and intrapersonal factors, such as predisposing vulnerabilities (9.3). These are similar to a range of factors identified by other writers (Hansson & Stroebe, 2007; Stroebe, W. & Schut, 2001). However, whilst these factors were broadly similar in Uganda and NI, different specific issues were highlighted in each setting.

In Uganda, informants highlighted the large number of deaths over the last 20 years, suggesting that, at times, the grieving process had been interrupted and people had become numb. References were also made to the impact of the AIDS pandemic and to violent deaths, for example, those attributed to the LRA. In NI, only two informants commented on terrorist-related deaths. Here, AIDS, although recognised as an issue in Western contexts (Howarth, 2007a), was not mentioned by informants, possibly due to the very low numbers of the NI population who have AIDS. In NI, bereaved individuals indicated a concern that death could have been avoided where '*life could have been saved*', suggesting a fundamental belief in the right to a long life, which was absent in Uganda.

Perhaps the most significant factor influencing help-seeking behaviour in both settings was considered to be the availability of family support (9.3). Strong family support was considered to make it much less likely that a bereaved individual would seek counselling. However, the character of preferred family support differed across the two settings. In Uganda, the expectations, roles and responsibilities of bereaved individuals were deemed to impact their grieving process. Here, the loss was defined, at least in part, as the loss of the contribution of that individual to the family's survival. Bereavement stressors were most often related to external factors, such as: poverty; cultural practices which, in particular, disempowered women; and roles and responsibilities within the family and community. In NI, interpersonal dynamics were most often cited as key, with the emotional aspects of familial relationships highlighted.

11.5 The Practice of Bereavement Counselling: An Overview of Findings

Some aspects of counselling practice were similar across settings. Informants in both settings described a traditional talking therapy which sought to facilitate the process of grief-work. However, informants' perception of counselling as either an individualistic or collective activity (10.1) had considerable influence on counselling practice. In Uganda, counsellors prioritised the repair of their clients' intense figurational networks, promoting connectedness to their communities. Working within these networks was a central and prominent feature of counselling practice. Counselling was not seen as a one-to-one activity. Instead counselling would always involve others, and in particular, the extended family. In contrast, in NI, one-to-one counselling was almost exclusively offered to individuals in isolation from their families. For bereavement counsellors in NI, intrapersonal concerns were the predominant focus, and although relational issues were addressed, individual clients were coached to negotiate these relationships outside the counselling arena. In my personal counselling practice I always offered one-to-one counselling in NI and always involved wider family members in Uganda.

The presenting problems brought by clients were similar across settings, and included a combination of spiritual, emotional, financial, relational, physical and behavioural issues (10.2). However, there was considerable variation in the importance of these problems. In NI, behavioural problems were highlighted, including an inability to complete normal routines and social isolation. Ugandan informants seldom discussed behavioural issues as, despite their loss, clients had no alternative but to remain

economically active, to ensure their own survival. However, Ugandan informants did emphasise financial concerns, where secondary losses related to poverty were commonly seen as the principal problem.

Informants in both settings acknowledged inhibition of emotional expression outside prescribed practices, but identified considerable differences in the role of local and domestic figurational networks. Ugandan informants presented an externally-validated grief process, characterised by a prescribed set of social rules which prohibited emotional expression outside tight, time-limited boundaries (7.2; 10.2). NI informants felt silenced by the relative absence of bereavement rituals and a collective script for processing their loss (7.2; 10.2). In NI, the control of emotional expression is internalised.

Whilst loss was widely processed in spiritual terms, spiritual paradigms differed across settings. In Uganda, a collective, syncretistic belief system was identified; this integrated a belief in witchcraft and traditional religions with Christianity (10.2). In NI, making sense of the loss was also most often processed in religious terms. A strong spiritual element was evident here, with many clients described as having a loss of faith or anger at God (10.2). However, NI respondents perceived little difference between Protestant and Catholic clients in this regard.

Informants also commented on the dynamics of the counselling interaction. The degree of client autonomy differed between settings, with a much more directive, authoritarian approach found among Ugandan informants (10.3). In contrast, informants in NI emphasised collaboration, seeking to empower clients to find their own solutions according to their own sets of beliefs and values. They described their role as facilitating a reflective narrative, by providing tools with which the client could work through their own problems, without reference to external standards (10.3).

The therapeutic relationship was seen as important in both settings. However, the need to ensure confidentiality and privacy represented a core value in NI but not in Uganda (10.3). The dynamics of transference and countertransference were highlighted in both settings (10.3).

These identified similarities and differences were interpreted within an overarching figurational framework, in which the habitus of bereavement counsellors and their

clients varied according the complexity of networked interdependencies, characteristic of each setting.

This discussion will now move on to revisit the seven comparative dimensions that were identified in the secondary literature, and to consider the ways in which the perceptions of counsellors in Uganda and NI confirm or challenge these key dimensions.

11.6 Application of Findings: Comparative Dimensions of Death and Dying

In Chapter 3, a set of seven broad dimensions which differentiated attitudes to, and experiences of, death and bereavement in contemporary Western and African societies was offered, taken from the secondary literature. These highlighted key differences in the manner in which death, grief and mourning were handled in different social contexts (McLeod, 2009; Stroebe & Schut, 1999; Valentine, 2009; Walter, 1999; Walter, 2012). Consideration is here given to the ways in which the perceptions of counsellors in Uganda and NI confirm or challenge these key dimensions, and how these dimensions might be associated with the informants' perceptions of their practice.

To a large extent, it appears that informants' perceptions are in line with the comparative characteristics of grief and bereavement management, summarised in Chapter 3 (Table 1). However, informants also highlighted challenges to these ideal-type portrayals.

The literature highlights that individualism and psychologising processes are characteristic of Western societies (Elias, 1994a [1939]; Giddens, 1991), and that, in African societies, belief systems require communal and family needs to take precedence over individual needs (Nwoye, 2000).

Perhaps the central theme in this study's findings, and one which strongly confirms this literature, has been the distinction discovered in the habitus and figural networks observed in the more communal social interdependencies characteristic of Uganda and the more individualised networks of NI. Informants in Uganda emphasised that they and their bereaved clients belonged to the community (7.2) and that the community was responsible for, and had made provision for, supporting its members following a death (7.2). In contrast, informants in NI presented bereaved individuals as autonomous, developing their self-concept through independent reflective processes (10.3). Grief was

seen to be unique to the individual; what was 'normal' was understood within the context of one's own experience (7.2; 10.3).

The usefulness of defining societies dichotomously, as either individualist or collectivist, has been debated; all societies are dynamic and to some degree diverse (Howarth, 2007a). The broad overview offered in this study cannot fully acknowledge cultural diversity within NI and Uganda, nor the dynamic nature of these societies. However, informants clearly identified the individualist and collectivist features of their respective societies as core factors which significantly shaped many of their clients' responses to death, and shaped their own counselling practice.

Differences were also highlighted in the negative impact of death in either setting, that is to say, as predominantly economic or predominantly emotional. Western grief is said to privilege the emotional aspects of loss (Hansson & Stroebe, 2007), whilst a combined economic and emotional focus is more prevalent in African settings (Nordanger, 2007). The findings of this study concur with the literature. Ugandan informants suggested that death was interpreted as a loss of the contribution of individuals to the functioning of their families, defining such contribution by role rather than relationship (9.3). Informants in NI focused on the complexity of family dynamics and how these impacted bereavement (9.3); loss was defined in emotional or relational terms with little reference to its economic or practical implications (10.2).

Distinctions were made in Table 1 in the length and intensity of mourning. In African settings, mourning is expected to be short and intensive, with public emotional expression validated within certain limits of time and space. In contrast, Western cultures are said to discourage the overt expression of emotion at funerals (Lovell et al., 1993; Rosenblatt, 1997; Rosenblatt et al., 1976), where quiet restraint is expected from bereaved individuals (Parkes et al., 1997; Walter, 2012).

Informants in NI and Uganda conformed to this literature. In NI, clients were perceived to be subject to social repression, in which, after a short period of permitted grief, there was a lack of freedom to discuss their loss or express their emotions outside the counselling environment. Additionally, there are limited channels of emotional expression in both public and private spheres of life; consequently, people, both bereaved and non-bereaved, struggle to know how to handle their grief (7.2). In Uganda, a short and intensive period of grief was identified. Mourning rituals were

presented by informants as encouraging freedom in emotional expression; during the wake, expressed emotion is required, which is usually loud and public (7.2). However, mourning was prohibited outside these restricted and time-limited rituals (7.2).

The Western-based bereavement literature characteristically makes unfavourable comparisons between the emotional repression evident in structurally complex societies, and the freedom in emotional expression thought to characterise structurally simple societies (Hockey, 1990). However, this common perception of a simple contrast does not match the present findings or those of other empirical studies (Atwine et al., 2005; Fjermestad et al., 2008; Oleke et al., 2007; Sharpe, 1999; Withell, 2009). Ugandan informants identified an embargo on emotional expression outside culturally-determined brief mourning periods, a finding which supports Walter's (1999) contention that the expression of grief is subject to more social control in non-Western than Western settings.

Differences were also identified in the belief systems through which death is understood. In African societies, illness and death are largely understood within a syncretistic framework incorporating magic and religious belief (Withell, 2009; Yamba, 1999). Death is often associated with human malice (Seeley & Kajura, 1995). This belief is particularly strong in response to the HIV pandemic, where HIV is said to be rooted in witchcraft (Hooper, 1987). Studies of Western societies suggest that bereaved individuals tend to process death through an individualised and secular framework (Rosenblatt, 1997; Walter, 1994) with a strong appeal to reason (Parkes, 2001). However, many grieving individuals will employ a spiritual narrative to make sense of death and dying (Agnew et al., 2008; Holloway, 2007; Howarth, 2007a; Kellehear, 2000).

Spiritual responses to loss were identified by informants in both NI and Uganda, but the nature of this spirituality differed fundamentally. Bereaved individuals in Uganda adopted a syncretistic belief system which included an appeal to witchcraft (10.2). This represented a much higher level of involvement (Elias, 1987a) within spiritual beliefs than found in NI. In NI death and bereavement had to be handled by each individual according to his or her own reflective processes; frequently, although not always, this was processed within a traditional Christian paradigm (10.2).

Distinctions in death narratives were also noted. Explanations for the death of a loved one may be associated with a collectively-imposed shared mythology or the lack of an agreed narrative (Davis et al., 2000; Douglas, 1963). Within communal African support networks, socially-sanctioned rituals around mourning and lamentation include a shared mythology for making sense of loss (Elias, 2001[1982]). Mourning rituals focus on the cohesion of the extended family, including continuity with ancestors. In the West, mourning rituals have tended to be replaced by discourse in which individual reflection and psychologising have become key to making sense of loss (Giddens, 1991). However, notwithstanding this individualism, the identification of domestic figurations conveys the continued significance of relationship networks in shaping bereaved individuals' responses to loss (Stanley & Wise, 2001).

In keeping with this literature, informants explained that Ugandan mourning rituals reinforce a syncretistic belief system, which is collectively imposed (10.2). In contrast, informants in NI suggested that there were no collective rules around the conduct of grief (7.2). Bereavement counsellors in NI suggested that making sense of the loss was autonomously determined by individual clients, although this was often understood within a broad spiritual paradigm (10.2).

The literature indicates that the concept of self, and, in particular, the degree of autonomy afforded to bereaved individuals, differs across societal contexts. In African settings, life is said to be characterised by the lack of individual freedom of choice, while social norms and authority structures impose behaviours which are reinforced through collective rituals and routines (Giddens, 1991). Following a death, prescribed rituals determine the appropriate behaviour for each person (Kilonzo & Hogan, 1999). In contrast, in Western settings, people are seen as autonomous individuals, in which self-identity has to be individually constructed (Dalal, 1998).

In this study Ugandan informants acknowledged their own authoritative practices, directing their clients to behave in particular ways (8.3; 10.3). They also identified a framework of authority within wider communities, governing both their practice as counsellors and the behaviour of their clients (10.3). However, bereavement counsellors in NI were less directive than those in Uganda. They suggested that a normal response to a death should be understood within the context of each client's own experience. Informants sought to empower their clients to develop a new life on their own terms

(8.3). Self-reflection was encouraged; clients developed their own individually-defined pathways through grief (10.3), placing self-imposed boundaries on emotional expression and behaviours (10.3).

Differences in grief sharing, seen through the visibility of death across societies, have also been highlighted in the literature. In Africa, death is said to be visible and integrated into day-to-day life (Middleton, 1987[1966]; Ochieng, 2010). Whilst the extent to which death is denied in Western settings is open to debate (Howarth, 2007a), compared with African societies, it is more likely to be denied and sequestered from public view (Elias, 2001[1982]).

Concurring with this literature, this study shows that, in Uganda, death is visible. People generally die at home surrounded by their families, with public, shared mourning rituals ensuring that death is incorporated into day-to-day life (7.2; 9.3). In contrast, in NI, bereavement counsellors perceived death to be sequestered from day-to-day life (7.2; 9.3). Deaths were more likely to occur in hospitals or other institutional settings. Bereaved clients were said to be silenced by a society which did not permit open discussion about death. NI informants presented the denial of death as characteristic of Western societies. From the foregoing review of these comparative dimensions, it appears that the literature concerning the beliefs, customs and experiences of death in Western and African settings were largely confirmed by the perceptions of bereavement counsellors in NI and Uganda. These beliefs underpin many of the similarities and differences observed in the characteristics of counsellors, clients and in bereavement counselling practices.

Freudian, post-Freudian and Elias theories will now be revisited, reflecting on the value of each in informing a comparative figurational analysis; where possible, broader insights into each theory will be offered.

11.7 The Heuristic Value of Freudian and Post-Freudian Theory

The utility of Freudian theory as an overarching framework for this study was considered. Whilst it was found to be limited in a number of important ways, it did contribute useful insights in understanding and explaining some of the findings.

Firstly, the counselling literature calls for the development of what is professionally known as ‘culturally appropriate’ counselling models (Arulmani, 2007; van Dyk &

Nefale, 2005). This literature suggests that Western models are unsuitable for non-Western settings (Bracken, 2002; Lago, 1996). Arguably, this present study goes further by elucidating the core principles which underpin Western bereavement counselling models, and critiquing their use in non-Western settings. This is achieved essentially through an examination of the influence and utility of Freudian theory. Freud laid down the principal conceptual framework of bereavement, and of counselling, within which subsequent theory and practice evolved. From Freud we have seen that Westernised bereavement counselling models are based on rational, scientific and medical concepts, which include the need for 'grief-work' as a necessary precondition for successfully negotiating a loss, and promote a Western, reflexive notion of the individualised self. These insights can contribute to the developing understanding of counselling across different settings, and will be further discussed in section 11.12 of this chapter.

Secondly, Freudian theory also provides insights into the dynamic aspects of counselling, aspects which were identified by informants in both settings. Freud stressed the importance of a strong therapeutic alliance, based on the client's realistic perceptions of the therapist, along with the transference relationship (Sandler et al., 1992). Whilst variations were noted in their understanding of the therapeutic relationship, informants in both settings acknowledged the therapeutic alliance to be a core aspect of the counselling process. Likewise, transference and countertransference dynamics were identified by informants in both NI and Uganda. It is widely agreed that transference is common in all forms of Western therapy (Sandler et al., 1992); the present findings suggest that this is the case in non-Western settings also. Given the differences in counselling practice identified in NI and Uganda – such as differences in the extent to which counsellors were directive or non-directive in their approach – it seems likely that the nature of transference dynamics will have varied in these two settings. This would suggest that transference is not a context-free process, but rather is embedded within a particular habitus.

Thirdly, Freud's core topographical model of the mind also provided a useful framework for interpreting informants' perceptions of their clients' behaviours. In this study, informants acknowledged the interaction of these three elements, id, ego and superego; for example, in discussing clients' feelings of anger, the constraints placed on these expressions of anger by a community's rules, and the mediating responses of clients in their attempts to conform to the expectations of others.

However, in spite of these useful insights, the usefulness of Freudian theory as an overarching framework was found to be limited in a number of important ways.

Essentially, Freud's universal psychodynamic model could not account for the impact of societal practices on grieving processes. Theorists have acknowledged the potential contradiction between, on the one hand, the emphasis Freud places on an entirely internal, instinct-driven and therefore universal psyche and, on the other hand, his awareness of external influences at least in part, specific to different social settings (Cavalletto, 2007; Dalal, 1998; Fromm, 1971; Hagman, 1995). Dalal concludes that Freud gives ontological priority to the individual over the external and to the biological over the social (Dalal, 1998). The present findings and ensuing discussion concur with this view. Freud theorises mourning as an entirely intra-psychic solitary process (Hagman, 1995) with no acknowledgement of the role played by external influences. Consequently, it has limited capacity to compare experiences of grief across settings.

Furthermore, whilst Freud has had a huge influence on the discourse in which bereavement counselling is based, informants in both NI and Uganda identified little or no awareness of Freudian theory. This lack of awareness was evident from their spoken understanding of grief processes and their preferred methods of intervention. Hagman suggests that the components of Freud's grief-work theory '*may appear so familiar and basic to us that they are beyond question*' (Hagman, 2001: 17). It is arguable that Freudian concepts are so deeply embedded in bereavement counselling practice that informants could no longer consciously attribute them to Freud. For example, generic Freudian concepts, such as transference dynamics, were identified by informants in this study without being attributed to Freud. Furthermore, Freudian methods have been heavily criticised in the counselling literature. The limited evidence for the efficacy of psychodynamic theory has encouraged service providers to favour other, empirically-validated treatments such as CBT and person-centred counselling (DHSSPS, 2010; Fonagy, 2003; NICE, 2011; Roth & Fonagy, 2005).

In response to these recognised limitations in psychotherapy, a range of other bereavement theories has emerged (Granek, 2010). These were reviewed earlier in this thesis and include other mid-century bereavement theorists, namely, Gorer, Lindemann, Bowlby and Parkes, more contemporary theorists, namely, Rubin and Malkinson, Hagman, Klass and Neimeyer, and the work of key theorists whose focus is on the area

of complicated grief, namely Prigerson and Jacobs, Holloway, and Doka. This review highlighted some key ways in which our understanding of bereavement and grief has undergone transformative change from Freud's original conception. Research evidence has not supported the notion of a trajectory of healthy grieving from distress to complete 'recovery', or a need to sever ties to lost loved ones, indicating that maintaining bonds with the deceased is a potentially healthy response to loss (Klass & Walter, 2001).

The work of these post-Freudian theorists provides insight into aspects of the findings of this study. Doka's (1999) theory of disenfranchised grief helps to explain the experiences of bereaved individuals whose expressions of grief, deviate from strictly-enforced societal norms. Niemeyer's (2001) concept of meaning reconstruction helps to clarify the prevalent need in both settings for bereaved individuals to make sense of their loss. Klass's continuing bonds theory helps to conceptualise informants' references to the ongoing relationship between bereaved individuals and their deceased loved ones (Klass et al., 1996; Klass & Walter, 2001). Prigerson and Jacob's (2001) and Holloway's (2006) accounts of traumatic and special deaths cast light on the ways in which informants conceptualised, and responded to, deaths in difficult situations, including suicide, armed political conflict and the AIDS pandemic.

A number of these theorists acknowledge that responses to loss vary according to the demands of particular social practices and belief systems (Doka, 1999; Klass et al., 1996; Neimeyer, 2001; Stroebe & Schut, 2001a). However, there remains a mismatch between these bodies of theory, which are still largely premised on assumptions of individuals as autonomous, individualistic and reflexive, and empirical findings of this and other studies which highlight collective and externally controlled grieving patterns in non-Western settings (Fjermestad et al., 2008; Rosenblatt, 2001; Turnbull, 1972). Thus, these theories have little to say about grief experiences in societies where there is less emphasis on an individualised ego, where the locus of control is external, and where bereavement practices are directed by others. Freudian and the post-Freudian discourse remains rooted in ethnocentric assumptions about the nature of the self and of bereavement. Moreover, the mechanisms through which societal norms influence grief reactions are not well articulated in these theories and lack a framework in which the relationship between structural features of societies and bereavement practices can be understood.

Arguably, therefore, neither Freudian nor post-Freudian theory offer a satisfactory conceptual framework to explain the present study's findings. Consequently, a different theoretical paradigm was needed which took account of the overarching social differences on mourning practices.

11.8 The Heuristic Value of Eliasian Theory

Elias's figurational theory offers a radical explanation of the reflexive relationship between social context and therapeutic interventions. It can therefore be used to address a significant limitation of contemporary counselling research (McLeod & Machin, 1998). The considerable differences identified here between NI and Uganda testifies to the significance of the wider societal context of counselling encounters. In this study, influences such as institutional features, and local community networks were identified. The relationship between these contextual features and the practice of counselling has been a core theme throughout this thesis. The strength of Elias's contribution is that he provides a conceptual framework which can be used to explain this relationship.

When applying figurational theory, these contextual features are not seen as reified entities. Rather Elias's theory helps us to see counsellors and clients as inseparable from their social worlds. The structures of the psyche and the structures of society were studied in conjunction with each other (van Krieken, 1998). Consequently, figurational dynamics reflexively shape the developing psyche of both clients and counsellors, and, ultimately, experiences of grief and the practice of bereavement counselling. Accordingly, differences in counsellor characteristics (for example, the different ways they manage their personal reactions to their work), in client characteristics (for example, their different reasons for seeking help) and in the counselling practice, can be understood as the outcome of variable global, local and domestic forms of figurational change.

Furthermore, by employing Eliasian theory it becomes possible to make connections between macro and micro elements of the findings, a necessary task when analysing comparative social research data (May, 2001). In linking habitus with figurations – or the micro factors at the level of the individual psyche with the macro development of societies – Elias offers an alternative interpretation to Freud of the nature of drives and their connection to external influences. Freud viewed mourning as universal; a process

in which the individual psyche comes to terms with loss, irrespective of time and place. In contrast, Elias emphasised the relational and processual nature of social life, arguing that long-term changes in the relations between individuals ultimately lead to changes in individuals' character and behaviour (Wouters, 2011). This conceptual framework is well suited to investigating bereavement experiences in diverse settings, offering, for example, explanations for differences in the management of emotion.

In particular, *On Human Beings and Their Emotions* (1987b), and Elias's (1987a) concept of 'involvement' and 'detachment', offers a framework within which these variable emotional responses can be understood. In the present study, counsellors in both settings acknowledged that they were emotionally impacted by their clients' experiences; however, they described very different responses to this. These differential responses can be understood to reflect differences in the habitus of informants observed in their differential presentation of relative emotional-involvement or emotional-detachment. Within NI, which is a highly structurally differentiated society compared with Uganda, figurational theory would suggest that past historical changes have led to increases in individuals' foresight and in their need for emotional-detachment and self-regulation. To a large extent, this prediction was confirmed in the present findings; counsellors in NI evidenced a reflexive account of the emotional impact of bereaved individuals on themselves; they also appeared cognisant of the causal relationship between their pain and that of their clients, and offered detached and analytical accounts of the emotional cost of their work.

In contrast, Ugandan informants appeared more likely to respond to their clients' pain, and to their own emotional pain, in an emotive and subjective way, with little evidence of emotional-detachment or reflection. They tended to minimise their personal reactions to their work, and sought to deny their emotional responses. In this relatively structurally undifferentiated society, there was a more involved, less rational and less psychological understanding of events.

Elias's theory also has the potential to contribute to the ongoing debate around the relative efficacy of group, family or individual therapeutic interventions following bereavement (Vlasto, 2010). In NI, bereavement counselling was offered almost exclusively to clients without family intervention, although informants occasionally referred clients to self-help groups or group counselling. In Uganda, other

people within clients' social networks were included in counselling; formal group work, although limited, was also referred to. Foulkes (1957), who incorporated Elias's figurational theory into his group psychoanalytic model, suggested that the need to belong remains one of the core organising principles driving human existence (Dalal, 1998). He argued that, as a consequence, individual therapy can only ever treat people artificially. This viewpoint is particularly relevant in bereavement counselling which seeks to restore individuals' social bonds and realign them with their communities (Seale, 1989). In NI, it was evident that informants offered an individualised therapeutic response to clients which appeared to belie the importance of relational issues. They articulated the importance of addressing relational issues but did not have a conceptual framework capable of incorporating these into their practice. Stroebe et al. (2001) have suggested that there has been a move beyond an intrapersonal analysis of grief: '*There is an interdependence of grieving within family and societal groups*' (Stroebe et al., 2001: 15). However, this interdependence is understood to occur at an '*inter-individual level*', a term which still essentially implies individuals' basic autonomy. The present findings, and their analysis, point towards the need to acknowledge individuals' essential relational interdependence, and to develop a therapeutic framework for bereavement counselling which can acknowledge this.

Eliasian theory has strong explanatory potential for this thesis. Conceptualised in terms of a comparative figurational analysis, the dynamic interrelationships between context, counsellor and client can be understood and key insights offered. However, there are apparent contradictions between Elias's theory and some of the key findings in this study; for example, at first sight contradictions might appear to exist between a simplistic reading of the civilising process and the empirical findings of this study concerning clients' emotional expression following a loss, and the 'failure of community'. These apparent contradictions will now be considered.

In Uganda, a setting of relatively low structural differentiation and weak centralisation, Ugandan informants identified that their clients experienced both strong social control of emotional expression and intense emotional expression. The policing of emotional expression through bereavement rituals and practices involved a wide network of people, including bereavement counsellors. In NI, a setting of relatively high structural differentiation and centralisation, there are few channels for the expression of intense emotion following bereavement. There is also an implicit injunction, to find individual

ways of resolving grief; in bereavement counselling, the process of grief work is deemed to enable clients to develop their own individual biographical narratives.

This contradicts a commonly held, albeit simplistic, interpretation of figurational theory and the civilising process (Mennell, 1989), which implies that societies with short and decentralised chains of interdependencies are characterised by a lack of social control of instinctive forces leading to volatile and untrammelled expression of drives at all time. In this view, more ‘civilised’ societies are characterised by the repression of drives through social regulations that produce repressed and undemonstrative people. In Uganda, however, the findings indicate both the presence of external controls as well as intense grief expression, in which even the intense mourning process is strictly controlled in time and space. In NI, bereavement counsellors, encourage clients to confront and integrate their grief into their selves, coming to terms with their emotions, albeit in a disciplined way.

However, Elias argues that the assumption of a continuous global process of increasing and strengthening self-restraint from ‘tribal’ to ‘developed’ societies represents a ‘vulgarised’ version of the civilising process. Rather, according to Elias, there are always elements of social control; drives never exist in a pure psychological form. There are no human settings outside of, or before, figurations. Constraints and restrictions are always imposed by individuals in relationship with others. In societies with low structural differentiation, very strong ‘we’ and ‘they’ feelings may be generated in groups and individuals. Strong ‘We-identification’ reflexively generates both powerful bonds of social control, and intense expressions of threat from others. These reactions create a habitus in which intense, simplified but channelled emotions are likely to be created and expressed. In designated situations – such as battles, festivals, orgies, and mourning – they can be expressed in explosive form, with a mix of restraint and abandonment.

‘A powerful ritualization and formalization of behaviour with corresponding caution and self-restraint in some situations often goes hand in hand with an unbridled liberation of affects in others’ (Elias, 1984: xxxv).

Moreover, Elias argues that in societies with relatively low levels of structural differential and figurational complexity, restraints are powerful but external, rather than internalised.

This theoretical perspective concurs with my personal findings that Ugandan informants identified an externally-validated grief process, that is, a prescribed set of rules which prohibited emotional expression outside tight, time-limited boundaries. Informants indicted that, when emotional expression was permitted, there appeared to be a flood of unprocessed feeling, both within and outside the counselling arena.

In contrast, in societies with relatively high levels of structural differentiation and figural complexity, individuals must adopt self-discipline and detachment in negotiating a complex variety of differing social settings; their 'I-identities' therefore become highly developed. The balance of constraint shifts towards self-restraint, which becomes unconscious, internalised and automatic (Elias, 1994a [1939]). In such societies, there are few generally agreed and accepted codes of behaviour, and, in negotiating personal relationships, people are expected to be guided by their own feelings. Thus, individuals are compelled to develop personal narratives of their unique biographies in order to make sense of their world. This theoretical perspective concurs with the observed beliefs, behaviours and expectations of NI counsellors and clients in the present study.

A second potential contradiction might appear to exist between a simplistic reading of Eliasian theory and the findings of this study concerning Ugandan informants' observations of a 'failed community'. Many figural changes have been taking place in Uganda in the last few decades, with a significant impact on community life. Informants have identified increasing state control, encroaching Westernisation, urbanisation and the introduction of many international agencies. Informants indicated that patterns of social interdependency are changing as a result of these global and national figural movements. For example, they described increasing individualism, a decreasing their sense of belonging, and weakening roles for the family. This fits with Elias's belief that communities become '*less differentiated as societies become more differentiated*' (Elias, 1974: xxii). Within this broad trajectory towards a more differentiated Ugandan society, informants have identified a '*failed community*'. This appears to be exacerbated by the AIDS pandemic, and to a lesser extent, by terrorist activities of the LRA, although the latter is geographically confined. As a result of the large number of AIDS victims, there is arguably a collapse of the social order, traditional bonds are broken and the range of social functions, traditionally provided

within the family group, are no longer available. With 63,000 AIDS related deaths in Uganda (UNAIDS, 2012), formal and informal support mechanisms have collapsed.

'HIV/AIDS has eroded this system of mutual obligations by affecting several family members at once, changing provider and dependency relations in unexpected ways' (Gysels et al., 2011, no page numbers).

Thus, in some environments, there is a near total loss of conventional forms of social support and new forms of support have not been established (Senyonyi et al., 2012). However, Elias cautions against assumptions that trajectories of social development will always be unilinear. His theory can therefore accommodate these potentially decivilising processes. However, given the extent of the impact of AIDS, it might also be argued that Ugandan society exhibits a sense of 'anomie' (Durkheim, 1897), with the breakdown of a previously relatively stable social order. Arguably, it is in response to 'anomie' that the introduction and expansion of Westernised bereavement counselling has occurred.

Finally, it must also be noted that the uniqueness of Elias's approach may cause difficulties in integrating his ideas with more established psychological theories of loss. He offers a unique and radical explanation of the research findings, but a key problem is that Elias's theory does not offer a detailed analysis of intrapsychic processes, limiting its suitability for exploring the psychological dimensions of bereavement counselling. While the Freudian and post-Freudian theories referred to here can explain specific aspects of the present findings, it is difficult to combine these with figurational theory, to create a unified theoretical framework. Much more research and analysis will be required in order to reconceptualise, in figurational terms, many of the long-established concepts on which bereavement counselling is based.

11.9 Contribution to Bereavement Counselling: Uganda

In response to a recognised gap in the research literature (McLeod, 2009), this study has provided a comprehensive exploration of bereavement counselling practises in a non-Western setting. In so doing, it has also given a voice to indigenous counsellors, an often neglected feature of comparative studies (Gerstein et al., 2009). As experts in adapting Western models of grief and counselling to their own socio-economic context, the perceptions of the Ugandan informants can potentially contribute to the

development of indigenous bereavement counselling models. The identification of such models is pivotal to the development of professional counselling in different contexts (Gerstein et al., 2009).

Ugandan informants dealt with the contradictions between their indigenous practices and the Western assumptions embedded in bereavement counselling theory and practice in two main ways: by adapting some aspects of counselling models to conform to their societal norms, and by subverting these norms in integrating other aspects of these models.

Ugandan counsellors, although trained in individualistic Western philosophy and psychology, continued to view their clients as part of a close knit network of interdependent relationships. Ugandan informants described a strong, collective moral code, understood in terms of a collective moral consciousness. Counsellors and clients looked outward in formulating behaviours which promoted a sense of communal allegiance, rather than inwards towards soul-searching. Individuals' sense of self appeared to be grounded in an adherence to collective values and fulfilling roles within the group, reflecting age, gender, social status and kinship identity.

In contrast, Western counselling theories and practices are directed towards promoting individualism, with grief being seen as a disruption of individual ego narratives; according to this paradigm, individuals must process their loss reflectively by exploring its implications for their ego development in order to detach from the pain of the loss and become autonomous individuals once more.

Faced with these contradictions, Ugandan informants responded by adapting Western models to suit their society. Counselling was not offered to individuals without also seeking to engage the family and the community in the counselling process. Acknowledging the importance of these collectives meant that decisions relating to the client were shared. Loci of control lay not with clients or bereavement counsellors but with all interested parties working towards the perceived good of the community.

Thus, Ugandan counsellors did not regard clients as free individuals en route to self-actualisation, but as members of social networks, some of which had power to constrain how they might act. In figurational terms, in Uganda, individuals were viewed as belonging to networks of interdependent people. Ugandan counsellors acknowledged

the habitus of their clients, despite the individualistic philosophy of Western counselling theory and practice.

Nevertheless, Ugandan bereavement counsellors also paradoxically subverted their societal mores in order to accommodate Western counselling models. Informants acknowledged that the appropriate behaviour for bereaved individuals in Uganda is a brief, time-limited and collectively-managed period of very intensive mourning, after which the bereaved individual must return to their roles and responsibilities. However, Western counselling models suggest that bereavement requires the successful completion of 'grief-work'. Drawing on this imported Western model of the psyche, the Ugandan informants urged their clients to express their individual feelings and emotions of sorrow. Some described resistance from their clients as this was contrary to societal rules; others identified clients as accepting their encouragement to express emotion, in some cases describing a flood of unprocessed feeling. The issue for counsellors was then how to deal with this expressed emotion. Western counselling models do not seek to re-impose external controls over grief, because counselling does not promote a collective moral order. Rather, the aim is to encourage clients to work on their ego development, to empower them to function successfully and resourcefully in the changed world they now face. Clients are expected to have the means to process their feelings reflectively in nuanced ways. This could be unfamiliar territory for Ugandan clients. Informants reported that, in some cases, the release of a previously-held-back flood of emotion threatened to overwhelm counsellors and clients alike. In managing these expressions of grief, Ugandan counsellors appealed once again to the duties of the collective life and the clients' responsibilities of role and position within their community.

Ugandan bereavement counsellors also sought to subvert indigenous belief systems in conceptualising sickness and death according to a Western mind-set. Western counselling philosophy promotes a scientific rationale which is at variance with the traditional discourses identified in African settings, where sickness and death is most often attributed to the consequences of witchcraft or ancestral interference. Drawing on this imported, narrative, many Ugandan informants appeared to promote a scientific, medicalised rationale with which to explain death. Their bereaved clients could therefore be faced with opposing, Western and African discourses around loss. In many

cases, it seems that clients were unable to accept the Westernised model. Within a society overwhelmed by HIV, Ugandans remain vulnerable; detached, 'rational' and causal explanations appeared insufficient to meet their cognitive and emotional needs (Elias, 2001[1982]). Moreover, counsellors themselves may not have developed the emotional detachment to engage whole-heartedly with Western scientific explanations of sickness and death.

It is unclear why informants integrated some aspects of Western counselling models into their practice whilst modifying others. One possible explanation is that their orientation towards communal figurations was so strong that it frequently overruled their attempts to offer counselling on an individualised basis. Furthermore, it appears that most indigenous counsellors modified Western models, without any conscious awareness of making these changes. Only those informants who had lived or trained outside Uganda articulated any incongruence between Ugandan social norms and the demands of counselling.

Thus, bereavement counsellors in Uganda, whilst ostensibly working within a Westernised theoretical framework, adjusted their practice to deal with the reality of their clients' psychological dispositions and societal requirements. Looking to the future, having the advantage of familiarity with both Western counselling models and their own socio-cultural circumstances, they could be encouraged to develop more culturally-appropriate models and practices instead of relying solely on Western-derived theory.

11.10 Contribution to Bereavement Counselling: Northern Ireland

Bereavement counsellors in NI did not face the same difficulties in utilising Western counselling models; there was a clear congruence between individualistic Western counselling models and a predominately individualistic setting. Nonetheless, contradictions in the practice of bereavement counselling were identified here also. These relate, in part, to the role of social context, and the function that community support plays in bereavement counselling. The limited attention that NI counsellors placed on this issues merits further discussion. Arguably, they could learn from their Ugandan counterparts' emphasis on the need to engage family and community in bereavement counselling. In NI, to a large extent, bereaved clients were treated

individually. Informants' goals focused on self-actualisation, and counselling practices supported clients in negotiating their own unique responses to loss. However, in contrast to these more individualistic practices, informants also acknowledged clients 'We-identities'. They recognised that their clients were members of families, the central role played by families in the grieving process, and the consequences of familial conflict on bereaved individuals. In contrast to Ugandan informants, NI interviewees appeared ambiguous in their approaches to family connections; they acknowledged the importance of interpersonal factors whilst working, to a large extent, only with intra-psychic processes. Consequently, clients were encouraged to negotiate relational issues outside the bereavement counselling arena.

This contradiction may have arisen because bereavement counsellors in NI do not have a conceptual framework for intervening in the interpersonal aspects of loss. The focus of their grief-work is determined by largely individualistic and psychologistic counselling models which have been profoundly influenced by Freud's intra-psychic grief-work theory. Some bereavement theorists acknowledge the interplay between intrapsychic and interpersonal processes; these include Strobe and Schut's (1998) DPM, Neimeyer's (2001) meaning-making model, and Klass's (Klass et al, 1996) continuing bonds theory. Some other therapeutic approaches, such as group counselling developed by the Institute of Group Analysis (IGA), founded by Foulkes (1957), and family therapy models (Minuchin, 1981), focus on interpersonal dynamics. However, none of these alternative models were widely utilised by the present informants, and their value for working with interpersonal and socially-determined aspects of loss would require further exploration.

It was informative to observe how NI informants interpreted the concept of community, which they invariably understood to refer to community organisations, such as churches and voluntary groups. It was to these that clients were directed for support. Support was therefore sought, not from established community and kinship relations, but from within institutions, in conjunction with other mourners who had suffered the same kind of loss. Group counselling was not offered to familial groups but to groups of individuals who had been similarly bereaved. This segregation of support into specialist, interdependent units is characteristic of structurally complex societies (Elias, 1994a [1939]).

Nevertheless, in these segregated group environments, clients were encouraged to develop new forms of social relationships. Such support groups, even if they are virtual, arguably create a form of micro-community (Howarth, 2011; Seale, 1998). Therefore, in referring clients to community organisations, NI bereavement counsellors were acknowledging their clients' need for a sense of belonging. This desire for a sense of belonging can be explained in terms of the need for a 'We-identity'; it appears to be an example of the ways in which local figurational movements might run counter to global processes (Elias, 1978[1970]; Wouters, 2002). Moreover, as Stanley and Wise (2011) have shown, sequestration does not necessarily negate the importance of domestic figurations. However, NI informants did not appear to be aware of this contradiction, perhaps reflecting their individualistic mind-set.

11.11 Impact of Armed Political Conflict

Informants in this study made relatively little reference to the impact of armed political conflict on their clients or counselling practices, a finding that deserves further comment.

Within NI, there was a lack of discussion in general by informants of the fractured social context of society. There was an absence of references to the religious identity of clients, or clients presenting with Troubles-related issues. This is in contrast to the strong national and religious divisions which persist in NI (Ewart & Schubotz, 2004).

There are a number of possible explanations for this apparent discrepancy. Firstly, these findings might reflect a bias in the research process. Sampling bias in the selection of informants however seems an unlikely explanation, as informants were representative of both Catholic and Protestant communities and also worked in organisations which offered counselling services to both communities. Another possibility concerns the interpersonal dynamics of the interview process. As a professional academic researcher I made a point of not revealing my personal views or allegiances to interviewees. However, this may have had unintended consequences; because my own political beliefs were not known (although perhaps assumed because of my 'Protestant' name), informants may not have felt safe in discussing issues that evidence deep-seated passions in NI. Within the research interviews, a range of broad, open questions were asked, with the aim of enabling informants to address sectarian issues if they felt these

to be important. Specific discussion of such issues might have arisen if more explicit questions had been asked. However, it should be noted that Campbell and McCrystal (2005) found that social workers in NI adopted a neutral, technical stance in relation to sectarian issues. Ironically, it is possible that, in this study, interviewees may have adopted similar tactics to my own, avoiding for professional reasons, discussion of contentious sectarian issues.

Another possible explanation for the absence of comment by NI interviewees about sectarian issues and conflict deaths concerns the nature of their professional worldview or habitus. As noted above in previous chapters, the conception of the self was presented in terms of internal psychological forces. As citizens, interviewees could not fail to be aware of conflict deaths and violence in NI. However, in their professional capacity they had no occupational language or conceptual vocabulary with which to address the issue. Societal conflicts were out with their professional domain.

It is also possible that sectarian issues were not raised by counselling clients because they did not consider their religious identity relevant or important in the counselling context. This was the finding of another research study I conducted recently, exploring the attitudes of mental health clients, and their key-workers to the legacy of the Troubles (Wilson et al., forthcoming). The findings indicated that clients did not define themselves according to their religious identity; rather their shared experiences of poor mental health and their need for support took precedence over religious differences and sectarian tensions. Perhaps, also, potential clients of bereavement counsellors selected themselves in this regard. Those with strong religious and community ties would turn to relatives and friends, or would use services that they might see as most sympathetic to their cause, as indicated in a number of other studies (Gibson & Iwaniec, 2003; Hendron et al., 2012; O'Kane & Millar, 2001). Moreover, as there has been a significant growth in counselling organisations specifically established for individuals affected by the conflict (Bloomfield, 1998; DHSSPS, 2002; DHSSPS, 2009; VSS, 2011), it seems likely that the majority of clients deeply traumatised by the Troubles now have the opportunity to seek help from specialist rather than generic counselling organisations. These clients would, therefore, be referred elsewhere. Hence, sectarian issues would not be salient in the professional work of respondents interviewed here. The findings of this study suggest that, at the present time, individuals bereaved by the Troubles are seeking specialist, rather than generalist, bereavement counselling support.

Whilst only two of the NI informants were working within specific Troubles-related organisations, some key observations can be deduced from their responses. These informants reflected on the personal and professional issues which arise in this work. In particular, they each sought to distance themselves from the conflict through emotional self-discipline, and appeared to create an environment of neutrality, to the extent of trying to avoid letting clients know if they were Protestant or Catholic. Thus, bereavement counselling was presented as a context-free, autonomous, professionally-defined process. This finding reinforces the possibility that interviewees may have felt it to be part of their professional ethos not to raise religious or sectarian issues.

In Uganda, many informants referred to past armed conflicts where multiple deaths were common. Informants suggested that this evoked a collective ‘numbing’, in which people became so familiar with death they did not feel the pain associated with it. A number of informants related these comments directly to the legacy of the Amin wars. This collective numbing was explained through an adaptation of psychodynamic theory (Ornstein, 2010). Multiple deaths were understood to lead to changes in the mourning process, in which the defence mechanism of ‘numbing’ protected individuals until the availability and support of others enabled grief-work to begin.

Whilst many Ugandan informants acknowledged the impact of the LRA only three informants described directly working with victims of the LRA. One indigenous informant was working specifically within the communities most affected, while two expatriate informants, both based in the capital city Kampala, also identified some clients who were victims of the LRA. This might be explained by the fact that the LRA is geographically confined to northern Uganda, and similar to NI, victims tend to be supported through specialist organisations. From these informants, it was suggested that the potential for complicated grief reactions came from the absence of traditional mourning rituals. The need to honour the dead, through traditional rituals, is particularly important in societies in which the dead are believed to intercede with the living (Maasdorp & Martin, 2009).

11.12 Contribution to Bereavement Counselling in Pluralistic Societies

Despite wide ranging societal differences, the literature suggests that, globally, professional counselling services are based on Westernised philosophy and psychology,

which are considered appropriate for all settings (Tseng, 1999). Thus, an individualised Western counselling framework has been imposed on the collectivist traditions of other settings (Arulmani, 2007; Rosenblatt, 1993; Tseng, 1999). There are unanswered questions around the universality of Western counselling models, with an acknowledgement that further research is needed in this area (Arulmani, 2007; Parkes et al., 1997; West, 2007).

There is an urgent need to address this issue as, within many African countries, there is a rapid expansion of professional counselling practice (Kilonzo & Hogan, 1999; Senyonyi et al., 2012). Moreover, many countries are becoming more pluralistic, with increasing diversity in religious beliefs and traditions. Meeting the needs of these changes will require the development of counselling models appropriate to specific figurational settings (van Dyk & Nefale, 2005). As McLeod highlights:

‘There is no evidence base available at present that would enable policy-makers to determine which therapy is most effective for members of specific cultural groups ... or would even suggest the ways in which existing therapy approaches might best be modified for use with these populations’ (McLeod, 2009: 319).

The findings from this study can provide insight into how existing theoretical and practical therapeutic approaches might best be modified for use in pluralistic societies. From a theoretical position, the findings of this study imply that current Western models of counselling are ethnocentric because they are based, fundamentally, on working with an individualised ego. They promote individualistic methods of intervention, in seeking to enable individuals to overcome their initial inhibition of emotion, and construct individual rational and detached narratives to make sense of loss. Understood in figurational terms, bereavement counsellors of all modalities must therefore address clients as though they have a predominant ‘I-identity’. Counselling models are based on the assumption that clients are self-disciplined in negotiating a complex variety of social settings, that restraint is internalised, and that clients are guided by their own feelings. However, in pluralistic societies, this assumption may be problematic as many counselling clients will have strong ‘We-identities’, generated in groups with strong social bonds and an external locus of control. At a theoretical level, this core contradiction, offers a valuable starting point in the development of contextually appropriate and sensitive counselling models.

At a practical level, the empirical data collected in this study highlighted how counselling practices were reflexively influenced by figurational pressures and tensions. These findings might usefully inform counselling in pluralistic settings. Among groups with a predominant 'We-identity' individual one-to-one counselling is problematic and should be modified. Counselling should always involve others, and in particular, extended families. Consequently, looser boundaries around confidentiality and privacy might be anticipated. Existing therapeutic approaches for bereavement favour a focus on the emotional component of the loss; however, a focus on the practical aspects of the loss may need to predominate in some settings.

The importance of meaning-making has been emphasised throughout this study (Neimeyer, 2001); it is important for counsellors to understand their clients' worldview. In societies with a predominant 'We-identity', illness and death may be understood within a framework incorporating magic and religious belief (Withell, 2009; Yamba, 1999). In such settings, counselling models would need to anticipate collective, syncretistic belief systems. The management of emotions has also been identified as a key component of bereavement counselling (Árnason, 2001). If emotions are not simply physiologically determined, but shaped by social interdependencies (Elias, 1994a [1939]), counselling models must come to accommodate the fact that emotional expression or repression may be managed through an externally-validated process.

Difficult and perhaps unforeseen consequences may be incurred in superimposing Western bereavement discourses on individuals with a strong 'We-identity'. Western models of bereavement counselling encourage emotional expression, an awareness of the needs of the individual and a scientific system of meaning-making. However, bereaved individuals may return to settings which may be authoritarian and harsh, where group needs must take precedence over those of individuals, and where a strong collective belief system is in place. The potential impact of these practices has been addressed in other studies; for example, Nordanger (2007) has identified that,

'In the Tigrayan setting, encouraging people to express their most painful memories and experiences would, in many cases, be equivalent to encouraging them to welcome forces aimed at destroying them from within' (Nordanger, 2007: 190).

Finally, utilising Western counselling models in 'I-orientated' societies also has its limitations. Bereaved clients are likely to be treated individually, with counsellors supporting clients to negotiate their own unique responses to loss. However, clients are also members of families, who may or may not offer support in the grieving process. Thus, currently, largely individualistic and psychologistic counselling models may not provide adequate conceptual frameworks for intervening in interpersonal aspects of loss. A core finding from the present research is that counselling models are needed which integrates psychological concepts with social theory.

11.13 Limitations and Further Areas for Research

With its strengths and challenges, comparative social research is said to be a double-edged sword (May, 2001). Essentially, the present study generated empirical findings and theoretical conclusions which an investigation confined to a single setting would have failed to identify. However, working across settings also introduced potential risks and limitations.

Social science methods seek to avoid ethnocentric assumptions by utilising skills of reflexivity, conceptual argument, and the systematic collection and evaluation of evidence. However, limitations remain.

In the present study, one such limitation related to the potential influence of researcher bias and ethnocentricity (Gerstein et al., 2009). The range of checks and balances employed to address these problems were outlined in Chapter 6. These included independent analysis of a sample of interview scripts to promote inter-rater reliability, and the use of desk research and participant observation to complement interview data. Arguably, however, the greatest corrective was the fact that I had already spent several years living and working in both countries before the formal research began. This long-term involvement in each country, combined with detachment generated from my academic training in social science and a well-developed self-awareness, will have helped to minimise my personal researcher bias. For example, I was familiar with the nuances of language in each setting, such as the need in Uganda to begin all interactions with greetings and good wishes, and the potential in NI to laden familiar phrases with sectarian meaning. Each setting represented a platform from which to view the other as both familiar and strange. This sharp juxtaposition of the two settings forced me to think

through my assumptions, and potentially diminish bias. For example, living in Uganda highlighted for me the more individualistic approach to bereavement counselling in NI, thus ensuring that this issue was raised in the research interviews with NI informants.

However, there are potential limitations in the ability to generalise from the study's findings represents a potentially bigger limitation. Qualitative findings can be rich in textual detail and insights but lacking in capacity for generalisation. As noted by Forte et al. (2004), purposive sampling problematises population representation. They identify consistent flaws in the design and analysis of much bereavement research, including inadequate reporting of findings and limited replication and development of previous research findings. Thus, the aims of a future research programme should include a deeper understanding of counselling practices in specific figurational settings (Ægisdóttir et al., 2009). In this study, many of the insights gained into bereavement counselling were necessarily tentative and would benefit from more detailed and specific exploration. Observations that are broad in scope lend themselves to the '*danger of homogenization*' (Williams, 1989, cited in May, 2001: 26), belying the inevitable diversity of peoples both within and across settings. In the present case, one way forward would be to conduct further research in both NI and Uganda on differences in the counselling relationship associated with the class, gender and ethnicity of clients. It would also be useful to examine the presence and management of somatic grief in both contexts.

In contrast, further comparative research would usefully focus on the nature of the therapeutic relationship, and differences in confidentiality and boundary issues in each setting. There is also a need for further comparative exploration of the influence of working across sectarian or ethnic divisions, and the impact of terrorist activity, on the governance and practice of bereavement counselling. A comparative study of clients' experiences of grief and of bereavement counselling would also be helpful; for example, to examine the continuing emotional bonds between bereaved individuals and their dead loved ones.

A second key aim of any future research programme would be to contribute to the further development of contextually appropriate counselling models (Arulmani, 2007). This study has identified the need, in NI, to develop a counselling model which is more sensitive to the social context of loss and grief. Further research in NI, on the

counselling context and the nature and influence of social networks and institutional factors on bereavement counselling, would be useful. Turning to the African context, collaboration with indigenous African counsellors and researchers would be needed (Gerstein et al., 2009). The academic literature would benefit from comparative studies of counselling in different African countries, researching broadly different ethnic groups such as Bantu and Non-Bantu. Likewise, a comparative study of traditional help-seeking activities and professional counselling in Uganda would also prove insightful. Such research could contribute to the development of a matrix of counselling theories and practices which could be combined to form a model appropriate to African social contexts (Arulmani, 2007).

11.14 Conclusion and Personal Statement

I began this research in part because of my interest in how Ugandans coped with the nature and extent of loss in their lives. Interviews with Ugandan informants confirmed for me the scope of this loss. I have been impacted by the richness of those interviews and many aspects of my participant observations. Seven years later, as I conclude this research, I am more informed about the need for, and the practice of, professional counselling services in Uganda. I am also persuaded that Ugandan counselling should be based on a counselling philosophy and model which reflects its cultural norms.

With regard to NI, I have been surprised by its counsellors' insistence on working with the individual. I am also aware that I previously took the individualistic nature of counselling for granted. Since my research in Uganda, I see this practice as culturally embedded and, in some respects, incompatible with the grieving process.

In 'A Grief Observed', the author and Christian apologist, C.S. Lewis, published his reflections on the death of his wife. He begins his diary by recording that, '*No one ever told me that grief felt so like fear*' (Lewis, 1985: 5). In reflecting on this research, I feel challenged by the account of people's lives marred by loss and fear, people who find the resilience to keep going despite feeling their lives to be significantly diminished by the absence of their loved ones. This was perhaps most strongly observed in Uganda where the extent of sickness, death and powerlessness is immense, and where, for many, this loss is compounded by the dynamics of a life already lived on the margins of survival. I feel humbled by the awareness that other people survive, and some thrive, in

circumstances which to my mind are almost intolerable. I have also felt privileged to hear the accounts of those helping professionals who, often with strong personal motivations, have sought to support, direct and sustain bereaved individuals through their grief. I hope this research and its dissemination will do them justice.

Glossary

Bantu: a term given to a large family of related ethnic groups in Sub-Saharan Africa which possess common language roots, with 450 known Bantu languages (Shillington, 1995).

Bereavement: the objective situation of having lost a significant person through death (Hansson & Stroebe, 2007).

Bereavement counselling: promoting a user-centred definition, bereavement counselling refers to a private and purposeful conversation which arises from the intention of one person to work through issues associated with bereavement and the willingness of a trained professional counsellor to assist in this process (BACP, 2010; McLeod, 2009). The terms, 'bereavement counselling' and 'grief counselling', are used interchangeably in the literature; the term 'bereavement care' has also been used as an umbrella term for a range of counselling and support services (Walter, 1999).

Bias: a term drawn from quantitative research. It refers to research findings which may deviate from 'true' findings as a result of differences in measurement instruments which do not have the same meaning within and across settings (Matsumoto & de Vijver, 2011). In qualitative research, the term may refer to an inclination on the part of a researcher to produce or interpret data that leads towards a particular conclusion.

Cathexis: a term which denotes that a certain amount of psychical energy is attached to an idea, an object or part of a body (Laplanche & Pontalis, 1988). It is analogous to an electrical charge which can switch from one structure to another (Rycroft, 1972).

Civilising process: a term which refers to the formation of manners and personality in Western Europe since the Middle Ages (van Krieken, 1998), reflecting the configuration of states and the monopolisation of power within them (Mennell, 1992).

Cognitive Behavioural Therapy: a talking therapy which enables clients to manage their emotional problems by changing the way they think and behave. The focus is on the 'here' and 'now'; clients are helped to become aware of, and change, the interconnection between their thoughts, feelings and actions.

Community-based participatory research (CBPR): collaborative approach to research which enables communities to actively participate in research, from conception to dissemination of results. The goal is to influence change in community health, systems, programs or policies.

Counselling: McLeod (2009), promoting a user-centred definition, presents counselling as a private and purposeful conversation which arises from the intention of one person to reflect on, or resolve an issue, and the willingness of another person to assist in this process. The British Association of Counselling and Psychotherapy (BACP, 2010) defines counselling as a talking therapy delivered by trained practitioners.

Counsellor: the terms ‘counsellor’ and ‘therapist’ are used interchangeably in the literature (McLeod, 2009). They refer to an individual who has acquired specific life experiences, possesses specific personal qualities and has developed specific competences through training, in order to act in the role of counsellor.

Collectivist societies: societies in which people acquire their sense of identity, and develop the narratives which give meaning to their lives, through participation in group activities, relationships, norms, ceremonies and rituals.

Counter-Transference: a term derived from psychoanalysis. It refers to the therapist’s emotional reactions towards his or her client. These reactions are based on responses to specific aspects of the client’s behaviour.

Critical Incident Stress Debriefing: a group-based therapeutic intervention offered to individuals who have experienced a significant traumatic incident.

‘Cross-cultural Counselling’: the pursuit and application of indigenous strategies and theories of counselling grounded in and informed by an understanding of the beliefs, values and norms of different societies and specific social settings worldwide (Gerstein et al., 2009).

Culture: the term is inconsistently defined, but usually refers to ‘a socially transmitted phenomenon learned through enculturation and socialization that is passed on from one generation to the next and one individual to another’ (Gerstein et al., 2009: 6). When used as an independent explanatory variable, the concept can become reified and ahistorical. In this study, the concepts of habitus and figuration have been preferred.

Decathexis: the withdrawal of cathexis, or quota of psychical energy, from an idea, object or part of a body.

Ethnocentrism: the assumption that one's own values, beliefs and norms, that are specific to particular historical periods and social settings, are normal, unproblematic and morally valuable against which all other groups are measured.

Equivalence: the equality of meaning of certain concepts across different cultural contexts.

Figurational analysis: an analysis of dynamic relationships of interdependence between people that constitute groups, and relationships between groups, as well as the long-term transformation of the figurations or networks that they form with each other (Quilley & Loyal, 2005). In this context, the unit of investigation is the evolving network of interdependent humans.

Grief: the primarily affective and psychological reaction to the loss of a loved one.

Grieving: the processes which the bereaved individual experiences and the psychological and emotional strategies which they utilise in this process (Holloway, 2007).

Habitus: a concept introduced by Norbert Elias to designate the personality-formation characteristic of people engaged in particular figurations.

Individualist societies: societies in which people acquire their sense of identity, and develop the narratives which give meaning to their lives, through the development of personal and individualised goals, activities, relationships and biographies.

Mourning: the social expression of grief often presented through a set of rituals and shaped by the practices of a particular culture or tradition (Hansson & Stroebe, 2007).

Participatory Action Research: seeks to understand and improve the world by changing it. Researchers and participants undertake collective, self-reflective inquiry, in order to understand and improve upon the practices in which they participate and the situations in which they find themselves. These processes should be empowering and lead to people having increased control over their lives (Baum, et al., 2006).

Person-centred approach: an approach to counselling in which the client is seen to have the potential to make the right choices and fulfil their own potential. The

therapeutic conditions in which this is achieved is based on a counsellor who is non-directive and conveys empathy, acceptance and genuineness.

Pre-bereavement: relating to the time period between the diagnosis of a terminal illness and the death of the person who was diagnosed.

Psychodynamic: in its broadest sense this refers to the study of mental processes by observing the interaction of feelings, emotions and behaviours within an individual. It can also be used more specifically to refer to the psychotherapeutic approach developed by Sigmund Freud.

Psychologising: a process through which individuals' responses to others become more permeated by observations and experience. A greater tendency towards psychologising leads to greater mutual identification (Mennell, 1992).

Psychoanalysis: a form of treatment for emotional problems invented by Freud, and developed since within the discipline of psychotherapy. The techniques employed consist of a therapist who instructs a patient or client to articulate freely whatever comes to his or her mind (free association). The therapist will then interpret these free associations and the meaning of the client's feelings about the therapist. The goal of psychoanalysis is increased self-awareness (Rycroft, 1972).

Psychotherapy: a broad term which refers to any method of treating emotional problems which utilise psychological means; it may be based on either the individual or the group (Laplanche & Pontalis, 1988).

Structurally simple, relatively undifferentiated societies: societies characterised by a limited range of multi-functional institutions, each of which undertakes a broad spectrum of activities that are weakly differentiated from one another. Chains of interdependencies are relatively short and simple. Kinship, clan, village and tribe typically play a significant part in a collective way of life.

Structurally complex, relatively differentiated societies: societies characterised by a wide range of separate, specialised institutions focused on specific and discrete activities and functions, such as education, health care, government, work, religion and so on. Chains of interdependencies are relatively long and complex, with hierarchies, boundaries and specialisation within and between sub-systems. The role of family and kinship is limited and relatively narrowly defined.

Structural differentiation: a theory of social change based on the differentiation of structures within society. It is particularly associated with classical sociological thinkers such as Durkheim (1984 ([1893])). It focuses on societal systems as a whole and how they operate and change, and analyses societies' potential to accommodate greater social complexity (Lukes, 1973).

Traditional counselling: relates to counselling as practiced in traditional (African) societies, where it often takes the form of sharing wisdom and giving advice. Often, village chiefs or elders symbolise authority and provide direction in the daily affairs of society. In this process, the chief and his elders provide a link between ancestors and the present generation.

Traditional healers: identified by a variety of names (shamans, medicine men) and utilising a variety of methods of intervention across diverse cultures. Many operate through entering an altered state of consciousness in order to utilise a power source which will heal or help others (Lago, 1996).

Transference: a term derived from psychoanalysis relating to a process by which a patient displaces onto his or her therapist thoughts and feelings which are derived from other figures in his or her life.

Appendix A: Interview Questions for Ugandan Counsellors

Counsellor details

Record counsellor details in terms of

- Age
- Gender
- Experience
- Nationality/ ethnicity
- Work setting i.e. private, NGO or government.
- Job role

What motivated you to become a counsellor?

What general counsellor training have you had?

What specific grief counselling training have you had?

Questions relating to generic counselling

Who comes for counselling?

Please describe the type of person who comes to you for counselling.

Who typically comes for counselling in terms of?

- Age,
- Gender
- Socioeconomic group
- Ethnicity

Referrals

What is the referral source?

What are the reasons for referral?

What are your referral criteria?

Typically, what is the presenting problem brought by clients?

What sort of counselling do you offer?

How many sessions? When and where?

What model of intervention do you use for general counselling?

What type of counselling do clients prefer? For example do they respond more to person centred or cognitive counselling?

What are your goals in general counselling?

Prompt: Do you think it is more important to help the client cope well within himself or her, to be independently happy and content, or is it more important to help them live well within their social settings, their families and communities?

Are you motivated to help your individual client or the community?

Questions relating to grief counselling

Who comes for grief/ bereavement counselling?

Please describe the type of person who comes to you for grief counselling.

Who typically comes for grief counselling in terms of?

- Age,
- Gender
- Socioeconomic group
- Ethnicity

Referral

What is the referral source?

What is the reason for referral following a death?

What are your referral criteria?

Intervention: What is offered in grief/bereavement counselling?

What aspect of the client's loss are they seeking help with?

- Emotional issues
- Financial or practical issues
- Relational issues
- Spiritual issues or a need to make sense of the loss

Could you describe how you would typically work with someone who came to you after a bereavement?

Prompts – re why do you work in that way? Why would you do that at that time?

Perhaps you could give me an example of some recent bereavement/grief counselling?

What do you see as the purpose/goals of your grief counselling?

What grief counselling model or theory do you use?

What aspect of the grief/ bereavement counselling do you think is of most benefit to the client?

How important is your therapeutic relationship in the counselling process?

Community role

How important for client recovery is the client's social support system?

For example family, friends, community? Why is this?

I appreciate that in Uganda someone's death, burial and mourning involves the whole village. What difference does this make to a person's need for grief counselling or to the issues that the client will come to you with?

Counsellor questions

What impact does grief counselling have on you personally?

If appropriate: How familiar are you with Westernised models of counselling?

What differences are you aware of between Western and indigenous Ugandan traditions regarding death and coping with grief?

How is the need for counselling understood in Uganda?

What differences are you aware of between Western and indigenous Ugandan styles of grief counselling?

Is there anything else relevant to what we have been talking about that you would like to say?

Appendix A (i): Second Round of Interview Questions for Ugandan Counsellors

(Sent by email and then followed up by recorded Skype interview.)

Dear (Name of Informant)

I have included below the list of questions I will ask, so that you have time to think about them before we chat. If it is possible, you could write down your answers to the questions and send them to me by email. Then we could discuss these by phone. If this is not possible we can just chat about them.

In my first set of interviews in Uganda there were four main topics highlighted by counsellors. I have identified a few questions in each topic, which I would like you to consider.

A Context of Counselling:

A1. Ugandan counsellors I have spoken to felt that grief counselling is needed because the community is failing to provide the support that people need following a death.

- Can you comment on this?

A2. Ugandan counsellors suggested three main reasons why the community is failing to provide support, as follows:

- Changes in Culture. Do you agree? What changes in culture would you identify?
- The consequences of HIV. Can you comment on this?
- The movement of people away from rural communities? Do you agree? What are the consequences of these changes in rural and urban populations?

B Information about the Counsellor:

B1. Ugandan counsellors identified their goal for counselling as helping both their clients and the communities in which their clients lived

- Can you comment on that?

B2. Ugandan counsellors identified an emotional burden to their work. Often they described needing to hide or repress this emotion.

- Can you comment on this?
- How do you think counsellors manage their emotions?

C. Information about clients who come for counselling following the death of their loved one:

C1. Violent, sudden or multiple deaths are common in Uganda. Counsellors stated that someone who is dealing with this type of death might be more likely to come for counselling.

- I am interested in knowing why violent, sudden or multiple deaths make such an impact if they are common to everyone?
- Could you also comment on the importance of finding someone to blame for the death?

C2. Ugandan counsellors suggested that the roles and responsibilities of the bereaved individuals impact their ability to grieve. For example expectations and responsibilities of a husband, wife or mother, makes grieving difficult.

- Can you comment on that? Do you agree?
- Can you comment on the interaction between the emotional burden of the loss of a loved one and the economic burden?

D. The Counselling Practice

D1. Ugandan counsellors highlighted that you cannot work with the individual client alone, you have to include others, because individuals cannot make decisions without consulting their community.

- Can you comment on this?

D2. Ugandan counsellors said that the Ugandan way is to hide your pain and repress your emotions; however clients are encouraged to express these emotions in counselling. Encouraging emotional expression seems to contradict this cultural expectation.

- Can you comment on that? Do you agree? Have you come across this issue?

D3. Ugandan counsellors described a directive approach to counselling, sometimes encouraging their clients to change their behaviours, for example, to support a husband who was HIV positive.

- Can you comment on this? Have you noticed a directive approach among Ugandan counsellors?
- Can you comment on whether you think counselling is directive or non-directive?

Appendix B: Interview Questions for NI Counsellors

Client Type

Who comes for bereavement counselling?

- Age
- Gender
- Socioeconomic group
- Ethnicity

Are there particular circumstances surrounding the death from which someone is more likely to be referred to your services? Prompt: Perhaps you could say a little bit more about that?

Referrals

Where do you receive your referrals?

What are your referral criteria?

Under what circumstances would you refer onto another agency? Perhaps you could give an example.

To whom would you refer?

Intervention: What is offered in terms of bereavement counselling/care?

Presenting problems

What presenting problems do clients typically come with?

Prompt: would these include?

- Emotional issues
- Financial or practical issues
- Relational issues
- Spiritual issues or a need to make sense of the loss

Do you carry out a risk assessment of the bereaved individual?

What, if any, assessment model do you use?

What do you typically offer someone who has been bereaved?

What bereavement care is offered immediately?

What ongoing bereavement care is offered?

Would your intervention include a focus on?

- Education

- Practical support
- Psychological support

Could you describe what you might offer in these categories?

What models of loss and bereavement do you utilise?

How long do you typically stay involved with someone who has been bereaved?

Is there any mismatch between what clients are seeking help with, and the help you can offer?

What, in your opinion do clients find most helpful?

Please comment on the importance of the relationship you develop with the client?

What impact, if any, does your statutory role of social worker/nurse/ (or role within Voluntary agency) have on this relationship? (Trigger issues of power and authority)

Community role

What family or community support is also offered to the individual?

Please comment on how you might engage with the family or community?

Outcome

Could you give me an example of a case that went well/did not go well?

Counsellor questions

What has motivated you to engage in this work?

What is your goal in supporting someone who has been bereaved?

What, if any, professional bodies do you belong to?

To whom are you responsible in terms of meeting standards of ethical practice?

Training

What, if any, specific training do you have around bereavement care?

How does this work impact you personally?

What issues and challenges arise?

What issues and challenges arise in the provision of bereavement care?

Do you have any other comments that you wish to make in relation to this topic?

Appendix B (i): Demographic Information NI

Thank you for agreeing to the interview today. Please take a few minutes now to complete these demographic details.

1. Are you male_____ female_____?
2. What age are you? _____
3. How would you describe your ethnicity? _____
4. What is your work context: statutory, voluntary, hospice, independent? _____
5. What is your role in the organisation? _____
6. What is the length of time you have worked in your current post
_____years?
7. What is your highest educational achievement in
counselling?_____
8. What is your professional background?

Appendix C: Desk Research, Uganda

Statutory Sector Documents re Counselling: Uganda.

A selection of statutory sector documents relating to Uganda, published between 2000 and 2014. These provide policy and procedural guidance which relates to the provision of counselling. There were no documents found which relate to the arena of end-of-life and bereavement care.

Government of Uganda, Home portal: <http://www.government.ug>

Accessed on 06-08-12

State of the Nation Address by President Yoweri Museveni.

Health Sector Strategy & Investment Plan. Promoting People's Health to Enhance Socio-economic Development. 2010/11 – 2014/15, Uganda

Ministry of Education and Sports Uganda. The Department of Guidance and Counselling was established in 2008, after the re-structuring of the Ministry of Education and Sports <http://www.government.go.ug/page/education>

The Statehouse Uganda: <http://www.statehouse.go.ug/node> 2011, 2012.

UCA (2013) Draft Uganda Counselling Association Bill. Available at <http://www.ugandacounselling.org/downloads/UCA%20DRAFT%20BILL.pdf>.

Voluntary Sector Documents re Counselling: Uganda.

Voluntary sector resources for patients and their families relating to bereavement and counselling in Uganda (2000-2014).

Hospice Africa, Uganda:

Hospice Africa, Uganda webpage: <http://www.hospiceafrica.or.ug/>

Mission and Vision Statement

Hospice Africa, Uganda: Ethos & Spirit of Hospices in Africa. Ethos statement “How can I understand a figure or a statistic unless I have held the hand that it represents? The people we are talking about are the same as us”

Hospice Africa, Uganda: Information Brochure 2007: Objectives

Hospice Africa, Uganda: Education and Training Brochure: Courses, 2007-2008

Palliative Care Association of Uganda Conference: September, 2008, Palliative Care Across All Ages: From Children to Old People

The AIDS Support Organization (TASO)

TASO centre webpage: <http://www.tasouganda.org/>.

Mission and Vision

Membership Philosophy

Core services

TASO Uganda, Information Booklet

The Mildmay Centre Uganda: AIDS Hospital

Mildmay Centre webpage: <http://www.mildmay.org/uganda/>

Services and Information

HIV Treatment and Care

The Mildmay Centre Uganda: HIV Prevention Care and Training Information Booklet

Uganda Counselling Association (UCA):

UCA Webpage: www.ugandacounselling.org

Mission statement,

Vision Statement

History

UCA Newsletter 2006 (2) 4

UCA Code of Ethics and Practice 2003 and 2009

UCA Annual Conference papers:

Building a Marriage, Helping the Family 2003

Challenges of Professional Counselling in Uganda 2006

National Conference for Ugandan Counselling Association: The Way Forward.

Appendix D: Desk Research, NI

Statutory Sector Documents re Bereavement: UK.

A selection of statutory sector documents relating to the UK, published between 2000 and 2014. These provide policy and procedural guidance for staff working in the arena of end-of-life and bereavement care.

DoH (2001). Making it Happen, A Guide to Delivering Mental Health Promotion.

DoH, (2002). The Human Organs Inquiry.

DoH, (2003). NHS Chaplaincy. Meeting the Religious and Spiritual Needs of Patients and Staff. Guidance for Managers and Those Involved in the Provision of Chaplaincy Spiritual Care.

DoH, (2004). Human Tissue Act.

DoH (2005). When a Patient Dies. Advice on Developing Bereavement Services in the NHS.

DoH, (2006). Our Health, Our Care, Our Say.

DoH, (2006). Preferred Place of Death.

Healthcare Commission, (2007). Complaints Report - Spotlight on Complaints.

National Association of Funeral Directors, Revised (2007). Code of Practice.

NICE, (2004). Improving Supportive and Palliative Care for Adults with Cancer.

NHS Estates, (2005). A Place to Die with Dignity: Creating a Supportive Environment.

Statutory Sector Documents re Bereavement: NI.

A selection of statutory sector documents relating to NI, published between 2000 and 2014. These provide policy and procedural guidance for staff working in the arena of end-of-life and bereavement care.

DHSSPS, (2002). Human Organs Inquiry - Implementing the Report.

DHSSPS, (2003). Promoting Mental Health: Strategy and Action Plan (2003-2008).

DHSSPS, (2003). Breaking Bad News. Regional Guidelines.

DHSSPS, (2003). Racial Equality in Health & Social Care. A Good Practice Guide.

DHSSPS, (2005). Post Mortem Examinations – A Code of Good Practice: Rights of Patients and Relatives: Responsibilities of Professionals.

DHSSPS, (2006). The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS.

DHSSPS, (2006). Protect Life, A Shared Vision, The Northern Ireland Suicide Prevention Strategy and Action Plan (2006-2011).

DHSSPS, (2009). Northern Ireland Health and Social Care Services Strategy for Bereavement Care.

DHSSPS, (2009). Northern Ireland Audit: Dying, death and bereavement. Policies, procedures and practices in hospital and hospice settings. GAIN Guidelines and Audit Implementation Network.

Northern Ireland Regional Audit, (2007). Northern Ireland Audit to Assess Care after Death: Systems, Processes & Practices in Bereavement Care.

A selection of statutory sector documents relating to NI: published between 2000 and 2014. These provide guidance and resources for people who have been bereaved.

DHSSPS, (2010). Have you, or someone you know been bereaved by suicide? Accessed from <http://www.northerntrust.hscni.net/about/1070.htm> (Basic introduction to support services).

DHSSPS, (2012). Look after yourself and others. Promoting Mental Health and Suicide Prevention within the Northern Area. (2012) Accessed from <http://www.publichealth.hscni.net/publications/look-after-yourself-and-others-%E2%80%93-promoting-mental-health-and-suicide-prevention> (List of voluntary, statutory sector organisations offering support).

DHSSPS, (2012). Look after yourself and others. Northern Area useful Contacts for Practical Support and Services to Help Improve Mental Health and Emotional Well Being, http://www.northerntrust.hscni.net/pdf/Mental_health_contacts.pdf. Accessed on 27-02-13 (List of voluntary, statutory sector organisations offering support).

Eastern Trauma Advisory Panel – Sudden Death Leaflets and Reference Book (2012) Accessed from www.belfasttrust.hscni.net

*Voluntary Sector Documents re Bereavement and Bereavement
Counselling: NI.*

Voluntary sector guidance and resources for patients and their families in relation to bereavement (2000-2014) (Voluntary sector documents in the UK were not considered relevant in this present study).

Contact Youth Counselling

Lifeline promotional material

CRUSE Bereavement Care

Cruse Bereavement Care, (2004). Document series for bereaved individuals:

Bereavement Care in Practice

Children's Grief

Bereavement and Older People

The Death of a Child

The Death of a Sibling

Grief within the Family

Understanding Grief

Bereaved by Suicide

Coping with a Major Personal Crisis

Has Someone Died: Restoring Hope

Marie Curie Hospice, Belfast

Patient and Family User Group Leaflet

Adult Bereavement Group Meetings; An Introduction

Share Your Story

Níamh Louise Foundation

Who's at risk from suicide?

Northern Ireland Cancer Network, (2007). Diagnosing Dying, Defining End of Life Care; A Position Paper

Northern Ireland Cancer Network (2011). Palliative & End of Life Care Competency Assessment Tool.

Northern Ireland Cancer & Palliative Care On-line Resource network

www.capricorn-ni.org

Northern Ireland Hospice

Document series for bereaved individuals:

Children and Grief

Bereavement Information Pack

Ulster Cancer Foundation

Document series for patients and bereaved individuals:

Family support services leaflet

Counselling Service. Sharing Anxieties for all those living with cancer

Art therapy. Express your feelings

Statutory Sector Documents re Counselling: UK

A selection of statutory sector documents relating to the UK, published between 2000 and 2014. These provide policy and procedural guidance in relation to counselling and psychological therapies.

DoH, (2001). Treatment Choice in Psychological Therapies and Counselling - Evidence Based Clinical Practice Guideline, Department of Health, London.

DoH, (2004). Improving Access to Psychological Therapies Organising and Delivering Psychological Therapies

DoH, (2008). Improving Access to Psychological Therapies Implementation Plan: National Guidelines for Regional Delivery

NICE (2003). *Depression Pathway*. London: National Institute for Health and Clinical Excellence.

NICE (2006). *Computerized Cognitive Behaviour Therapy for Depression and Anxiety, Technology Appraisal 97*.

NICE (2009). *Depression: Treatment and Management of Depression in Adults, Clinical Guideline 90*.

NICE (2009). *Depression in Adults with a Chronic Physical Health Problem: Treatment and Management, Clinical Guideline 91*.

NICE (2011). *Common Mental Health Disorders: Identification and Pathways to Care, Clinical Guideline 123*.

NHS Centre for Reviews and Dissemination, (1997). June Vol. 3 No 3. Effective Healthcare: Mental Health Promotion in High Risk Groups. York, University of York.

NHS Centre for Reviews and Dissemination (2001). August Vol. 5, Issue 2. Effectiveness Matters: Counselling in Primary Care. York, University of York.

NHS Executive, (1996). NHS Psychotherapy Services in England, Review of Strategic Policy. Department of Health, London.

Statutory Sector Documents re Counselling: NI

A selection of statutory and voluntary sector documents relating to NI, published between 2000 and 2014. These provide policy and procedural guidance in relation to counselling and psychological therapies.

DHSSPS, (2001). Best Practice - Best Care, Department of Health, Social Services and Public Safety, Belfast.

DHSSPS, (2002). Counselling in Northern Ireland Report of the Counselling Review

DHSSPS, (2007). Clinical Psychology Specialty Advisory Committee *Psychological Services – Post RPA in Northern Ireland*

DHSSPS, (2010). A Strategy for the Development of Psychological Therapies in Northern Ireland. Accessed from <http://www.dhsspsni.gov.uk/a-strategy-for-the-development-of-psychological-therapy-service-june-2010.pdf>. Accessed on 01-13-13

Northern Ireland Counselling Forum NICF. Accessed from <http://nicounsellingforum.com/default.aspx> Accessed on 10-01-12

Northern Ireland Division of the Royal College of Psychiatrists, (2003). Psychological Therapy Services-A Strategy for Northern Ireland

Appendix E: Participant Observation Record

Activity	Uganda	Northern Ireland
Counselling	Counsellor in Kenya: Based in NGO purpose built counselling facility. Working with expatriate and indigenous Kenyan communities. January, 2004 — August, 2004	Accredited counsellor since 1998: Maintaining 100 hours supervised practice per annum, accreditation requirements for continued professional development maintained.
	Counsellor in Uganda: Established counselling service in Uganda as a satellite unit to counselling facility in Kenya. Providing counselling and mental health assessments to humanitarian aid agencies for both expatriate and indigenous staff. September, 2004 — July, 2008.	Social worker within a multi-disciplinary psychiatric treatment team; specific therapeutic role. June, 1989 – December, 1999
	Counsellor with Africa wide responsibility; responding to traumatic incidents. Between January 2004 and July 2008 responded to incidents relating to: Mali, Côte d'Ivoire, Kenya, DR Congo, Sudan, and Tanzania.	August 2008 to date. Bereavement counselling offered through Voluntary Agency.
Strategic Responsibility	Member of Ugandan Counsellors Association. Attending meetings and annual conferences between 2004 and 2008.	Board member, supervisor and counsellor-Voluntary sector counselling organisation.
	Planning, facilitating and evaluating training courses for Ugandan counsellors on issues relating to trauma and loss.	Member of Health & Social Care Trust (HSCT) Bereavement Strategy planning group and Palliative Care Training subgroup. Member of a Troubles- related Trauma Advisory Panel.
	Planning, facilitating and evaluating therapeutic input with Ugandan counsellors following traumatic incident.	Providing lectures on loss and bereavement in academic and professional practice environments.

Appendix F: Journal Extracts, Uganda

A. Journal extracts following research interviews.

Whilst in Uganda, I kept a reflective journal, taking brief notes following each research interview. These focused on my impressions of the informant, of the research interview process and of the counsellors' organisational context. The following extracts have been included as they refer to significant issues raised in this study.

1. 25-04-08:

1st interview with Martha originally planned for Martyrs Memorial University but Martha called, changed the venue to the Carna restaurant. We sat in the garden, under a tree, windy day which impacted the recorder, concern about recording. Felt that I deviated too much from the questions, also need to gather more information on demographics, tribal important factor?

2. 29-04-08:

3rd interview with Jane: pokey wee office, little privacy, charged 35,000 USH. Left door open, no sense of privacy, not very engaged in BC and not very reflective.

3. 02-05-08:

5th interview with Jennifer: Interview in University counselling department. Interview almost impossible because of the noise from a Compassion AIDS workshop. Interrupted: - no privacy, women stood outside the window looking in. Jennifer nervous, not good information. Counselling seen as informal support- did not understand the complexity of questions. Interrupted a number of times; Jennifer locked the door.

4. 05-05-08

8th interview with Priscilla in AIDS organisation. Ethical approval required from Director. Most tuned in counsellor (so far). Interrupted so often, she locked the door. Woman came to the window and called through it to have a conversation. Discussed well the personal impact, continued discussion after the tape had been turned off.

5. 09-05-08:

13th interview with Roberta. Formal corporate organisation: high security. Surprised by formality: impressive organisation and buildings. Roberta dressed in a formal suit: most knowledgeable informant, although still not very strong on theory. Had been a founding member of UCA, hoping to do her own PhD. Strong, reflective, confident answers. Used her counselling office for the research interview; quite public and had windows from the corridor. Phone rang several times and she answered it.

6. 09-05-08

14th interview with Lynn: UCA leadership role: more confrontational than most Ugandans. Won't tell me her age. Awful counselling rooms: not private, a lot of interruptions. People had to walk through our room to get to other counselling rooms; we had to move rooms during the research interview. She was confident, promoting the strategic development of counselling in Uganda, networking to influence government.

7. 14-05-08:

17th interview Sylvia. Involved in research projects, knew the score, works for International NGO, American parent organisation. Appeared confident and knowledgeable. Had a role supervising other counselling projects and took a strategic view of counselling. Reflective of LRA and its impact, still presenting awful things in a matter of fact way.

B. Journal extracts relating to a series of interventions following a fatal fire at Budo Junior Primary School: April, 2008:

Context: Budo Junior is a primary boarding school located in Wakiso district, in central Uganda, 20 kilometres northwest of Kampala. It has about 1400 female pupils. This was the third fatal fire with similar death toll in two years (UK Guardian, 05- 08-08). The classroom had been converted to a dormitory and the girls were locked in at night- this is normal practice for security reasons. The school housemother was not present. 20 girls aged 8 and 9 died in the fire, along with a man who was also found in the locked school dormitory.

This is how it was reported in one of Uganda's English language daily newspapers 'The New Vision' 16th April 2008.

"Tragedy: 19 Budo Junior girls burn to death"

"Wails and groans rent the air at the school, as the parents picked their children. One man, upon confirming the death of his daughter, wept. Police constables rushed to console him. At the scene, in front of the dormitory, basins, beddings, metallic trunks, sandals and shoes lay strewn in the grass. The asbestos roofing had caved in and the burnt wooden doors were smouldering.

Betty Kigozi, a bereaved parent, said she had promised to pick her twin daughters on Friday, since they had finished their examinations. However, Nakato died in the fire.

A survivor, Sheila Nanyonjo, said: We were asleep when the fire started. Jackie Nakibule woke me up, but I refused. She then slapped and pinched me and I jumped from my bed and went out.

Other pupils thought that it was a lie because we had just gone to bed. So, they slept on and they were burnt. There was no power and we did not attend evening preps. Sharon Kanyunyuzi, another survivor, said: We were not allowed to use lanterns or candles save for torches.

The Inspector General of Police, Maj. Gen Kale Kayihura, toured the scene yesterday and expressed bitterness. This is criminality. How do you convert a classroom into a dormitory? Kayihura asked. This is murder. Children are so congested like soya-beans. Are there no standards for constructing modern dormitories in this country?"

C. Journal record of the psychological debrief following this traumatic incident:

Context: Though word of mouth, counsellors belonging to the UCA were asked to attend a planning meeting in order to facilitate a psychological debrief for the bereaved families, one week after the fire. Two such planning meetings took place with the Critical Incident Stress Debriefing Model (CISD) (Mitchell & Mitchell) used as a framework for the planned therapeutic intervention. I attended one of the planning meetings, the intervention, and a follow up meeting.

Bereaved individuals were invited to a psychological debriefing session, which was the impetus of an American counsellor living in Uganda. The debriefing session lasted about 3 to 4 hours in total, and took place in the grounds of another primary school in Kampala city about 20 kilometres away from the original incident. Approximately 12 counsellors were present, supporting 100-130 participants. At the therapeutic debrief, bereaved individuals were divided into groups, with two counsellors asked to facilitate the debriefing session with each group. People who attended had to register, were given a name badge and allocated to one of the following groups:

- Parents and relatives of children who died
- Children who were survivors of the fire and were in the dormitory that went on fire, along with their parents and relatives
- Parents and relatives of children who attended the school
- School staff
- Any other person who considered themselves to be impacted by the fatal fire

I co-facilitated one group, which was made up of parents of children who had died, and other individuals impacted by the fire (the membership of these groups had become mixed-up from the original plan). The actual debrief session lasted about 2 hours after which there was a plenary session where all the bereaved individuals were brought together. TV cameras were present for this. The following observations were made in my journal at this time:

- Religious themes: music, prayer, hymns, singing, closed in prayer. Muslims in attendance had to ascribe to Christian practices.
- No privacy for parents: given label, placed in categories, which were visible from their label. Paraded in front of the media.
- ‘Any other group’ included concerned people some of whom had no personal contact with the bereaved individuals or no personal connection to the school. For example a head master from another school.
- Anger was the strongest emotion expressed.
- Parents of surviving children, and bereaved parents, apparent inability to express feelings. Couple in my group of bereaved parents sat quietly, did not speak. This couple were ‘separated’—man living with another woman.

- Judgemental attitudes were expressed by my co-facilitator. For example, in relation to anxieties expressed by a parent about the school my co-facilitator responded: ‘Why didn’t you take the children out’.
- Great respect for the counsellors: Groups ended with a spokesperson saying ‘Mam, I want to thank you for helping us today’

D. Journal extracts following the co- facilitation of a training course on Critical Incident Stress Debriefing (CISD) for the UCA: Training days 6th & 7th June, 2008: Venue Hotel Africana, Wampewo Avenue, Kampala. 70 Ugandan counsellors in attendance.

I was part of a team of four, Ugandan and expatriate, counsellors who facilitated this training course. The following notes relate to a role-play that a subgroup of participants was asked to enact.

Journal notes: observation of a role-play. A group of Ugandan counsellors were asked to role-play a psychological debriefing session relating to a case scenario of a burglary in a Ugandan home. The scenario centred on a burglary in which the mother, who was at home alone, was subject to a sexual assault.

This group of 10 Ugandan counsellors were chosen to enact the role play. They divided themselves into two groups: one of counsellors (3), the other group role-played family members. I had recorded the following notes at the time of the training:

‘Role-play was chaotic: many acting as family members (6), many as counsellors (3). (1) acted as police officer. Venue was in the family home.

Very collective: everyone sat huddled in groups; answers were shared.

Someone role-played the policeman: he improvised: he was drinking, had no car couldn’t come to help anyone, as he was drunk, was hopeless: a lot of humour here.

No one mentioned the sexual assault; it was clearly shameful. Every time it was intimated the grandmother wailed. It was always unspoken, only intimated.

Grandmother wailing throughout.

The actors improvised: family refused to continue the debriefing session, as they had no food and were hungry, (still in role).

Major theme, we have been cursed.

E. Information taken from my notes on counselling two Ugandan families who had been bereaved

Family A. Visited my office in Entebbe, Uganda, October 2004. Ugandan family: mother, father, two sons, one aged 4 years and the other 5 months. The family were from the Bagungu people group; whilst Lagungu was their mother-tongue both parents spoke English well. Mr A was employed by an NGO and was therefore offered the chance to have counselling for himself and his family.

Presenting problem: their eighteen-month-old daughter died two weeks before they came for counselling. On that day the parents had both been out at work, a 12-year-old neighbour was caring for their daughter. When the mother returned home at the end of the day; her baby daughter was clearly unwell. The mother ran with her to a local clinic but the child died; she had been bitten by a snake earlier in the day.

Observations of counselling process: Mrs A came for 4 sessions, of which Mr A accompanied her on two occasions. Children stayed in their home village. Mr A was an academic, Mrs A, a nurse. They did not live together as they needed to be near their respective work places. Mrs A cared for their children.

In individual counselling Mrs A would sit on the floor; she was nursing another baby, which had been born 5 months ago. I had a small low African stool and was able to sit on that next to her.

Mrs A spoke little; she appeared to express her sadness through silence. She did not cry but when pushed described deep sadness at the loss of her daughter and regret at having left her baby with a girl who did not seek help when needed. She believed that her child could have been saved if treated earlier. She stated that the worst thing for her was the perception of the village that the death was the result of a curse on her family and that she did not do enough to save her daughter.

In the joint sessions with Mr A we all sat on chairs. Mr A expressed intense anger; this was directed at his employers because he needed to live away from his family. Had he been at home, this might have been prevented. He also expressed concern for his wife. He did not show any other emotion and appeared resilient.

Family B: Sudanese/ Ugandan family. Visited my office in Entebbe, Uganda, March 2007. Mr B was employed in an NGO and was based in Sudan; he was offered the chance to have counselling for himself and his family following the death of his 16-year-old son.

The family travelled from Sudan, by bus to Entebbe, Uganda. Because of the political unrest in Sudan the family remained in Uganda for some months after the counselling. Mrs B was pregnant and gave birth to a baby boy in Uganda.

Presenting problem: The oldest child of this family, a 16-year-old boy suffered from cancer and had died earlier in the year. The family were struggling to come to terms with his death.

Given travel commitments I saw this family for five, two hour sessions on consecutive days. The parents attended with their five remaining children aged 11, 10, 6, 5, 2. Mr B and their two older children spoke English well. Mr B translated for his wife and younger children who did not speak English. The family expected to be seen together but during sessions I would also ask to see subgroups of the family: parents together, older children together.

Many of the issues relating to the loss of this son were similar to those observed in NI. The parents recounted in intimate detail the story of this boy's diagnosis, treatment and death. The lack of resources for treatment was a great difficulty for Mr B who felt strongly that the boy may have lived if enough money was available to pay for further treatments. Much of the family's resources were sold in seeking a cure. Mr B stated that he would have lived on the street, if only it would have saved his son.

Much of Mr and Mrs B's hope and expectations for their future, were placed on this first-born child. In counselling he was compared to his surviving siblings, in more favourable terms. In particular his 11-year-old brother, who now represented the oldest male, was told that 'the wrong boy was taken'.

Counselling focused on allowing each family member to describe the loss and its impact, using drawings for younger children, and encouraging ways to remember this dead boy. Additionally, discussion focused on the current relationship of the parents to their 11-year-old son, insights were offered on the perspective of this 11-year-old boy who felt rejected.

I managed this as I would with a Western family, but I was conscious of the differences in culture and the imposition of Western values onto this family, such as the rights of the remaining children to be heard, respected and valued.

Appendix G: Journal Extracts, NI

A. During the research period in NI, I kept a reflective journal, taking brief notes following each research interview. These focused on my impressions of the counsellor, of the research interview process and of the organisational context. The following extracts have been included, as they related to issues which have been address within the thesis:

- a) Interview 2. Barbara. 18-03-10. Lots of emotional investment in this work, little organisational support, Barbara tearful at times, dealing with a lot of death. She welcomed the chance to off load in this research interview. Working long hours, boundaries between work and home fluid, client contacting her at home. Gave an example, which I found disturbing, of a baby turning black before he died.
- b) Interview 3. Colin. 18-03-10. Motivation for becoming a counsellor was the suicide of his son, 7 years ago. Careful to present himself as coping and it was not interfering with his counselling. Community question was understood around what organisations are available: 'I try to find out what is available for my clients'.
- c) Interview 5. Ellen. 23-03-10. Excellent informant; knowledgeable, reflective, challenging, dense interview. Wide range of experiences in both England and NI. Discussed systems, sense in which society had repressed death 'the madness of our society'. Saw this as having significant impact on clients. Discussed disfiguring and traumatic nature of cancer, I had not expected this.
- d) Interview 12. Maureen. 21-04-10. Mother of 12-year-old girl, who had completed suicide several years ago. I was cautious, careful with my own language, aware of sensitivities. Wide view of counselling; alternative therapies offered. Critical of failure of the community to provide anything, critical of services provided by statutory Trusts.
- e) Interview 13. Niamh. 29-04-10. Informant Assistant Director, we shared acquaintances in common. Difficult to follow; described both strategic development of child bereavement service and details of her counselling. I was moved by an account of a child coping with the death of her father; quoted client as saying, 'this was my dad and this is what he looked like and he loved me'. Presented service evaluation and audit of organisational achievements.
- f) Interview 19. Tanya. 05-12-12. Currently working in Church, ongoing bereavement counselling described four roles: Social worker in hospice: social worker in hospital, support worker in church and counsellor in voluntary counselling agency. Bereavement counselling offered in all four. Discussed expectations of families around the dying process. Media, society presents this as peaceful and beautiful: raises false expectations of death.

Appendix H: Informant Biographies

Informant Biographies: Uganda

Lynn:

Would not disclose her age but said that she was a grandmother.

Ethnicity: Paddola

Agency: private practice which was co-founded by Lynn and 3 partners; additional counselling rooms are rented out to independent counsellors.

Qualifications: MA Counselling Psychology from a Ugandan university (Makerere)

Role: Counsellor and manager

Location: Kampala City Centre

Additional information: founding member of the UCA and on their Board of Directors

Joyce: 30-year-old woman

Ethnicity: Mugandan

Agency: AIDS facility providing inpatient care, day services and community outreach.

Qualifications: Counselling Certificate: in-house qualification

Role: Counsellor

Location: Small town 40 kilometres south of Kampala

Roberta: 47-year-old woman

Ethnicity: Mugandan

Agency: counsellor employed by a large corporate organisation

Qualifications: MA Counselling Psychology from a university in the USA

Role: Counsellor and counselling lecturer

Location: Kampala City Centre

Additional information: founding member of the UCA, and on their Board of Directors.

Clarissa: 35-year-old woman

Ethnicity: Mugandan

Agency: Hospice Africa, International NGO

Qualifications: Counselling Certificate

Role: Counsellor and manager

Location: Kampala City Centre

Thelma: 52-year-old woman

Ethnicity: Mbufora

Agency: Co-founded counselling agency with her husband; previously lived in the UK.

Qualifications: MA in Counselling from a Ugandan university (2000) (Makerere)

Role: Counsellor and counselling lecturer

Location: Kampala City Centre

Jane: 49-year-old woman

Ethnicity: Mugandan

Agency: Co-founder of a private counselling practice with two other counsellors, recently established.

Qualifications: MA in Counselling from a Ugandan university (2005) (Makerere)

Role: Counsellor and counselling lecturer

Location: Kampala City Centre

Martha: 45-year-old woman

Ethnicity: Mugandan

Agency: Private practice-generic

Qualifications: Diploma in Counselling (currently working towards MA). Holds a MA in another discipline

Role: Counsellor and counselling lecturer

Location: Kampala City Centre

Priscilla: 36-year-old woman

Ethnicity: Mugandan

Agency: AIDS facility offering assessment, diagnosis, treatment and support for HIV patients

Qualifications: Certificate in Counselling; in-house qualification

Role: Counsellor

Location: Small town, 40 kilometres south of Kampala

Sandra: 30-year-old woman

Ethnicity: Mugandan

Agency: In patient unit and day hospital for people diagnosed with AIDS

Qualifications: BA Counselling and Theology from a university in the UK

Role: Counsellor

Location: Rural community 10 kilometres south of Kampala

Moses: 40-year-old male

Ethnicity: Mugandan

Agency: AIDS facility offering assessment, diagnosis, treatment and support.

Qualifications: Counselling Certificate

Role: Counsellor and manager

Location: Small town, 40 kilometres south of Kampala

Additional information: Moses was the only male counsellor in this organisation and was the manager

Maud: 52-year-old woman

Ethnicity: Mugandan

Agency: Private practice offering generic counselling

Qualifications: BA Counselling from a Ugandan university (Kyambogo)

Role: Counsellor

Location: Kampala City Centre

Rose: 42-year-old woman

Ethnicity: Anchoi

Agency: Recently established private practice offering generic counselling

Qualifications: BA Counselling

Role: Counsellor

Location: Kampala City Centre

James: 55-year-old male

Ethnicity: Lugbara

Agency: Private practice, as an individual counsellor

Qualifications: MA counselling from a Ugandan university (Mukono)

Role: Counsellor

Location: Large town in north Uganda

Gloria: 40-year-old woman

Ethnicity: British

Agency: Private practice, based in a local health clinic

Qualifications: Counselling Diploma from the UK, seeking accreditation with BACP

Role: Counsellor, seeing both Ugandan and expatriate clients

Location: Based in a health clinic in Kampala

Additional Information: Expatriate lived in Uganda for 10 years, person centred counsellor

Sylvia: 49-year old woman

Ethnicity: Mugandan

Agency: Large international NGO working with victims of LRA in Northern Uganda

Qualifications: MA Counselling from a university in Kenya

Role: Counsellor and manager

Location: Kampala City Centre, and Gulu, north Uganda, working within International Displaced Persons (IDP) camps

Valerie: 50-year-old woman.

Ethnicity: American, lived in Uganda since 1985

Agency: Counsellor and counselling lecturer

Qualifications: PhD in Counselling Psychology from a university in USA

Role: Counsellor and counselling lecturer

Location: Kampala City Centre

Lucy: 58-year-old woman

Ethnicity: Afro American, lived in Uganda for 5 years

Agency: Established her own NGO providing counselling and training to people involved in ethnic conflict

Qualifications: PhD in Counselling Psychology from a university in USA

Role: Counsellor and manager

Location: Kampala City Centre

Francis: 52-year-old woman

Ethnicity: Mumasaba

Agency: Private practice based in a university

Qualifications: BA Counselling from a Ugandan university (Kyambogo)

Role: Counsellor

Location: Kampala Suburbs

Informant Biographies: NI

Averill: 45-year-old woman

Ethnicity: White

Nationality: British

Agency: Statutory Agency, Hospital

Qualifications: BA (Hons) Social work. Counselling certificate

Role: Social worker with a bereavement counselling remit, based in a maternity ward

Location: District General Hospital (DGH), Co. Antrim

Barbara: 51 year old woman

Ethnicity: White

Nationality: British

Agency: Statutory agency

Qualifications: BA Nursing, Counselling diploma

Role: Children's Palliative Care Nurse Specialist with a counselling remit

Location: Wide rural and urban catchment area, Co. Antrim

Colin: 47-year-old man

Ethnicity: White

Nationality: Northern Irish

Agency: Voluntary agency specialising in bereavement counselling

Qualifications: BA, Counselling certificate

Role: Counsellor, Manager

Location: Co. Antrim

Debra: 42-year-old woman

Ethnicity: White

Nationality: British

Agency: Hospital based in a cancer unit, with a dual role between statutory and voluntary agencies

Qualifications: Advanced Diploma in Counselling

Role: Counsellor

Location: DGH, Co. Antrim

Ellen: 44-year-old woman

Ethnicity: White

Nationality: Northern Irish

Agency: Hospital based in a cancer unit, with a dual role between statutory and voluntary agencies

Qualifications: BSc, Post Graduate Diploma in Counselling

Role: Counsellor and manager

Location: DGH, Co. Antrim

Fran: 45-year-old woman

Ethnicity: White

Nationality: British

Agency: Voluntary agency specialising in bereavement counselling

Qualifications: In-house Counselling Certificate

Role: Counsellor: adults and children

Location: Co. Antrim

Grace: 66-year-old woman

Ethnicity: White

Nationality: Irish

Agency: Voluntary agency specialising in issues related to the Troubles

Qualifications: MA Counselling

Role: Counsellor

Location: Co. Antrim

Helen: 26-year-old woman

Ethnicity: White

Agency: Voluntary agency specialising in issues related to the Troubles

Qualifications: BSc, BA Social work, in-house Counselling Certificate

Role: Counsellor

Location: Co. Antrim

Verona: 53-year-old woman

Ethnicity: White

Nationality: British

Agency: Statutory agency providing support for people with physical disability including terminal illnesses

Qualifications: Certificate in Social Work, Certificate in Counselling

Role: Social worker with a counselling specialism

Location: Co Londonderry

Jan: 49-year-old woman

Ethnicity: White

Nationality: Irish

Agency: Statutory agency providing support for people with physical disability including terminal illnesses

Qualifications: BSc Social Administration, and Counselling Diploma

Role: Social worker with a counselling specialism

Location: Co Londonderry

Kate: 60-year-old woman

Ethnicity: White

Nationality: British

Agency: Voluntary agency specialising in bereavement counselling

Qualifications: RGN, Open University Degree

Role: Counsellor

Location: Co. Antrim

Maureen: 42-year-old woman

Ethnicity: White

Nationality: Irish

Agency: Voluntary agency which specialises in support following suicide

Qualifications: Counselling certificate

Role: Counsellor and manager

Location: Offices in three strategic locations throughout NI including Belfast.

Additional Information: Maureen was one of the original founders of this organisation, which was started following the personal experience of a family member completing suicide.

Niamh: 46-year-old woman

Ethnicity: White

Nationality: Irish

Agency: Voluntary agency with a specialism in child bereavement

Qualifications: BA, CQSW, In-house bereavement counselling training

Role: Counsellor and manager

Location: Belfast

Orla: 62-year-old woman

Ethnicity: White

Nationality: Irish

Agency: Independent agency

Qualifications: Advanced Diploma in Counselling

Role: Counsellor

Location: Belfast, also provides services throughout NI

Patsy: 59-year-old woman

Ethnicity: White

Nationality: Irish

Agency: Hospice

Qualifications: Post Graduate Counselling Diploma

Role: Counsellor and manager

Location: Belfast

Sarah: 56-year-old woman

Ethnicity: White

Nationality: British

Agency: Hospice

Qualifications: BSc

Role: Counsellor and Chaplin

Location: Belfast

Ruth: 52-year-old woman

Ethnicity: White

Nationality: British

Agency: Statutory agency providing support for people with physical disability including terminal illnesses

Qualifications: BSc, Counselling Certificate

Role: Social worker with a counselling remit

Location: Co. Antrim

Sharon: 47-year-old woman

Ethnicity: White

Nationality: British

Agency: Dual role: 1. Voluntary agency providing services for individuals coping with an addiction. 2. Voluntary counselling agency

Qualifications: Counselling Diploma

Role: Counsellor

Location: Co Armagh

Tanya: 62-year-old woman

Ethnicity: White

Nationality: British

Agency: Dual role: 1. Church based support worker. 2. Voluntary counselling agency: generic

Qualifications: BSW. Counselling Diploma

Role: Counsellor

Location: Co Down

Wilma: 54-year-old woman

Ethnicity: White

Nationality: British

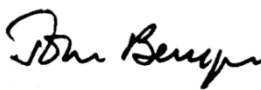
Agency: Private practice, works independently

Qualifications: MA Family Systemic Therapy

Role: Counsellor

Location: Co. Antrim. Clients come from all over NI

Appendix I: Research Ethics Approval Form: University of Leicester

Institute of Lifelong Learning Research Ethics Review Approval Form
Name of student/researcher: Lorna Dalzell
Course title:
Title of research: A comparative study of grief counselling between the UK and Uganda
Contact details +255 0 782547244 lorna_dalzell@sil.org
Status (please tick as appropriate): Undergraduate <input type="checkbox"/> Postgraduate <input checked="" type="checkbox"/> Researcher <input type="checkbox"/> Staff <input type="checkbox"/>
Name of supervisor: <i>(For office use only)</i> Dr Val Owen-Pugh
Course director: <i>(For office use only)</i>
I am pleased to confirm that I have read the research proposal and I consider the researcher has considered all the research ethics and has answered the relevant questions satisfactorily.
Professor John Benyon <div style="text-align: right; margin-right: 50px;">  </div> Institute of Lifelong Learning Research Ethics Officer
Date: 1 October 2008

Appendix J: Research Ethical Approval Letter: NHS Northern Ireland

Ms Lorna Montgomery
APSW
Social Services Training Centre
34 Station Road
ANTRIM
BT41 4AB

Dear Lorna

Re: 'Application of Research Methods in Social Work'

I wish to acknowledge receipt of your letter dated 18th January in respect of the above course in which you outline your proposal for a qualitative evaluation of bereavement care in the Northern Trust area.

I am pleased to confirm the NHSCT's approval for the project entitled:

'A qualitative evaluation of the provision of bereavement care accessed by service users living in the Northern Trust Area'

I look forward to hearing how the findings of this evaluation can improve our care of bereaved individuals in the Trust.

Yours sincerely



Cecil Worthington
Director of Children's Services

Appendix K: Research Information and Consent Forms: Northern Ireland

Written information sent to potential informants in NI

Title: A qualitative evaluation of the provision of bereavement care accessed by service users living in the Northern Trust Area.

Introduction

My name is Lorna Montgomery and I work as an Assistant Principal Social Worker in the NHSCT Social Services Training Department. I facilitate training in Loss and Bereavement. I am currently undertaking the Application of Research Methods Course for Social Workers and as part of this course am completing a qualitative evaluation of the provision of bereavement care in the Northern Trust Area in both statutory and voluntary organisations.

You are invited to take part in this project. Before you decide if you wish to take part it is important that you are given sufficient information about the project and what you will be asked to do. This information is provided below. Please feel free to ask any questions about any aspect of which might not be clear to you. Thank you for taking the time to consider this.

What is the purpose of the project?

This study seeks to explore the bereavement care offered to bereaved individuals living in the 'Northern Trust' area and to identify the challenges and issues relating to this care as seen from a staff perspective. This information will be used to inform staff training and service delivery. In this context bereavement care is defined as a process of helping an individual to cope emotionally and practically following the death of a loved one. It will include therapeutic, practical and educational services.

Why have I been invited to take part?

I am hoping to interview 15 people, some from voluntary agencies and others from within the NHSCT. You have been asked to consider taking part because you offer bereavement care as part of your job.

Do I have to take part?

No, it is up to you to decide whether or not to take part. If you choose not to take part it will have no implications for you or your agency. Even if you choose to take part now, you can change your mind and withdraw without giving a reason.

How do I consent to my involvement in this project?

If you agree to take part you will be asked to sign a consent form which outlines what you will be asked to do and what will happen to the information you give.

Will my taking part be kept confidential?

Yes. If you take part in this project your name will not be disclosed and will not be revealed in any reports or publications. Whilst I will meet you and record the interview on audiotape, your name will not be recorded on the interview, which instead will be given a unique identification code which will only be identified by myself. You will be asked to confirm if you want your name and address to be stored in a secure filing cabinet until completion of the project. This will enable me to invite you to (a) a voluntary discussion with the other participants of the findings from the study (b) to an oral presentation of these findings I will give to the Trust. All information will be handled and stored in accordance with the requirements of the Data Protection Act 1998

What will happen to the results of this study?

The results of this study may be used to inform training around loss and bereavement and to improve the bereavement care we offer in the Trust. The findings will be written up in a report and shared with the Trust and the voluntary agencies involved. An oral presentation will also be given of the findings to Trust and voluntary agency staff. The findings from this study may be later used in publications in professional journals or in my PhD research. However when these findings will be reported in any way all details about the people who took part will be kept anonymous.

What will I have to do?

You will be invited to attend an interview with me which will be held in private and will take about one hour. I will ask you some questions about: yourself in relation to the role that you have, about who receives bereavement support, what is offered and what issues and challenges arise. The interview will be audio taped and later transcribed. Afterwards you will be invited to a voluntary discussion with the other participants of the findings from the study.

Who can I contact for further information?

Lorna Montgomery, Researcher
Social Services Training Department
34 Station Road
Antrim
02894 416590

Dr Anne Campbell
Supervisor University of Ulster

Informant Consent form, NI

Name of researcher: Lorna Montgomery APSW (training)
 Contact details. Social Services Training Department
 34 Station Road
 Antrim BT41 4AB
 02894 416590
 lorna.montgomery@northerntrust.hscni.net

Title: A qualitative evaluation of the provision of bereavement care accessed by service users living in the Northern Trust Area.

	I confirm that I have read and understood the participant information sheet dated (25-02-10). I have had the opportunity to clarify any questions and if required have had these answered satisfactorily.	<input type="checkbox"/>
	I understand that as a participant I can terminate the interview at any stage. I also have the right to withdraw consent for involvement in this project at any time.	<input type="checkbox"/>
	I understand that my interview will be recorded by audiotape which will be transcribed. This transcription and all other information will be kept in a secure place. My name will not be recorded on the interview, which instead will be given a unique identification code which will only be identified by the researcher.	<input type="checkbox"/>
	I understand that my name and address will be stored in a secure filing cabinet until completion of the project. This will enable me to be invited to:- a) a voluntary discussion with the other participants of the findings from the study b) to an oral presentation of these findings given to the Trust. All information will be handled and stored in accordance with the requirements of the Data Protection Act 1998.	<input type="checkbox"/>
	I understand that the findings arising from this project will be confidential and that all efforts will be made to ensure that I cannot be identified as a participant in this project.	<input type="checkbox"/>
	I understand that the anonymised findings from this study may be later used by the researcher in publications in professional journals or in the researchers PhD study.	<input type="checkbox"/>

Signed _____ Date _____

Countersigned _____ Date _____

Appendix L: Research Information and Consent Forms: Uganda

Written information given to informants in Uganda

Thank you for taking the time to meet with me. I want to introduce myself and explain a little of what I am hoping to do. My name is Lorna Dalzell, and I have been living in Entebbe since 2004 with my husband and 4 children. I come from the UK and am working with an organization called International Counselling Ministries, which is a subgroup of SIL, an NGO based in Uganda. For the past four years I have worked as a counsellor mainly to the expat and missionary communities here. I have enjoyed making links with some Ugandan counsellors and attending the Annual Counsellors Conference.

I am interested in understanding more about the counselling Ugandans offer their own people. In particular I wish to explore the nature of grief counselling and compare this to grief counselling in the UK. It seems to me that Ugandans often face bereavement associated with the sudden, violent or premature death of loved ones. I am interested in exploring if counselling is offered or sought in these circumstances and the nature of this counselling.

In order to research this area I hope to interview 10 to 20 counsellors asking them about the nature of the counselling that they offer. In so doing I will be seeking to understand what counselling, or bereavement counselling models are used, what issues the clients bring in relation to the bereavement or if emotional, physical, spiritual or financial issues are dealt with. I am also interested in knowing what the counsellor feels is most effective in helping their client, and why.

After completing these interviews I hope to compile a questionnaire for a much larger group of counsellors in order to gather some data about grief counselling in Uganda. If possible this questionnaire would be given out at the Ugandan Counsellor's Conference (2009). There will be careful guidelines in place to ensure that all information gathered in both interviews and questionnaire is handled confidentially and with consent.

Having completed this research in Uganda I plan to follow the same process in the UK with individual interviews and a questionnaire. This should enable a comparison of counselling in each setting to be made.

I appreciate you taking the time to read this, if you have any questions please feel free to ask or contact me on 0782 547244. Webale nyo!

Informant consent form, Uganda

SIL International

PO Box 750

Entebbe

Uganda

Lorna_dalzell@sil.org

Dear

As part of the research I am conducting into grief counselling in Uganda and the UK I would like to discuss with you your personal experience of grief counselling.

Any views expressed would be given in confidence, and any quotes used would be anonymised and used solely to help myself and colleagues conduct, publish and disseminate our research.

It is important to note that you can withdraw from the research at any time.

If you are willing to take part in this research, would you please sign below. If you would like to ask any questions concerning this process, please feel free to contact me on 0782 547244 or at lorna_dalzell@sil.org.

Yours sincerely

Bibliography

Ægisdóttir, S., Gerstein, L., Leung, S., Kwan, K. & Lonner, W. (2009). Theoretical and methodological issues when studying culture. In L. Gerstein, P. Heppner, S. Ægisdóttir, S. Leung & K. Norsworthy (eds) *International Handbook of Cross-Cultural Counselling. Cultural Assumptions and Practices Worldwide*. London: Sage.

Agnew, A., Manktelow, R. & Donaghy, K. (2008). User perspective on palliative care services: Experiences of middle-aged partners bereaved through cancer known to social work services in Northern Ireland. *Practice: Social Work in Action*, 20 (3): 164-180.

Agnew, A., Manktelow, R., Taylor B.J. & Jones, L. (2009). Bereavement needs assessment in specialist palliative care: A review of the literature. *Palliative Medicine*, 24 (1): 46-59.

Ainsworth, M.D., Blehar, M.C., Waters, E. & Wall, S. (1978). *Patterns of Attachment: A Psychological Study of the Strange Situation*. Hillsdale, NJ: Lawrence Erlbaum.

Alao, K. (2004). Silver and gold we have none but what we have we give unto thee: Indigenous African counselling and the rest of the world. *International Journal for the Advancement of Counselling*, 26 (3): 249-2.

Aldridge, S. (2012). Counselling an insecure profession. A sociological and historical analysis. PhD Thesis, Available at <http://hdl.handle.net/2381/10261>. Accessed: 11-11-12.

Allumbaugh, D.L. & Hoyt, W.T. (1999). Effectiveness of grief therapy: A meta-analysis. *Journal of Counseling Psychology*, 4: 370–380.

Anttonen, A. (2005). New trends in social policy research: comparative approach to social policy. *Janus. The Finnish Journal of Social Policy and Social Work Research*, 13 (3): 268–288.

Archer, J. (2001). Grief from an evolutionary perspective. In M.S. Stroebe, R.O. Hansson, W. Stroebe & H. Schut (eds) *Handbook of Bereavement Research: Consequences, Coping and Care*. Washington, DC: American Psychological Association.

Ariès, P. (1962). *Centuries of Childhood. A Social History of Family Life*. New York: Vintage Books.

Ariès, P. (1974). *Western Attitudes Towards Death: From the Middle Ages to the Present*. London: John Hopkins University Press.

Ariès, P. (1983). *The Hour of Our Death*. Harmondsworth: Penguin.

Árnason, A. (2000). Biography, bereavement, story. *Mortality* 5 (2): 190-204.

Árnason, A. (2001). Experts of the ordinary: Bereavement counselling in Britain. *Journal of Anthropological Institute*, 7 (2).

Árnason, A. & Hafsteinsson, B.S. (2003). The revival of death: Expression, expertise and governmentality. *British Journal of Sociology*, 54 (1): 43-62.

Árnason, A., Hafsteinsson, B.S. & Grétarsdóttir, T. (2004). New dawn: Death, grief and the 'nation form' in Iceland. *Mortality*, 9 (4): 329-343.

Arulmani, G. (2007). Counselling psychology in India: At the confluence of two traditions. *Applied Psychology*, 56 (1): 69-82.

Atwine, B., Cantor-Graae, E. & Bajunirweb, F. (2005). Psychological distress among AIDS orphans in rural Uganda. *Social Science and Medicine*, 61 (3): 555-564.

Babbie, E. (2007). *The Practice of Social Research* (11th edition). California: Wadsworth.

BACP (2010). *What is counselling and psychotherapy?* Available at <http://www.bacp.co.uk/crs/Training/whatiscounselling.php> Accessed: 22 -06-14

BACP (2013). *Ethical framework*, Available at http://www.bacp.co.uk/admin/structure/files/pdf/9479_ethical%20framework%20jan2013.pdf Accessed: 22 -06-13.

Badcock, C. (1992). *Essential Freud*. Oxford: Blackwell.

Bagilishya, D. (2000). Mourning and recovery from trauma: in Rwanda, tears flow from within. *Transcultural Psychiatry*, 37 (3): 337-353

Baginsky, J. (2004). *School counselling in England, Wales and Northern Ireland: A review*. NSPCC Information briefing. London: NSPCC

Barbato, A. & Irwin, H.J. (1992). Major therapeutic systems and the bereaved client. *Australian Psychologist*, 27 (1): 22-27.

Baum, F., MacDougall, C. & Smith, D. (2006). Participatory action research. *Journal of Epidemiology Community Health*. 60 (10): 854–857.

Bauman, Z. (1992). *Mortality, Immortality and Other Life Strategies*. Cambridge: Polity Press.

Benkel, I., Wijk, H. & Molander, U. (2009). Family and friends provide most support for the bereaved. *Palliative Medicine*, 23 (2): 141-149.

Beresford, P., Croft, S. & Adshead, L. (2008). We don't see her as a social worker: A service user case study of the importance of the social worker's relationship and humanity. *British Journal of Social Work*, 38 (7): 1388-1407.

Berger, P. & Luckman, T. (1966). *The Social Construction of Reality*. New York: Anchor Books.

Best, D.L. (2001). Gender concepts: Convergence in Cross-cultural research and methodologies. *Cross-Cultural Research*, 35 (1): 23-43.

Bikaako-Kajura, W., Luyirika, E., Purcell, D.W., Downing, J., Kaharuzam F., Mermin, J., Malamba, S. & Bunnell, R. (2006). Disclosure of HIV status and adherence to daily drug regimens among HIV-infected children in Uganda. *AIDS Behaviour*, 10 (4): 85-93.

Blanche, H.T. & Parkes, C.M. (1997). Christianity. In C.M. Parkes, P. Laungani & B. Young (eds) *Death and Bereavement Across Cultures*. London: Routledge.

Blok, A. (1982). Primitief en geciviliseerd [Primitive and civilised]. *Sociological Gids*, 29 (3-4): 197-209.

Bloomfield, K. (1998). *'We Will Remember Them': Report of the Northern Ireland Victims' Commissioner*. Belfast: The Stationery Office Northern Ireland.

Bocock, R. (1991). *Freud and Modern Society*. London: Chapman and Hall.

Bolton, D. & Rankin, G. (2008). *Mapping of Psychological Therapies in Northern Ireland. Report No. 3: The Voluntary and Community Sector*. Belfast: Commissioner for Victims and Survivors. Social Research Centre.

Bonanno, G. (1998). Emotional dissociation, self-deception, and adaptation to loss. In C. Figley (ed) *The Traumatology of Grieving*. Washington DC: Taylor and Francis.

Bonanno, G. (2001). Grief and emotion: A social-functional perspective. In M.S. Stroebe, R.O. Hansson, W. Stroebe, & H. Schut (eds) *Handbook of Bereavement Research: Consequences, Coping and Care*. Washington DC: American Psychological Association.

Bonanno, G. & Kaltman, S. (2001). The varieties of grief experience. *Clinical Psychology Review*, 21: 705-734.

Bond, M.H. & van de Vijver, F.J.R. (2011). Making scientific sense of cultural differences in psychological outcomes: Unpacking the *Magnum Mysterium*. In D. Matsumoto & F.J.R. van de Vijver (eds) *Cross-Cultural Research. Methods in Psychology*. Cambridge: University Press.

Bond, T. (1998). Metamorphosis of counselling: On becoming a profession. In K.F. Hunt & M.A. Robson (eds) *Counselling and Metamorphosis*. Durham: University of Durham.

Bowlby, J. (1969). *Attachment and Loss* (Volume 1): *Attachment*. New York: Basic Books.

Bowlby, J. (1973). *Attachment and Loss* (Volume 2): *Loss*. New York: Basic Books.

Bowlby, J. (1980). *Attachment and Loss* (Volume 3): *Loss, Sadness and Depression*. New York: Basic Books.

Bracken, P. (2002). *Trauma: Culture, Meaning and Philosophy*. London: Whurr Publishing Ltd.

Bradbury, M. (2001). Freud's mourning and melancholia. *Mortality*, 6 (2): 212-219.

Braun, K.L., Browne, C.V., Ka'oupa, L.S., Kim, B.J., & Mokuau, N. (2014). Research on indigenous elders: from positivistic to decolonizing methodologies. *Gerontologist*, 54 (1):117-26.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3 (2): 77-101.

Brewer, J. (2001). The paradox of Northern Ireland. *Sociology*, 35 (3): 779-783.

Brewer, J. & Sparkes, A.C. (2011). Young people living with parental bereavement: Insights from an ethnographic study of a UK childhood bereavement service. *Social Science and Medicine*, 72 (2): 283-290.

Broadfoot, P. (2000). Interviewing in a cross-cultural context: Some issues for comparative research. In C.J. Pole & R.G. Burgess (eds) *Studies in Qualitative Methodology* (Volume 6). Atlanta, GA: Elsevier Science.

Bryman, A. (2004). *Social Research Methods*. New York: Oxford University Press.

CAIN (2011). *Gross Domestic Product: Northern Ireland, 1990-1996*. Available at <http://cain.ulst.ac.uk/ni/economy.htm#Table1>. Accessed: 20-09-13.

CAIN (2012). *Background Information on Northern Ireland Society*. Available at <http://cain.ulst.ac.uk/>. Accessed: 01-03-12

CAIN (2013). *Background Information on Northern Ireland Society - Agriculture* <http://cain.ulst.ac.uk/ni/agric.htm>. Accessed: 20-09-13

Cairns, E. & Wilson, R. (1993). Stress, Coping and Political Violence in Northern Ireland. In J.P. Wilson & B. Raphael (eds) *International Handbook of Traumatic Stress Syndromes*. New York: Plenum Press.

Campbell, J. (2007). Social work, political violence and historical change: Reflections from Northern Ireland. *Social Work and Society International Online Journal*, 5(3) <http://www.socwork.net/sws/article/view/143/512>. Accessed: 17-04-15.

Campbell, J. & McCrystal, P. (2005). Mental health social work and the Troubles in Northern Ireland: A study of practitioner experiences. *British Journal of Social Work*, 5 (2): 173–90.

Carhart-Harris, R., Mayberg, H., Malizia, A. & Nutt, N. (2008). Mourning and melancholia revisited: correspondence between principles of Freudian metapsychology and empirical findings in neuropsychiatry. *Annals of General Psychiatry*, 7 (9): 1-23.

Cavalletto, G. (2007). *Crossing the Psycho-Social Divide. Freud, Weber, Adorno and Elias*. Farnham: Ashgate Publishing Limited.

Church, A. & Lonner, W. (1998). The cross-cultural perspective in the study of personality. *Journal of Cross-Cultural Psychology*, 29 (special edition): 32-62.

Clewell, M. (2002). *Mourning Beyond Melancholia: Freud's Psychoanalysis of Loss*. Kent State University. Kent, USA: JAPA.

Cohen, S. (2001). *States of Denial: Knowing about Atrocities and Suffering*. London: Polity Press.

Cooper, M. (2008). *Essential Research Findings in Counselling Psychotherapy: The Facts are Friendly*. London: Sage.

Cooper, M. (2011). Meeting the demand for evidence-based practice. *Therapy Today*, 22 (4): 10-16.

Corey, G. (2008). *Theory and Practice of Group Counselling* (8th edition). Belmont, CA: Wadsworth.

Coulter, C. (1999). *Contemporary Northern Irish Society. An Introduction*. London: Pluto Press.

Crowley, M. (1995). Crisis as a challenge: Counselling counsellors, persons living with HIV/AIDs and survivors. *Journal of Social Development in Africa*, 10 (2): 35-52.

Currier, J., Holland, J. & Neimeyer, R. (2007). The effectiveness of bereavement interventions with children: A meta-analytic review of controlled outcome research. *Journal of Clinical Child and Adolescent Psychology*, 36 (2): 253-259.

Currier, J., Neimeyer, R. & Berman, J. (2008). The effectiveness of psychotherapeutic interventions for the bereaved: A comprehensive quantitative review. *Psychological Bulletin*, 134 (5): 648-661.

CVS. (2011). *Troubled consequences: A report on the mental health impact of the civil conflict in Northern Ireland*. <http://www.cvsni.org/images/policy-research/pubs/Troubled-Consequences-Oct-2011.pdf>. Accessed: 18-04-15.

Dalal, F. (1997). A transcultural perspective on psychodynamic psychotherapy. *Group Analysis*, 30 (2): 203-215.

Dalal, F. (1998). *Taking the Group Seriously. Towards a Post-Foulkesian Group Analytic Theory*. London: Jessica Kingsley Publishers.

Davis, C., Wortman, C., Lehman, D. & Silver, R. (2000). Searching for meaning in loss: Are clinical assumptions correct? *Death Studies*, 24 (6): 497-540.

Demmer, C. (2007). Responding to AIDS-related bereavement in the South African context. *Death Studies*, 31 (9): 821-843.

Demmer, C. & Burghart, G. (2008). Experiences of AIDS-related bereavement in the USA and South Africa. *International Social Work*, 51 (3): 360-370.

Denzin, N.K. & Lincoln, Y.S. (eds) (2003). *Strategies of Qualitative Inquiry* (2nd edition). Thousand Oaks, CA: Sage Publications.

Denzin, N.K. Lincoln, Y.S., & Smith, L. T. (eds) (2008). *Handbook of Critical and Indigenous Methodologies*. Thousand Oaks, CA: Sage Publications.

DeSpelder, L. & Strickland, A. (2002). *The Last Dance: Encountering Death and Dying* (6th edition). New York: McGraw-Hill.

DETI (2006). *The Northern Ireland Quarterly Employment Survey*, Available at <http://www.detini.gov.uk/deti-stats-index/stats-surveys/stats-qes.htm>. Accessed: 20-09-13.

Derluyn, I., Broekaert, E., Schuyten, G., & De Temmerman, E. (2004). Post-traumatic stress in former Ugandan child soldiers. *Lancet*, 363: 861–863. doi:10.1016/S0140-6736(04)15734-6

DHSS (1997). *Living with the Trauma of the Troubles*, Available at www.ofmdfmi.gov.uk/livingwiththetraumaofthetroubles.pdf. Accessed: 03-09-09.

DHSSPS (2002). *Counselling in Northern Ireland: Report of the Counselling Review*, Available at <http://www.dhsspsni.gov.uk/counsel.pdf>. Accessed: 25-06-14.

DHSSPS (2003). *Racial Equality in Health & Social Care: A Good Practice Guide*. <http://www.scie-socialcareonline.org.uk/racial-equality-in-health-and-social-care-good-practice-guide/r/a11G000000182xRIAQ>. Accessed: 25-06-14.

DHSSPS (2009a). *Northern Ireland Health and Social Care Services Strategy for Bereavement Care*, <http://www.dhsspsni.gov.uk/nihsc-strategy-for-bereavement-care-june-2009.pdf>. Accessed: 25-06-14.

DHSSPS (2009b). *Northern Ireland Audit: Dying, death and bereavement. Policies, procedures and practices in hospital and hospice settings*. GAIN Guidelines and Audit Implementation Network. Available at <http://www.gain-ni.org/images/Uploads/Audit/Dying%20Death%20%20Bereavement%20Audit.pdf>
Accessed: 08-08-12

DHSSPS (2010). *A Strategy for the Development of Psychological Therapies in Northern Ireland*, Available at <http://www.dhsspsni.gov.uk/a-strategy-for-the-development-of-psychological-therapy-service-june-2010.pdf>. Accessed: 01-13-13.

DHSSPS (2013). *Look after yourself and others. Northern Area useful Contacts for Practical Support and Services to help Improve Mental Health and Emotional Well Being*, Available at http://www.northerntrust.hscni.net/pdf/Mental_health_contacts.pdf. Accessed: 27-02-13.

Dillenberger, K., Montserrat, F., & Akhonzada, R. (2008). Long-term effects of political violence: Narrative inquiry across a 20 year period. *Qualitative Health Research*, 18 (10): 1312-1322.

Dixon, P. (2004). *The Truth About AIDS*. London: ACET International Alliance.

DoH (2002). *The Human Organs Inquiry*, Available at <http://www.dhsspsni.gov.uk/hoi-mainreport.pdf>. Accessed: 25-06-14.

DoH (2005). *When a Patient Dies: Advice on Developing Bereavement Services in the NHS*. Available at http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4122193.pdf.

Accessed: 25-06-14.

Doka, K.J. (1989). *Disenfranchised Grief: Recognizing Hidden Sorrow*. Michigan: Lexington Books.

Doka, K. J. (1999). Disenfranchised grief. *Bereavement Care*, 18 (3): 37–39.

Douglas, M. (1963). *The Lele of the Kasai*. London: Oxford University Press.

Douglas, M. (1966). *Purity and Danger*. Baltimore: Penguin Books.

Dozois, D. (2000). Influences on Freud's mourning and melancholia and its contextual validity. *Journal of Theoretical and Philosophical Psychology*, 20 (2): 167-195.

Draper, P., Holloway, M. & Adamson, P. (2013). A qualitative study of recently bereaved people's beliefs about death: implications for bereavement care. *Journal of Clinical Nursing*, 23(9-10):1300-1308. doi: 10.1111/jocn.12326.

Duerr, H.P. (1988). *Nacktheit und Scham: der Mythos vom Zivilisationsprozess* (Volume 1). Frankfurt: Suhrkamp.

Dunning, E. & Hughes, J. (2013). *Norbert Elias and Modern Sociology. Knowledge, Interdependence, Power, Process*. London: Bloomsbury.

Dunphy, R. & Schniering, C. (2009). The experience of counselling the bereaved. *The Humanistic Psychologist*, 37 (4): 353-369.

Durkheim, E. (1984[1893]). *The Division of Labour in Society*. New York: The Free Press.

Durkheim, E. (2006[1897]). *On Suicide*. London: Penguin Books.

Dush, D. (1998). Balance and boundaries in grief counselling. An intervention framework for volunteer training. *Hospice Journal*, 4 (1):79-93.

Egan, G. (1998). *A Problem- Management and Opportunity-Development Approach to Helping*, (6th edition.). Pacific Grove, CA: Brooks/Cole Publishing Company.

Eisenbruch, M. (1984a). Cross-cultural aspects of bereavement 1: A conceptual framework for comparative analysis. *Culture, Medicine and Psychiatry*, 8 (3): 283-309.

Eisenbruch, M. (1984b). Cross-cultural aspects of bereavement 2: Ethnic and cultural variations in the development of bereavement practices. *Culture, Medicine and Psychiatry*, 8 (4): 315-347.

Elias, N. (1974). Foreword: Towards a Theory of Communities. In C. Bell & H. Newby (eds) *The Sociology of Community. A Selection of Readings*. London: Frank Cass and Company Limited.

Elias, N. (1978 [1970]). *What is Sociology?* London: Hutchinson.

Elias, N. (1984). *Über die Zeit*. Frankfurt: Suhrkamp.

Elias, N. (1986). Figuration, Prozesse, Soziale Zivilisation. In B. Schafers (ed) *Grundbegriffe der Soziologie*. Leverkusen: Leske and Budrich.

Elias, N. (1987a). *Involvement and Detachment: Contributions to the Sociology of Knowledge*. (ed: M. Schröter). Oxford: Blackwell.

Elias, N. (1987b). On human beings and their emotions: A process-sociological essay. *Theory, Culture and Society*, 4 (2-3): 339-361.

Elias, N. (1991a [1987]). *The Society of Individuals*. Oxford: Blackwell.

Elias, N. (1991b [1989]). *The Symbol Theory*. London: Sage.

Elias, N. (1994a [1939]). *The Civilizing Process* (Volume 1, *The History of Manners & Volume 2, State Formation and Civilisation*). Oxford: Blackwell.

Elias, N. (1994b [1987]). *Reflections on a Life*. Cambridge: Polity Press.

Elias, N. (1997 [1989]). *The Germans* (ed: M. Schröter). Cambridge: Polity Press.

Elias, N. (2001 [1982]). *The Loneliness of the Dying*. London: Continuum International Publishing Group.

Elias, N. (2006 [1933])). *The Court Society*. Dublin: University College Dublin Press.

Elias, N. (2012). *On the Process of Civilisation (Collected Works of Norbert Elias)* (eds S. Mennell, E. Dunning, J. Goudsblom & R. Kilminster). Dublin: University College Dublin Press.

Elias, N. & Dunning, E. (1986). *Quest for Excitement: Sport and Leisure in the Civilising Process*. Oxford: Blackwell.

Elliot, R. & James, E. (1989). Varieties of client experience in psychotherapy: An analysis of the literature. *Clinical Psychology Review*, 9 (4): 443–46.

Elliott, R. & Timulak, L. (2005). Descriptive and interpretive approaches to qualitative research. In J. Miles & P. Gilbert (eds) *A Handbook of Research Methods in Clinical and Health Psychology*. Oxford: Oxford University Press.

Erikson, E.H. (1950). *Childhood and Society*. New York: Norton.

Etherington, K. (1996). The counsellor as researcher: Boundary issues and critical dilemmas. *British Journal of Guidance and Counselling*, 24 (3): 339-346.

Ewart, S. & Schubotz, D. (2004). *Voices Behind the Statistics: Young People's Views on Sectarianism in Northern Ireland*. London: National Children's Bureau.

Exley, C. (2004). The sociology of dying, death and bereavement. *Sociology of Health & Illness*, 26 (1): 110-122.

Fay, M., Morrissey, M. & Smyth, M. (1999). *Northern Ireland's Troubles: The Human Costs*. London: Pluto Press.

Featherstone, M. (1987). Norbert Elias and Figural Sociology. *Theory, Culture and Society*, 4 (2): 197-211.

Fenton, S. (1984). *Durkheim and Modern Sociology*. Cambridge: Cambridge University Press.

Field, D., Payne, S., Relf, M. & Reid, D. (2007). Some issues in the provision of adult bereavement support by UK hospices. *Social Science and Medicine*, 64 (2): 428–438.

Field, D., Reid, D., Payne, S. & Relf, M. (2004). Survey of UK hospice and specialist palliative care adult bereavement services. *International Journal of Palliative Nursing*, 10 (12): 569-576.

Firth, S. (2000). Approaches to Death in Hindu and Sikh Communities. In D. Dickenson, M. Johnson & J. Katz. (eds) *Death, Dying and Bereavement* (2nd edition). London: Sage.

Fjermestad, K., Kvestad, I., Daniel, M. & Lie, I. (2008). ‘It can save you if you just forget’: closeness and competence as conditions for coping among Ugandan Orphans. *Journal of Psychology in Africa*, 18 (3): 445–455.

Fonagy, P. (2003). Psychoanalysis today. *World Psychiatry*, 2 (2): 73-80.

Forte, A., Hill, M., Pazder, R. & Feudtner, C. (2004). Bereavement care interventions: A systematic review. *BMC Palliative Care*, 3 (3): doi:10.1186/1472-684x-3-3

Foucault, M. (1980). *Power/Knowledge: Selected Interviews and Other Writings, 1972-1977*. New York: Random House.

Foucault, M. (1994[1966]). *The Order of Things: An Archaeology of the Human Sciences*. New York: Random House.

Foulkes, S.H. (1957). Group analytic dynamics with specific references to psychoanalytic concepts. *International Journal of Group Psychotherapy*, 7:40-52.

Fraley, R.C. & Shaver, P.R. (1999). Loss and bereavement: Attachment theory and recent controversies concerning “grief work” and the nature of detachment. In J. Cassidy & P.R. Shaver (eds) *Handbook of Attachment Theory and Research: Theory, Research, and Clinical Applications*. New York: Guilford Press.

Freeman, R. (1994). The concept of transference: An introduction to its role in the psychoanalytic process. In R. Ekins & R. Freeman (eds) *Centres and Peripheries of Psychoanalysis*. London: Karnac Books.

Freud, S. (1905). *Three Essays on the Theory of Sexuality* (standard edition), London: Hogarth Press.

Freud, S. (1912-1913). *Totem and Taboo* (standard edition), London: Hogarth Press.

Freud, S. (1914). *On Narcissism* (standard edition), London: Hogarth Press.

Freud, S. (1915). *Repression*. (standard edition), London: Hogarth Press.

Freud, S. (1916). *On Transience* (standard edition), London: Hogarth Press.

Freud, S. (1917). *Mourning and Melancholia* (standard edition), London: Hogarth Press.

Freud, S. (1920). *Beyond the Pleasure Principle* (standard edition), London: Hogarth Press.

Freud, S. (1921). *Group Psychology and the Analysis of the Ego* (standard edition), London: Hogarth Press.

Freud, S. (1923). *The Ego and the Id* (standard edition), London: Hogarth Press.

Freud, S. (1927). *The Future of an Illusion* (standard edition), London: Hogarth Press.

Freud, S. (1930). *Civilisation and its Discontents* (standard edition), London: Hogarth Press.

Freud, S. (1939). *Moses and Monotheism* (standard edition), London: Hogarth Press.

Freud, S. (1991 [1923]). *The Ego and the Id*. London: Penguin Press.

Fromm, E. (1971 [1935]). *The crisis of psychoanalysis: Essays on Freud, Marx and social psychology*. Greenwich: Fawcett Publications.

Frosh, S. (1987). *The Politics of Psychoanalysis: An Introduction to Freudian and Post-Freudian Theory*. London: Macmillan.

Gallagher, M., Tracey, A. & Millar, R. (2005). Ex-client's evaluation of bereavement counselling in a voluntary sector agency. *Psychology and Psychotherapy: Theory, Research and Practice*, 78 (1): 59-76.

Gans, H. (1968). The Participant-observer as human being: Observations on the personal aspects of field work. In H.S. Becker, B. Greer, D. Riesman & R.S. Weiss (eds) *Institutions and the Person: Papers Presented to Everett C. Hughes*. Chicago: Aldine.

- Gardner, K. (1998). Death, burial and bereavement amongst Bengali Muslims in Tower Hamlets, East London. *Journal of Ethnic and Migration Studies*, 24 (3): 507-521.
- Garfield, C.A. & Jenkins, G.L. (1981). Stress and coping of volunteers: Counselling the dying and bereaved. *Omega Journal of Death and Dying*, 12 (1): 1-13.
- Garnham, N. (2001). Reaching for my revolver. Problems with the concept of culture. *European Review*, 9 (4): 413-420.
- Gay, P. (1989). *The Freud Reader*. New York: Norton.
- Genevro, J.L., Marshall, T. & Miller, T. (2004). Report on Bereavement and Grief Research. Center for Advancement in Health. *Death Studies*, 28 (6): 491-575.
- Gerstein, L., Heppner, P., Ægisdóttir, S., Leung, S. & Norsworthy, K. (2009). *International Handbook of Cross-Cultural Counselling: Cultural Assumptions and Practices Worldwide*. London: Sage.
- Gibson, M. & Iwaniec, D. (2003). An empirical study into the psychosocial reactions of staff working as helpers to those affected in the aftermath of two traumatic incidents. *British Journal of Social Work*, 33(7): 851–70.
- Giddens, A. (1991). *Modernity and Self-Identity: Self and Society in the Late Modern Age*. Cambridge: Polity Press.
- Gielen, U.P. (1997). A death on the roof of the world: The perspective of Tibetan Buddhism. In C.M. Parkes, P. Laungani & B. Young (eds) *Death and Bereavement Across Cultures*. London: Routledge.

Gilbert, P. (2008). The therapeutic relationship in cognitive-behavioural therapy. *Behavioural and Cognitive Psychotherapy*, 36 (6): 769-777.

Gilbert, P. & Leahy, R. (eds) (2007). *The Therapeutic Relationship in the Cognitive Behavioural Psychotherapies*. London: Routledge.

Glaser, B.G. & Strauss, A. (1967). *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Chicago: Aldine.

Goldstein, R. (2009). 'Blowin' in the Wind': Holding on to values in the face of regulation in Britain. In L. Gerstein, P. Heppner, S. Ægisdóttir, S. Leung & K. Norsworthy (eds) *International Handbook of Cross-Cultural Counselling. Cultural Assumptions and Practices Worldwide*. London: Sage.

Gómez, M.V. & Kuronen, M. (2011). Comparing local strategies and practices: recollections from two qualitative cross-national research projects. *Qualitative Research* 11(6): 683–697.

Goody, J. (2002). Elias and the Anthropological Tradition, *Anthropological Theory*, 2(4): 401–412.

Gorer, G. (1965). *Death, Grief and Mourning in Contemporary Britain*. London: Cresset.

GOU. Ministry of Education and Sports (2008) *Guidance and Counselling*. Available at <http://www.education.go.ug/data/smenu/18/Guidance%20and%20Counselling.html>.

Accessed: 07-08-14.

Goudsblom, J. (1987). The sociology of Norbert Elias: Its resonance and significance. *Theory, Culture and Society*, 4 (2): 323-327.

Grafanaki, S. (1996). How research can change the researcher: The need for sensitivity, flexibility and ethical practice. *British Journal of Guidance & Counselling*, 24 (3): 329-338.

Granek, L. (2010). Grief as pathology. The evolution of grief theory in psychology from Freud to the present. *History of Psychology*, 13 (1): 46-73.

Grant, E., Brown, J., Leng, M., Bettega, N. & Murray, S. (2011). Palliative care making a difference in rural Uganda, Kenya and Malawi. *BMC Palliative Care*, 10: 8
doi:10.1186/1472-684X-10-8

Grant, E., Murray, S., Grant, A. & Brown, J. (2003). A good death in rural Africa? Listening to patients and their families talk about care needs at the end of life. *Journal of Palliative Care*, 19 (3): 159–167.

Green, J. (2000). The role of theory in evidence-based health promotion practice. *Health Education Research*, 15 (2): 125-129.

Grinstead, O. & van der Straten, A. (2000). Counsellors' perspectives on the experience of providing HIV counselling in Kenya and Tanzania. *Aids Care*, 12 (5): 625-642.

Guba, E. & Lincoln, Y. (1994). Competing paradigms in qualitative research. In N. Denzin & Y. Lincoln (eds) *Handbook of Qualitative Research*. Thousand Oaks, CA: Sage.

Gusdal, A., Obua, C., Andualem, T., Wahlström, R., Chalker, J. & Fochsen, J. (2011). Peer counselors' role in supporting patients' adherence to ART in Ethiopia and Uganda. *AIDS Care*, 23 (6): 657-662.

Gysels, M., Pell, P., Straus, L. & Pool, R. (2011). End-of-life care in Sub-Saharan Africa: A systemic review of the qualitative literature. *BMC Palliative Care*, 10: 6. doi:10.1186/1472-684X-10-6

Hagman, G. (1995). Mourning: A review and reconsideration. *International Journal of Psychoanalysis*, 76 (5): 909-925.

Hagman, G. (1996). The role of the other in mourning. *Psychoanalytical Quarterly*, 65: 327-352.

Hagman, G. (2001). Beyond decathexis: Toward a new psychoanalytic understanding and treatment of mourning. In R.A. Neimeyer (ed) *Meaning, Reconstruction and the Experience of Loss*. Washington DC: American Psychological Association.

Hansson, R.O. & Stroebe, M. S. (2007). *Bereavement in Late Life: Coping, Adaptation, and Developmental Influences*. Washington DC: American Psychological Association.

Healthcare Commission (2007). *Spotlight on complaints: A report on second-stage complaints about the NHS in England*, Available at http://www.healthcarecommission.org.uk/db/documents/spotlight_on_complaints.pdf
Accessed: 15-12-09.

Her Majesty's Government (2013). *Parliament Counsellors and Psychotherapists (Regulation) Bill 2013-14*, Available at

<http://services.parliament.uk/bills/201314/counsellorsandpsychotherapists.html>.

Accessed: 14-04-14.

Hendron, J., Irving, P. & Taylor, B. (2014). The unseen cost: A discussion of the secondary traumatization experience of the clergy. *Pastoral Psychology*, 61 (2): 221-231.

Hertz, R. (1960 [1907]). *Death and the Right Hand* (trans: R. & C. Needham). New York: The Free Press.

Hillyard, P., Kelly, E., McLaughlin, D., Patisos, D. & Tomlinson, M. (2003). *Bare Necessities: Poverty and Social Exclusion in NI*. Belfast: Democratic Dialogues.

Higson-Smith, C. (2014). Complicated grief in help-seeking torture survivors in sub-Saharan African contexts. *American Journal of Orthopsychiatry*, 84 (5): 487–495.

HM Treasury (2011). *Rebalancing the Northern Ireland Economy*

Available at:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/81554/rebalancing_the_northern_ireland_economy_consultation.pdfhttps://www.gov.uk/government/uploads/system/uploads/attachment_data/file/81554/rebalancing_the_northern_ireland_economy_consultation.pdf. Accessed on 1-07-14

HMSO (1998a). *Data Protection Act*. London: HMSO.

HMSO (1998b). *Human Rights Act*. London: HMSO.

Hockey, J. (1990). *Experiences of Death: An Anthropological Account*. Edinburgh: Edinburgh University Press.

Hodge, D. (2010). Sub-Saharan African women living with HIV/AIDS: An exploration of general and spiritual coping. *Social Work*, 55 (1): 27-37.

Holloway, M. (2006.) Death the Great Leveller? Towards a transcultural spirituality of dying and bereavement, *Journal of Clinical Nursing, Special Issue Spirituality*, 15 (7): 833-839.

Holloway, M. (2007). *Negotiating Death in Contemporary Health and Social Care*. University of Bristol: The Policy Press.

Holloway, M. (2009). Dying Old in the Twenty-first Century: a neglected issue for social work. *International Social Work*, 53 (5): 1-13.

Holmes, J. (1993). *John Bowlby and Attachment Theory*. London: Routledge.

Holt, W. & Larson, D. (2010). What have we learned from research on grief counselling? *Bereavement Care*, 29 (1): 10-13.

Hooper, E. (1987). AIDS in Uganda. *African Affairs*, 86: 469-477.

Hornstein, G.A. (1992). The return of the repressed: Psychology's problematic relations with psychoanalysis, 1909-1960. *American Psychologist*, 47 (2): 254-263.

Howarth, G. (1996). *Last Rites: The Work of the Modern Funeral Director*. New York: Baywood.

Howarth, G. (2000). Dismantling the boundaries between life and death. *Mortality*, 5 (2): 127-136.

Howarth, G. (2007a). *Death and Dying. A Sociological Introduction*. Cambridge: Polity Press.

Howarth, G. (2007b). Whatever happened to social class? An examination of the neglect of working class cultures in the sociology of death. *Health Sociology Review*, 16 (5): 425-435.

Howarth, G. (2007c). The rebirth of death: Continuing relationships with the dead. In M. Mitchell (ed) *Remember Me? Constructing Immortality*. Washington DC: Taylor and Francis.

Howarth, G. (2011). The emergence of new forms of dying in contemporary societies. In B. Monroe, D. Olivieri & S. Payne (eds) *Death, Dying and Social Differences* (2nd edition). Oxford: Oxford University Press.

IGA (2014) *The Institute of Group Analysis*, Available at <http://www.groupanalysis.org/Home.aspx> Accessed: 05-06-14.

IMF (2000). *Debt Relief for Uganda Increased to a Total of US\$2 Billion*, Press Release No. 00/6, 8th February 2000, Available at <http://www.imf.org/external/np/sec/pr/2000/pr0006.htm>. Accessed: 20-09-13.

Irish, D., Lundquist, K. & Nelson, V. (1993). *Ethnic Variations in Dying, Death and Grief*. London: Taylor and Francis.

Jalland, P. (2013). A culture of silent grief? The transformation of bereavement care in 20th Century England. *Bereavement Care*, 32 (1): 16-22.

Jacobsen, J.C., Zhang, B., Block, S.D., Maciejewski, P.K. & Prigerson, H.G. (2010). Distinguishing symptoms of grief and depression in a cohort of advanced cancer patients. *Death Studies*, 34 (3): 257–273.

Janoff-Bulman, R. (1989). Assumptive worlds and the stress of traumatic events: Applications of the schema construct. *Social Cognition*, 7 (2): 113-136.

Jarman, N. (2005). *No longer a problem? Sectarian violence in Northern Ireland*, Institute for Conflict Research, Available at <http://www.ofmdfmi.gov.uk/violence.pdf>. Accessed: 14-04-14.

Jones, E. E. (Ed.). (1996). Attachment and psychopathology [Special section]. *Journal of Consulting and Clinical Psychology*, 64, 5–73.

Jonker, G. (1997). The many facets of Islam: Death, dying and disposal between orthodox rule and historical convention. In C.M. Parkes, P. Laungani. & B. Young (eds) *Death and Bereavement Across Cultures*. London: Routledge.

Jordan, J. & Neimeyer, R. (2003). Does grief counseling work? *Death Studies*, 27 (9): 765-786.

Jowell, R. (1998). How comparative is comparative research? *American Behavioral Scientist*, 42 (2): 168.

Kairania, R., Gray, R., Kiwanuka, N., Makumbi, F., Sewankambo, N., Serwadda, D., Nalugoda, F., Kigozi, G., Semanda, J. & Wawer, M. (2010). Disclosure of HIV results among discordant couples in Rakai, Uganda: A facilitated couple approach. *AIDS Care*, 22 (9): 1041-1051.

Kaleeba, N., Kalibala, S. & Kaseje, M. (1997). Participatory evaluation of counselling, medical, and social services of the AIDS support organization (TASO), Uganda. *AIDS Care*, 9 (1): 13-26.

Kalu, W.J. (1989). Widowhood and its process in contemporary African society: A psychosocial study. *Counseling Psychology Quarterly*, 2 (2): 143-152.

Kang'ethe, S.M. (2009). Traditional healers as caregivers to HIV/AIDS clients and other terminally challenged persons in Kanye community home-based care programme (CHBC), Botswana. *Sahara*, 6 (2): 83-91.

Karamagi, C.A., Lubanga, R.G., Kiguli, S., Ekwaru, P.J. & Heggenhougen, K. (2004). Health providers' counselling of caregivers in the integrated management of childhood illness (IMCI) Programme in Uganda. *African Health Science*, 4 (1): 31-39.

Kauffman, J. (2002). The Psychology of Disenfranchised Grief: Shame, Liberation and Self-Disenfranchisement. In K. J. Doka (ed.), *Disenfranchised Grief: New Directions, Challenges, and Strategies for Practice*. Champaign, IL: Research Press.

Kellehear, A. (1984). Are we a death denying society? A sociological review. *Social Science and Medicine*, 18 (9): 713-723.

Kellehear, A. (2000). Spirituality and palliative care: a model of needs. *Palliative Medicine*, 14 (2):149-155.

Kelly, A. & Ford, L. (2009). Aid to Uganda: How the UK government is supporting the country. *The Guardian*, 30th January 2009, Available at <http://www.theguardian.com/katine/2009/jan/30/dfid-aid-to-uganda>. Accessed: 20-09-13.

Kiboneka, A., Nyatia, R. J., Nabiryo, C., Anema, A., Cooper, C. L., Fernandes, K. A., et al. (2009). Combination antiretroviral therapy in population affected by conflict: Outcomes from large cohort in Northern Uganda. *BMJ*, 338, doi: <http://dx.doi.org/10.1136/bmj.b201>. Accessed: 05-03-15.

Kikule, E. (2003). A good death in Uganda. Survey of needs for palliative care for terminally ill people in urban areas. *British Medical Journal*, 327: 192-194. (Published 24 July 2003).

Kilonzo, G. & Hogan, M. (1999). Traditional African mourning practices are abridged in response to the AIDS epidemic. Implications for mental health. *Transcultural Psychiatry*, 36 (3): 259-283.

Kipp, W., Kabagamb, G. & Kondelule, J. (2002). HIV Counselling and testing in rural Uganda. *AIDS Care*, 14 (5): 699-706.

Klass, D. (1996). Ancestor worship in Japan: Dependence and the resolution of grief. *Omega, Journal of Death and Dying*, 33 (4): 279–302.

Klass, D. (1999). Developing a cross-cultural model of grief: The state of the field. *Omega, Journal of Death and Dying*, 39 (3): 153–178.

Klass, D. (2008). Grief and Mourning in Cross-Culture Perspective. *Encyclopaedia of Death and Dying*, Available at <http://www.deathreference.com/Gi-Ho/Grief-and-Mourning-in-Cross-Cultural-Perspective.html>. Accessed: 26-01-08.

Klass, D. & Goss, R. (1999). Spiritual bonds to the dead in cross-cultural and historical perspective: Comparative religion and modern grief. *Death Studies*, 23 (6): 547-567.

Klass, D. & Walter, T. (2001). Processes of grieving: How bonds are continued? In M.S. Stroebe, R.O. Hansson, W. Stroebe & H. Schut (eds) *Handbook of Bereavement Research: Consequences, Coping and Care*. Washington DC: American Psychological Association.

Klass, D., Silverman, P. R. & Nickman, S. (Eds.) (1996). *Continuing Bonds: New Understandings of Grief*. Washington, DC: Taylor & Francis.

Kohls, R. & Brussow, H. (eds) (1995). *Training Know-how for Cross Cultural and Diversity Trainers*. Texas: Adult Learning Systems Inc.

Kohn, M.L. (1977). *Class and Conformity. A Study in Values* (2nd edition). Chicago: University of Chicago Press.

Kubler-Ross, E. (1969). *On Death and Dying*. New York: Macmillan.

Kvale, S. (1996). *Interviews: An Introduction to Qualitative Research Interviewing*. Thousand Oaks, CA: Sage.

Labi, N. (1999). The Grief Brigade, *Times Magazine*, 153:19, Available at <http://tanadineen.com/media/MediaInterviews/TIMEMagazine%20-Grief-Counseling.html>. Accessed: 12-02-11.

Lago, C. (1996). *Race, Culture and Counselling*. Buckingham: Open University Press.

Lalande, K. & Bonanno, G. A. (2006). Culture and continued bonds during bereavement: A prospective comparison in the United States and China. *Death Studies*, 3 (4): 303-324.

Laplanche, J. & Pontalis, J. (1988). *The Language of Psychoanalysis*. London: Karnac Books.

Larson, D. & Hoyt, W. (2007). What has become of grief counseling? An evaluation of the empirical foundations of the new pessimism. *Professional Psychology: Research and Practice*, 38 (4): 347-355.

Laungani, P. (1996). Death and bereavement in India and England: A comparative analysis. *Mortality*, 1(2): 191 – 212.

Laungani, P. (1997). Death in a Hindu Family. In C.M Parkes, P. Laungani & B. Young (eds) *Death and Bereavement Across Cultures*. London: Routledge.

Lavie, J. (2005). The lost roots of the theory of group analysis: Taking interrelational individuals seriously. *Group Analysis*, 38 (4): 519-535.

Lazarus, R. & Folkman, S. (1984). *Stress, Appraisal, and Coping*. New York: Springer.

Leach, E.R. (1986). Violence. *London Review of Books*, 23rd October.

Leming, M.R. & Dickinson, G.E. (1994). *Understanding Dying, Death, and Bereavement*. Orlando: Harcourt Brace College Publishers.

Levine, E. (1997). Jewish views and customs on death. In C.M Parkes, P. Laungani. & B. Young (eds) *Death and Bereavement Across Cultures*. London: Routledge.

Lewis, C.S. (1985). *A Grief Observed*. London: Faber & Faber.

Lie, G. & Biswalo, P. (1994). Perceptions of the appropriate HIV/AIDS counselor in Arusha and Kilimanjaro regions of Tanzania: Implications for hospital based counselling. *AIDS Care*, 6 (2): 139-151.

Lincoln, Y. & Guba, E. (1985). *Naturalistic Inquiry*. Beverly Hills, CA: Sage.

Lindemann, E. (1944). Symptomatology and management of acute grief. *American Journal of Psychiatry*, 101 (2): 141-148.

Liston, K. & Mennell, S. (2009). Ill met in Ghana: Jack Goody and Norbert Elias on process and progress in Africa. *Theory, Culture and Society*, 26 (7-8): 52-70.

Littlejohn, S. (2002). *Theories of Human Communication*. Albuquerque NM: Wadsworth.

Lloyd, M. (1997). Dying and bereavement, spirituality and social work in a market economy of welfare. *British Journal of Social Work*, 27 (2): 175-190.

London Bereavement Network (2001). UK Standards for Bereavement Care, *MABF Forum Newsletter*, Winter 2001-2002, 4 (3) Available at http://www.mabf.org.uk/newsletter_archive.asp?archive=43. Accessed: 10-09-12.

Lovell, D., Hemmings, G. & Hill, A. (1993). Bereavement reactions of female Scots and Swazis: A preliminary comparison. *British Journal of Medical Psychology*, 66 (3): 259-274.

Loyal, S. & Quilley, S. (eds) (2004). *The Sociology of Norbert Elias*. Cambridge: Cambridge University Press.

Luke, T.W. (1990). *Social Theory and Modernity. Critique, Dissent and Revolution*. London: Sage.

Lukes, S. (1973). *Emile Durkheim. His Life and Work. A Historical and Critical Study*. CA: Stanford University Press.

Maasdorp, V. & Martin, R. (2009). Grief and Bereavement in the Developing World. In J. Morgan, P. Laungani & S. Palmer (eds) *Death and Bereavement Around the World*. New York: Baywood Publishing Company.

Mabbett, D. & Bolderson, H. (1999). Theories and methods in comparative social policy. In J. Clasen (ed) *Comparative Social Policy: Concepts, Theories and Methods*. Oxford: Blackwell.

Machin, L. (1998). Grief counselling in context: multiple roles and professional compromise. *British Journal of Guidance and Counselling*, 26 (3): 387-397.

Madu, S., Baguma, P. & Pritz, A. (1997). *African Traditional Healing: Psychotherapeutic Investigation*. Kampala, Uganda: Access Communications.

Malinsoki, B. (1948 [1925]). *Magic, Science and Religion, and Other Essays*. Boston: Beacon Press.

Manktelow, R. (2007). The needs of victims of the Troubles in Northern Ireland: The Social Work contribution. *British Journal of Social Work*, 7 (1): 31-50.

Mantala-Bozos, K.I. (2003). The role of religion and culture on bereavement: The example of the Orthodox Christian tradition. *Journal of Critical Psychology, Counselling and Psychotherapy*, 3 (2): 1-10.

Marshall, S. (2007). Bereavement counselling - is it viable? *Therapy Today*, 18 (5): 4-6.

Martin, J. & Dean, L. (1993). Bereavement following death from AIDS: Unique problems, reactions, and special needs. In M.S. Stroebe, W. Stroebe & R.O. Hansson (eds) *Handbook of Bereavement*. Cambridge: Cambridge University Press.

Mason, J. (2006). Mixing methods in a qualitatively driven way. *Qualitative Research*, 6 (1): 9-25.

Masson, J. (1989). *Against Therapy*. London: Collins.

Matsumoto, D. & Van de Vijver, F.J.R. (2011). *Cross-Cultural Research Methods in Psychology*. Cambridge: Cambridge University Press.

May, T. (2001). *Social Research Issues, Methods and Process*. Buckingham: Open University Press.

McGuinness, J., Alfred, G., Cohen, N., Hunt, K. & Robson, M. (2001). Application of humanistic counselling in Kenya. *British Journal of Guidance and Counselling*, 29 (3): 293-300.

McKittrick, D., Kelters, S., Feeney, B. & Thornton, C. (1999). *Lost Lives: The Stories of the Men, Women and Children who Died as a Result of the Northern Ireland Troubles*. London: Mainstream Publishing.

McLaren, J. (1998). A new understanding of grief: A counsellor's perspective. *Mortality*, 24 (3): 275-290.

McLeod, J. (1996). Qualitative approaches to research in counselling and psychotherapy: Issues and challenges. *British Journal of Guidance and Counselling*, 24 (3): 309-316.

McLeod, J. (2003). *Doing Counselling Research*. London: Sage.

McLeod, J. (2009). *An Introduction to Counselling*. Milton Keynes: Open University Press.

McLeod, J. & Machin, L. (1998). The context of counselling: A neglected dimension of training, research and practice. *British Journal of Guidance & Counselling*, 26 (3): 325-336.

McLeod, J. & Wheeler, S. (1995). Person-centred and psychodynamic counselling: A dialogue. In S. Palmer, S. Dainow & P. Milner (eds) *Counselling: The BAC Counselling Reader*. London: Sage.

McMullen, J., O'Callaghan, P., Richards, J., Eakin, J. & Rafferty, H. (2012). Screening for traumatic exposure and psychological distress among war-affected adolescents in post-conflict northern Uganda. *Social Psychiatry and Psychiatric Epidemiology*, 47 (9): 1489-98.

McNally, D. (2007). The significance of social and political context: A qualitative study of adults bereaved during childhood and adolescence due to the Northern Ireland troubles. *Quest*, 5 30-46.

McNally, D. (2011). Bereavement and the troubles in Northern Ireland. *Bereavement Care*, 30 (2): 17-22.

Meichenbaum, D. (1977). *Cognitive-Behavior Modification: An Integrative Approach*. New York: Plenum Press.

Mellor, P. & Shilling, C. (1993). Modernity, self-identity and the sequestration of death, *Sociology*, 27 (3): 411–432.

Mennell, S. (1992). *Norbert Elias: An Introduction*. Dublin: University College Dublin Press.

Mennell, S. (2006). Civilizing processes. Problematizing global knowledge and the new encyclopaedia project: An introduction. *Theory, Culture and Society*, 23(2): 1-20.

Mennell, S. & Goudsblom, J. (1997). Civilizing processes – myth or reality? A comment on Duerr's critique of Elias. *Comparative Studies in Society and History*, 39 (4): 729-733.

Merton, R.K. (1967). *On Theoretical Sociology*. New York: Free Press.

Middleton, J. (1987 [1966]). *Lugbara Religion: Ritual and Authority among an East African People*. London: Lit Verlag.

Miles, M. (1979). Qualitative data as an attractive nuisance. *Administrative Science Quarterly*, 24 (4): 590-601.

Miller, L. & Brewer, J. (2003). *The A-Z of Social Research: A Dictionary of Key Social Science Research Concepts*. London: Sage.

Minuchin, S. & Fishman, H.C. (1981). *Family Therapy Techniques*. Cambridge, MA: Harvard University Press.

Moore, B.E. & Fine, D. (eds) (1990). *Psychoanalytic Terms and Concepts*. New Haven: Yale University Press for the American Psychoanalytic Association.

Morgan, J.D., Laungani, P. & Palmer, S. (eds) (2009). *Death and Bereavement Around the World. Volume 5: Reflective Essays*. New York: Baywood Publishing Company.

Mpolo, M. (1985). *The Risk of Growth: Counselling and Pastoral Theology in the African Context*. Nigeria: Daystar Press.

Muhwezi, W., Ågren, H., Neema, S., Musisi, S. & Maganda, A. (2007). Life events and depression in the context of the changing African family: The case of Uganda. *World Cultural Psychiatry Research Review*, January: 10-26.

Naidoo, A. & Kagee, S. (2009). The quest for relevance: Counselling psychology in South Africa. In L. Gerstein, P. Heppner, S. Ægisdóttir, S.A. Leung & K.L. Norsworthy (eds) *International Handbook of Cross-Cultural Counseling: Cultural Assumptions and Practices Worldwide*. Thousand Oaks, CA: Sage.

National Audit Office (2008). *End of Life Care: Report by the Controller and Auditor General*, Available at

<http://www.nao.org.uk/wp-content/uploads/2008/11/07081043es.pdf>. Accessed: 07-01-14.

Nefale, M. (2004). HIV/AIDS counselling and psychotherapy – challenges to the traditional psychotherapeutic framework. *Journal of Psychology in Africa*, 14 (1): 61-67.

Neimeyer, R. (2001). *Meaning Reconstruction and the Experience of Loss*. Washington DC: American Psychological Association.

Neimeyer, R. (2010). Grief counselling and therapy: The case for humility. *Bereavement Care*, 29 (1): 4-7.

Neimeyer, R. & Burke, L.A. (2011). Complicated grief in the aftermath of homicide: Spiritual crisis and distress in an African American sample. *Religions*, 2 (2): 145-164.

Neimeyer, R. & Currier, J. (2009). Grief therapy: Evidence of efficacy and emerging directions. *Current Directions in Psychological Science*, 18 (6): 352-256.

Neimeyer, R. & Hogan, N. (2001). Quantitative or qualitative? Measurement issues in the study of grief. In M.S. Stroebe, R.O. Hansson, W. Stroebe, & H. Schut (eds) *Handbook of Bereavement Research: Consequences, Coping and Care*. Washington DC: American Psychological Association.

Neki, J., Joinet, B., Hogan, M., Hauli, M. & Kilonzo, G. (1985). The cultural perspective of therapeutic relationship – a viewpoint from Africa. *Acta Psychiatrica Scandinavica*, 71 (6): 543-550.

NHSCT (2009). *Vision for Palliative Care*, Available at http://www.northerntrust.hscni.net/pdf/Vision_for_Palliative_Care.pdf Accessed: 07-07-14.

NICE (2003). *Depression Pathway*. London: National Institute for Health and Clinical Excellence. Available at <http://pathways.nice.org.uk/pathways/depression#path>. Accessed: 21-11-13.

NICE (2004). *Guidance on Cancer Services: Improving Supportive and Palliative Care for Adults with Cancer: The Manual*. London: National Institute for Health and Clinical Excellence. Available at <http://www.nice.org.uk/nice>. Accessed: 08-08-14.

NICE (2006). *Computerized Cognitive Behaviour Therapy for Depression and Anxiety, Technology Appraisal 97*. London: National Institute for Health and Clinical Excellence. Available at <http://www.nice.org.uk/nice>. Accessed: 08-08-14.

NICE (2009a). *Depression: Treatment and Management of Depression in Adults, Clinical Guideline 90*. London: National Institute for Health and Clinical Excellence. Available at <http://www.nice.org.uk/Guidance/CG90>. Accessed: 08-08-14.

NICE (2009b). *Depression in Adults with a Chronic Physical Health Problem: Treatment and Management, Clinical Guideline 91*. London: National Institute for Health and Clinical Excellence. Available at <http://www.nice.org.uk/Guidance/CG91> . Accessed: 08-08-14.

NICE (2011). *Common Mental Health Disorders: Identification and Pathways to Care, Clinical Guideline 123*. London: National Institute for Health and Clinical Excellence. Available at <http://www.nice.org.uk/guidance/CG123>. Accessed: 08-08-10.

NISRA (2011). *Census, 2011*, Available at http://www.nisra.gov.uk/Census/2011_results_population.html. Accessed: 20-09-13.

Nisbit, R.A. (1979). *The Sociological Tradition*. London: Heinemann.

Nordanger, D. (2007). Coping with loss and bereavement in post-war Tigray, Ethiopia. *Transcultural Psychiatry*, 44 (4): 545-565.

Nwoye, A. (2000). Sources of gain in African grief therapy. *Journal of Family Therapy*, 11 (1): 59-72.

O'Callaghan, P., Storey, L. & Rafferty, H. (2012). Narrative Analysis of Former Child Soldiers Traumatic Experiences. *Journal of Educational & Child Psychology*, 29(2): 87-97.

Ochieng, J. (2010). Outward peace, inward pieces: A case of the effects of the Kenya post-election violence. *British Journal of Guidance and Counselling*, 38 (3): 275-286.

Ochieng, L. (2006). *Challenges of Professional Counselling in Uganda: An Overview*. Paper presented to the 3rd Uganda National Conference for Counsellors, Kampala, Uganda. March, 2006.

O'Kane, S. & Millar, B. (2001). An investigation into the counselling-type work of Roman Catholic priests: A survey of one diocese in Northern Ireland. *British Journal of Guidance & Counselling*, 29 (3): 323-335.

O'Keeffe, C. & Frankham, J. (2002). HIV-Positive Healthcare Professionals in Uganda: An Examination of Contributions Made to HIV/AIDS Care and the Needs of Positive Workers for Support. Paper presented to the *International Conference on AIDS* (14), Barcelona, Spain July 7-12 Abstract no. ThPeG8299.

O'Leary, E. & O'Shea, E. (2009). Our aspirations are our possibilities: Growth and features of counselling psychology in Ireland. In L. Gerstein, P. Heppner, S. Aegisdóttir,

S. Leung & K. Norsworthy (eds) *International Handbook of Cross-Cultural Counselling: Cultural Assumptions and Practices Worldwide*. London: Sage.

Oleke, C., Blystad, A., Rekdal, O. & Mola, M. (2007). Experiences of orphan care in Amach, Uganda: Assessing policy implications. *Journal of Social Aspects of HIV/AIDS*, 4 (1): 532-543.

Oloka-Onyango, J. (2004). 'New breed' leadership, conflict and reconstruction in the great lakes region of Africa: A sociopolitical biography of Uganda's Yoweri Kaguta Museveni. *Africa Today*, 50 (3): 29-52.

ONS (2008). *Population Estimates: August 2008*, Available at <http://www.statistics.gov.uk/CCI/nugget.asp>. Accessed: 10-09-09.

ONS (2011) *Census 2011*, Available at <http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Population, and> <http://www.ons.gov.uk/ons/rel/census/2011-census/population-and-household-estimates-for-the-united-kingdom/The-structure-of-the-population-of-the-United-Kingdom>. Accessed: 13-09-13.

ONS (2013). *Population Estimates: June 2013*, Available at <http://www.statistics.gov.uk/hub/population/population-change/population-estimates/index.html>. Accessed: 20-09-13.

Ornstein, A. (2010). The missing tombstone: Reflections on mourning and creativity. *Journal of the American Psychoanalytic Association*, 58 (4): 631-648.

Ortlipp, M. (2008). Keeping and using reflective journals in the qualitative research process. *The Qualitative Report*, 13 (4): 695-705.

Oyewumi, L.K. (1986). Psychotherapy in Nigerian psychiatric practice: An overview. *Psychiatric Journal of the University of Ottawa*, 11 (1): 18-22.

Parkes, C.M. (1984). Comments on A. Kellehear: 'Are we a death denying society? A sociological review'. *Social Science and Medicine*, 18 (9): 713-723.

Parkes, C.M. (1993). Bereavement as a psychosocial transition: processes of adaption to change. In D. Dickenson & M. Johnson (eds) *Death, Dying and Bereavement*. London: Sage/Open University press.

Parkes, C.M. (1995). Guidelines for conducting ethical bereavement research. *Death Studies*, 19 (2): 171-181.

Parkes, C.M. (1996). *Bereavement: Studies of Grief in Adult Life* (3rd edition). London: Routledge.

Parkes, C.M. (2000). Comments on D. Klass: 'Developing a cross-cultural model of grief'. *Omega Journal of Death and Dying*, 41 (3): 323-326.

Parkes, C.M. (2001). A historical overview of the scientific study of bereavement. In M.S. Stroebe, R.O. Hansson, W. Stroebe, & H. Schut (eds) *Handbook of Bereavement Research: Consequences, Coping and Care*. Washington DC: American Psychological Association.

Parkes, C.M. (2006). *Love and Loss: The Roots of Grief and Its Complications*. London: Routledge.

Parkes, C.M., Laungani, P. & Young, B. (eds) (1997). *Death and Bereavement Across Cultures*. London: Routledge.

Partridge, S. (2005). Loss and bereavement counselling in a hospice setting. *Healthcare Counselling and Psychotherapy Journal*, 5 (3): 28.

Patel, V. & Sumathipala, A. (2006). Psychological approaches to somatisation in developing countries. *Treatment*, 12: 54–62. doi: 10.1192/apt.12.1.54

Pattison, S. & Corr, A. (2009). *School Counselling For Girls in the Gambia: A Research Study On Effectiveness*. Lutterworth: BACP.

Payne, S., Jarrett, N., Wiles, R. & Field, D. (2002). Counselling strategies for bereaved people offered in primary care. *Counselling Psychology Quarterly*, 15 (2): 161–177.

PHA (2012). *Sexually Transmitted Infections*, Available at <http://www.publichealthagency.org/directorate-public-health/health-protection/sexually-transmitted-infectionsdownloaded>. Accessed: 01-11-12.

Pines, M. (2002). The coherency of group analysis. *Group Analysis*, 35 (1): 13-26.

Pinker, S. (2011). *The Better Angels of Our Nature: The Decline of Violence in History and Its Causes*. London: Penguin Books Ltd.

Pinkerton, J. & Campbell, J. (2002). ‘Social work and social justice in Northern Ireland: Towards a new occupational space’, *British Journal of Social Work*, 32 (6): 723–37.

Pletzer, K. (1999). A process model of ethno cultural counselling for African survivors of organised violence. *Counselling Psychology Quarterly*, 12 (4): 335-351.

Pointon, C. (2003). The psychological fallout of 30 years of conflict in Northern Ireland *Counselling and Psychotherapy Research Journal*, 14 (3): 12-15.

Pole, C.J. & Burgess, R.G. (2000). Some issues and problems in cross-cultural case study research. In C.J. Pole & R.G. Burgess (eds) *Cross-Cultural Case Study*. Bingley: Emerald Group Publishing Limited.

Prigerson, H. G., & Jacobs, S. C. (2001). Traumatic grief as a distinct disorder: A rationale, consensus criteria, and a preliminary empirical test. In M. Stroebe, R. O. Hansson, W. Stroebe, & H. Schut (eds) *Handbook of Bereavement Research: Consequences, Coping, and Care*. Washington, DC: American Psychological Association.

Prigerson, H. G., Horowitz, M. J., Jacobs, S. C., Parkes, C. M., Aslan, M., Goodkin, K., Raphael, B., Marwit, S.J. et al. (2009). Prolonged Grief Disorder: Psychometric Validation of Criteria Proposed for DSM-V and ICD-11. *Medicine*, 6 (8). e1000121.doi: 10.1371/journal.pmed.1000121

Prior, L. (1989). *The Social Organisation of Death: Medical Discourse and Social Practices in Belfast*. London: Macmillan Press.

Prior, L. (2000). The social distribution of sentiments. In D. Dickenson, M. Johnston & S. Katz (eds) *Death, Dying and Bereavement* (2nd edition). London: Sage, in association with the Open University.

Public Health England (2010). *End of Life Care Profiles*, Available at <http://www.endoflifecare-intelligence.org.uk/resources/publications.aspx>. Accessed: 01-11-12.

Puterbaugh, D. (2008). Spiritual evolution of bereavement counselors: An exploratory qualitative study. *Counseling and Values*, 52 (3): 198–210.

Quilley, S. & Loyal, S. (2005). Eliasian sociology as a 'central theory' for the human sciences. *Current Sociology*, 53 (5): 807-828.

Ramon, S., Campbell, J., Lindsay, J., McCrystal, P. & Baidoun, N. (2006). The impact of political conflict on Social Work: Experiences from Northern Ireland, Israel and Palestine. *British Journal of Social Work*, 36 (3): 435–50.

Rando, T. (ed) (2008). Mourning Forum. *Encyclopaedia of Death and Dying*, Available at <http://www.deathreference.com/Me-Nu/index.html>. Accessed: 26-01-08.

Raphael, B., Minkov, C. & Dobson, H. (2001). Psychotherapeutic and pharmacological interventions for bereaved persons. In M.S. Stroebe, R.O. Hansson, W. Stroebe, & H. Schut (eds) *Handbook of Bereavement Research: Consequences, Coping and Care*. Washington DC: American Psychological Association.

Rothbaum, F., Weisz, J Pott, M, Miyake, K & Morelli, G. (2000). Attachment and culture: Security in the United States and Japan. *American Psychologist*. 55 (10): 1093-1104

Renganathan, S. (2009). Exploring the Researcher-participant relationship in a multi-ethnic, multicultural and multilingual context through reflexivity. *Qualitative Research Journal*, 9 (2): 3-17.

Reissman, C.K. (1987). When gender is not enough: Women interviewing women. *Gender and Society*, 1 (2): 172-207.

Richardson, V.E. (2007). A dual process model of grief counseling: Findings from the changing lives of older couples (CLOC) study. *Journal of Gerontology Social Work*, 48 (3-4): 311-329.

Roberts, B., Ocaka, K.F., Browne, J., Oyok, T. & Sondorp, T. (2008). Factors associated with post-traumatic stress disorder and depression amongst internally displaced persons in northern Uganda. *Biomedcentral Psychiatry*, 8: 38 doi:10.1186/1471-244X-8-38

Rogers, C.R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Clinical Psychology*, 21 (2): 95-103.

Rogers, E. (1999). Georg Simmel's Concept of the Stranger and Intercultural Communication Research. *Communication Theory*, 9 (1): 58-74.

Rønnestad, M.H. & Skovholt, T.M. (2003). The journey of the counselor and therapist: Research findings and perspectives on development. *Journal of Career Development*, 30 (1): 5-44.

Rønnestad, M.H. & Skovholt, T.M. (2012). *The Developing Practitioner: Growth and Stagnation of Therapists and Counselors*. London: Routledge.

Rose, N. (1989). *Governing the Soul: The Shaping Of the Private Self*. London: Routledge.

Rosenblatt, P. (1993). *Bitter, Bitter Tears*. Minneapolis: University of Minneapolis Press.

Rosenblatt, P. (1997). Grief in small-scale settings. In C.M. Parkes, P. Laungani & B. Young (eds) *Death and Bereavement Across Cultures*. London: Routledge.

Rosenblatt, P. (2001). A social constructivist view on cultural differences in grief. In M.S. Stroebe, R.O. Hansson, W. Stroebe, & H. Schut (eds) *Handbook of Bereavement Research: Consequences, Coping and Care*. Washington DC: American Psychological Association.

Rosenblatt, P, Walsh, P.C. & Jackson, D. (1976). *Grief and Mourning in Cross-Cultural Perspective*. New Haven, CT: Human Relations Area Files Press.

Roth, A. & Fonagy, P. (2005). *What Works for Whom? A Critical Review of Psychotherapy Research* (2nd edition). New York: Guilford Press.

Rowling, L. (2000). Grief and school communities: The impact of social context, a comparison between Australia and the UK. *Death Studies*, 24 (1): 35.

Rubin. S.S. (1999). The Two-Track model of bereavement: Overview, retrospect and prospect. *Death Studies*, 23 (8): 685.

Rubin, S.S., Malkinson, R. & Witztum, E. (2012). *Working with the Bereaved: Multiple Lenses on Loss and Mourning*. New York: Routledge.

Rycroft, C. (1972). *A Critical Dictionary of Psychoanalysis*. London: Penguin Books.

Sanders, C. (1999). *Grief: The Mourning After: Dealing With Adult Bereavement* (2nd edition). New York: J. Wiley.

Sanders, D. & Wills. F. (2005). *Cognitive Therapy: An Introduction*. London: Sage.

Sandler, J., Dare, C. & Holder, A. (1992). *The Patient and the Analyst*. London: Karnac Books.

Saunders, C. (2012). *First National Voices Survey of Bereaved People: Key Findings Report*. London: Department of Health.

Scheff, T. (2004). Elias, Freud and Goffman: Shame as the master emotion. In S. Loyal, & S. Quilley (eds) *The Sociology of Norbert Elias*. Cambridge: Cambridge University Press.

Schut, H. (2010). Grief counselling efficacy. Have we learned enough? *Bereavement Care*, 29 (1): 8-9.

Schut, H. & Stroebe, M.S. (2005). Interventions to enhance adaptation to bereavement. *Journal of Palliative Medicine*, 8 (1): 140–147.

Schut, H., Stroebe, M., van de Bout, J. & Terheggen, M. (2001). The efficacy of bereavement interventions: Determining who benefits. In M.S. Stroebe, R.O. Hansson, W. Stroebe & H. Schut (eds) *Handbook of Bereavement Research: Consequences, Coping and Care*. Washington DC: American Psychological Association.

Schwartzberg, S. S. & Halgin, R. P. (1991). Treating grieving clients: The importance of cognitive change. *Professional Psychology: Research and Practice*, 22 (3): 240-246.

Seale, C. (1989). What happens in Hospices: A review of research evidence. *Social Science and Medicine*, 28 (6): 551-559.

Seale, C. (1998). *Constructing Death: The Sociology of Dying and Bereavement*. Cambridge: Cambridge University Press.

Seale, C., Gobo, G., Gubrium, J. & Silverman, D. (eds) (2004). *Qualitative Research Practice*. London: Sage.

Seeley, J. & Kajura, E. (1995). Grief and the Community. In L. Sherr (ed) *Grief and Aids*. London: Wiley.

Seeley, J., Wagner, U., Mulemwa, J., Kengeya-Kayondo, J. & Mulder, D. (1991). The development of a community-based HIV/AIDS counselling service in a rural area in Uganda. *AIDS Care*, 3 (2): 207-217.

Seidman, S. & Alexander, J. (eds) (2008). *The New Social Reader*. London: Routledge.

Senyonyi, R., Ochieng, L. & Sells, J. (2012). The development of professional counselling in Uganda: Current status and future trends. *Journal of Counselling and Development*, 90 (4): 500-504.

Servaty-Seib, H. (2004). Connections between counseling theories and current theories of grief and mourning. *Journal of Mental Health Counselling*, 26 (2): 125-145.

Shapiro, E. (2001). Grief in interpersonal perspective: Theories and their implications. In M.S. Stroebe, R.O. Hansson, W. Stroebe & H. Schut (eds) *Handbook of Bereavement Research: Consequences, Coping and Care*. Washington DC: American Psychological Association.

Sharpe, U. (1999). *The Expression of Grief Among Orphans of the AIDS Epidemic in Southwest Uganda*, Unpublished MA Dissertation, cited with permission. Makerere, Uganda: Makerere University.

Shaver, P. & Tancredy, C. (2001). Emotion, attachment and bereavement: A conceptual commentary. In M.S. Stroebe, R.O. Hansson, W. Stroebe & H. Schut (eds)

Handbook of Bereavement Research: Consequences, Coping and Care. Washington DC: American Psychological Association.

Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *American Psychologist*, 65 (2): 98-109.

Shillington, K. (1995). *History of Africa*. London: Macmillan Educational Ltd.

SIL (2008). *Partners in Language Development*, Available at <http://www.sil.org/about-sil>. Accessed: 15-09-13.

Silverman, D. (ed) (2004). *Qualitative Research: Theory, Method and Practice*. London: Sage.

Sinclair, R., Cole, P. & Kelly, B. (2004). The views of young people in Northern Ireland on anti-sectarianism. *Child Care in Practice*, 10 (2): 155-166.

Smelser, N. (2003). On Comparative Analysis, Interdisciplinarity and Internationalization in Sociology. *International Sociology*, 18 (3): 643-657.

Smith, J.A. & Eatough, V. (2006). Interpretative phenomenological analysis. In G. Breakwell, C. Fife-Schaw, S. Hammond & J.A. Smith (eds) *Research Methods in Psychology* (3rd edition). London: Sage.

Smyth, M. (2000). The human consequences of armed conflict: constructing 'victimhood' in the context of Northern Ireland's Troubles. In M. Cox., A. Guelke & F. Stephen (eds) *A Farewell to Arms? From 'Long War' to Long Peace in Northern Ireland*. Manchester: Manchester University Press.

Smyth, M. (2013). Injured and disabled casualties of the Northern Ireland conflict: Issues in immediate and long-term treatment, care and support. *Medicine, Conflict and Survival*, 29 (3): 244-266.

Smyth, M. & Campbell, J. (1996). Social work, sectarianism and anti-sectarian practice in Northern Ireland, *British Journal of Social Work*, 26 (1): 77-92.

Stacey, R. (2003). *Complexity and Group Processes: A Radically Social Understanding of Individuals*. Oxford: Taylor and Francis.

Stanley, L. & Wise, S. (2011). The domestication of death: The sequestration thesis and domestic figuration. *Sociology*, 45 (6): 947-62.

Stephen, A., Wimpenny, P., Unwin, R., Work, F., Dempster, P., Mac Duff, C., Wilcock, S. & Brown, A. (2009). Bereavement and bereavement care in health and social care: Provision and practice in Scotland. *Death Studies*, 33 (3): 239-261.

Strauss, A. & Corbin, J. (1998). *Basics of Qualitative Research: Grounded Theory Procedures*. London: Sage.

Stroebe, M.S. (2004). Religion in coping with bereavement: Confidence of convictions or scientific scrutiny? *International Journal for the Psychology of Religion*, 14 (1): 23-26.

Stroebe, M.S. & Schut, H. (2001a). Models of coping with bereavement: A review. In M.S. Stroebe, R.O. Hansson, W. Stroebe & H. Schut (eds) *Handbook of Bereavement Research: Consequences, Coping and Care*. Washington DC: American Psychological Association.

Stroebe, M.S. & Schut, H. (2001b). Meaning making in the Dual Process model of coping with bereavement. In R. Neimeyer (ed) *Meaning Reconstruction and the Experience of Loss*. Washington DC: American Psychological Association.

Stroebe, M.S. & Schut, H. (2010). The Dual Process model of coping with bereavement: A decade on. *Omega Journal of Death and Dying*, 61 (4): 273-289.

Stroebe, M.S., Gergen, M.M., Gergen, K.J. & Stroebe, W. (1992). Broken hearts or broken bonds: Love and death in historical perspective. *American Psychologist*, 47(10): 1205-1212.

Stroebe, M.S., Hansson, R.O., Stroebe, W & Schut, H. (2001) Introduction: Concepts and issues in contemporary research on bereavement. In M.S. Stroebe, R.O. Hansson, W. Stroebe & H. Schut (eds) *Handbook of Bereavement Research: Consequences, Coping and Care*. Washington DC: American Psychological Association.

Stroebe, M.S., Stroebe, W. & Schut, H. (2003). Bereavement research: Methodology issues and ethical concerns. *Palliative Medicine*, 17 (3): 235-240.

Stroebe, W. & Schut, H. (1998). Culture and grief. *Bereavement Care*, 17 (1): 7-11.

Stroebe, W. & Schut, H. (1999). The Dual Process model of coping with bereavement: Rationale and description. *Death Studies*, 23 (3): 197–224.

Stroebe, W. & Schut, H. (2001). Risk factors in bereavement outcome: A methodological and empirical review. In M.S. Stroebe, R.O. Hansson, W. Stroebe & H. Schut (eds) *Handbook of Bereavement Research: Consequences, Coping and Care*. Washington DC: American Psychological Association.

Stroebe, W., Schut, H. & Stroebe, M.S. (2005). Grief work, disclosure and counseling: Do they help the bereaved? *Clinical Psychology Review*, 25 (4): 395-414.

Sudnow, D. (1967). *Passing On: The Social Organisation of Dying*. New Jersey: Prentice Hall.

Sue, D. & Sue, D. (2003). *Counselling the Culturally Different* (4th edition). New York: Wiley.

Swartz, S. (2007). The power to name: South African intersubjective psychoanalytic psychotherapy and the negotiation of racialized histories. *European Journal of Psychotherapy and Counselling*, 9 (2): 177-190.

Symington, N. (1986). *The Analytic Experience: Lectures from Tavistock*. London: Tavistock.

Tartaglia, C. (1989). AIDS and anxiety syndromes. In J.W. Dille, C. Pies & M. Helquist (eds) *Face to Face: A Guide to AIDS Counselling*. California: Celestial Arts.

Théoden van Velzen, H.U.E, (1982). The Duka civilisation. *Netherlands Journal of Sociology*, 20 (2): 85-97.

Theun, F. (1997a). Received social support from informal networks and professionals in bereavement. *Psychology Health and Medicine*, 21 (1): 51-59.

Theun, F. (1997b). Social support after the loss on an infant child: A long-term perspective. *Scandinavia Journal of Psychology*, 38 (2): 103-110

Tomlinson, M. (2007). Suicide and young people: The case of Northern Ireland. *Child Care in Practice*, 13 (4): 435-443.

Traylor, E. S., Hayslip, B., Kaminski, P. L. & York, C. (2003). Relationships between grief and family system characteristics: A cross-lagged longitudinal analysis. *Death Studies*, 27 (7): 575-601.

Trivasse, M. & Trivasse, K. (2002). Counselling skills for Kenya. *Counselling and Psychotherapy Journal*, 13 (9): 34-36.

Tseng, W.S. (1999). Culture and psychotherapy: Review and practical guidelines. *Transcultural Psychiatry*, 36 (2): 131-179.

Turnbull, C. (1972). *The Mountain People*. New York: Simon & Schuster.

Turnbull, C. (1978). Rethinking the Ik: A functional non-social system. In D. Charles, D. Laughlin, Jr., & I. A. Brady (eds) *Extinction and Survival in Human Populations*. New York: Columbia University Press.

UBS (2002). *Population and Housing Census* Available at <http://www.ubos.org>. Accessed: 10-09-08.

UCA (2006). *President's Pen*. *UCA Newsletter*, 2 (4): 1-12.

UCA (2009). *Code of Ethics and Practice*, Ugandan Counsellors Association: Uganda

UCA (2013) *Draft Uganda Counselling Association Bill*. Available at <http://www.ugandacounselling.org/downloads/UCA%20DRAFT%20BILL.pdf>. Accessed on 14-07-14.

Ugwuegbulam, C., Homrich, A. & Kadurumba, C. (2009). Cross-cultural counselling in Nigeria. In L. Gerstein, P. Heppner, S. Ægisdóttir, S. Leung, & K. Norsworthy (eds) *International Handbook of Cross-Cultural Counselling: Cultural Assumptions and Practices Worldwide*. London: Sage.

UNAIDS (2010). *United Nations General Assembly Special Session (UNGASS) Country Report: Uganda*, Available at http://data.unaids.org/pub/report/2010/Uganda_country-progress-report. Accessed 20-09-13.

UNAIDS (2012). *HIV and AIDS estimates*, Available at <http://www.unaids.org/en/regionscountries/countries/uganda/>. Accessed: 06-07-14.

Ungar, M., Clark, S.E., Kwong, W., Makhnach, A. & Cameron C.A.(2005). Studying resilience across cultures. *Journal of ethnic and cultural diversity in Social Work*. 14 (3-4): 1-19.

UNHCR (2014) United Nations High Commissioner for Refugees *Country operations profile – Uganda*. Available at <http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e483c06&submit=GO>. Accessed: 25-06-14.

University of Leicester (2006). *Research Ethics Code of Practice*, Available at <http://www2.le.ac.uk/institution/committees/research-ethics/code-of-practice>. Accessed: 22-06-08.

USCRI (2014) *World Refugee Survey*, Available at <http://www.refugees.org/resources/refugee-warehousing/archived-world-refugee-surveys/2009-wrs-country-updates/uganda.html>. Accessed: 25-06-14.

USDS Bureau of Africa Affairs (2007). *Crystal Reports COP07*, Available at http://www.state.gov/www/regions/africa/country/cp_uganda.html. Accessed: 10-09-08.

USDS Bureau of Africa Affairs (2013). *Human Rights Reports: Uganda* Available at <http://www.state.gov/documents/organization/160149.pdf>. Accessed: 07-01-14.

Valentine, C.A. (2006). Academic constructions of bereavement. *Mortality*, 11 (1): 57-78.

Valentine, C.A. (2009). Continuing bonds after bereavement: A cross-cultural perspective. *Bereavement Care*, 28 (2): 6-11.

Van Dyk, G. & Nefale, M. (2005). The split-ego experience of Africans: Ubuntu therapy as a healing alternative. *Journal of Psychotherapy Integration*, 15 (1): 48-66.

Van Gennep, A. (1960 [1909]). *The Rites of Passage*, Chicago: University of Chicago Press.

Van Krieken, R. (1998). *Norbert Elias*. London: Routledge.

Van Krieken, R. (2005). Occidental self-understanding and the Elias-Duerr dispute: 'Thick' versus 'thin' conceptions of human subjectivity and civilization. *Modern Greek Studies*, 13:273-281.

Van de Vijver, F. & Leung, K. (1997). *Methods and Data Analysis for Cross-Cultural Research*. London: Sage.

Van de Vijver, F. & Leung, K. (2011). Equivalence and bias: A review of concepts, models, and data analytic procedures. In D. Matsumoto & F.J.R. van de Vijver (eds) *Cross-Cultural Research Methods in Psychology*. Cambridge: Cambridge University Press.

Vella, J. (1997). *Learning to Listen, Learning to Teach: The Power of Dialogue in Educating Adults*. CA: Jossey-Bass Publishers.

Verhoeven, J. (2000). Some reflections on cross-cultural interviewing. In C.J. Pole & R.G. Burgess (eds) *Cross-Cultural Case Study*. Bingley: Emerald Group Publishing Limited.

Vernon, G.M. & Cardwell, J.D. (1981). *Social Psychology: Shared, Symbolled and Situated Behavior*. Washington DC: University Press of America.

Vlasto, C. (2010). Therapists view of the relative benefit and pitfalls of group work and one to one counselling for bereavement. *Counselling and Psychotherapy Research*, 10 (1): 60-66.

Vinck, P., Pham, P. N., Stover, E. & Weinstein, H. M. (2007). Exposure to war crimes and implications for peace building in northern Uganda. *Journal of the American Medical Association*, 298: 543–554. doi:10.1001/jama.298.5.543

Wallace, E. (1983). *Freud and Anthropology. A History and Reappraisal*, New York: International Universities Press.

Walsh, T., Foreman, M., Curry, P., O'Driscoll, S. & McCormack, M. (2008). Bereavement support in an acute hospital: An Irish model. *Death Studies*, 32 (6): 768-786.

Walter, T. (1994). *The Revival of Death*. London: Routledge.

Walter, T. (1996). A new model of grief: Bereavement and biology. *Mortality*, 1 (1): 7-25.

Walter, T. (1999). *On Bereavement: The Culture of Grief*. Buckingham: Open University Press.

Walter, T. (2007). Modern grief, postmodern grief. *International Review of Sociology*, 17 (1): 123–34.

Walter, T. (2010). Grief and Culture. *Bereavement Care*, 29 (2): 5-9.

Walter, T. (2012). Why different countries manage death differently: A comparative analysis of modern urban societies. *The British Journal of Sociology*, 63 (1): 123–145.

Webber, M (1949 [1904]). *The Methodology of the Social Sciences* (eds and trans: E.A. Shils & H.A. Finch). New York: Free Press.

West, W. (2007). Kenyan students' expectations upon beginning a master's course in counselling studies. *British Journal of Guidance and Counselling*, 35 (2): 237-245.

WHO (1998). World Health Assembly Resolution WHA51.12 - Health Promotion. <http://www.who.int/healthpromotion/wha51-12/en/>. Accessed: 22-04-11.

WHO (2003). *Report on WHO Traditional Medicine Strategy 2002-2005*. Geneva: World Health Organization. Available at http://whqlibdoc.who.int/hq/2002/who_edm_trm_2002.1.pdf. Accessed: 22-04-11.

Wiles, R., Jarrett, N., Payne, S. & Field, D. (2002). Referrals for bereavement counselling in primary care: A qualitative study. *Patient Education and Counselling*, 48 (1): 79-85.

Williams, P., Vibbert, M., Mitchell, L. & Serwanga, R. (2009). Health and human rights of children affected by HIV/AIDS in urban Boston and rural Uganda. *International Social Work*, 52 (4): 539–545.

Wills, F. & Sanders, D. (1997). *Cognitive Therapy: Transforming the Image*. London: Sage.

Wilson, G., Montgomery, L., Houston, S., & Davison, G. (forthcoming). *A study to understand current provision of services for people with mental health problems in Northern Ireland*. Belfast: Queen's University Belfast.

Wimpenny, P., Unwin, R., Dempster, P., Grundy, M., Work, F., Brown, A. & Wilcock, S. (2006). *Literature Review on Bereavement and Bereavement Care*. Aberdeen: The Robert Gordon University. Available at <http://www.rgu.ac.uk/files/BereavementFinal.pdf>. Accessed: 03-08-2008.

Wimpenny, P., Unwin, R., Dempster, P., Grundy, M., Work, F., Brown, A. & Wilcock, S. (2007). A literature review on bereavement and bereavement care: Developing evidence based practice in Scotland. *Bereavement*, 26 (1):1-4.

Winkel, H. (2001). A postmodern culture of grief? On individualization of mourning in Germany. *Mortality*, 6 (1): 65-79.

Withell, B. (2009). The pre-bereavement psychological needs of AIDS-affected adolescents in Uganda. *International Journal of Palliative Nursing*, 15 (3): 128-133.

Wollheim, R. (1991). *Freud*. London: Fontana Press.

Worden, W. (1991). *Grief Counselling and Grief Therapy: A Handbook for the Mental Health Practitioner* (2nd edition). London: Routledge.

Wortman, C.B. & Silver, R.C. (1987). Coping with irrevocable loss. In G.R. Vanden Bos & B.K. Bryant (eds) *Cataclysms, Crises And Catastrophes: Psychology in Action*. Washington DC: American Psychological Association.

Wortman, C.B. & Silver, R.C. (2001). The myths of coping with loss revisited. In M.S. Stroebe, R.O. Hansson, W. Stroebe, & H. Schut (eds) *Handbook of Bereavement Research: Consequences, Coping and Care*. Washington DC: American Psychological Association.

Wouters, C. (1977). Informalisation and the civilising process. In P.R. Gleichmann, J. Goudsblom & H. Korte (eds) *Human Figurations: Essays for Norbert Elias*. Amsterdam: Stichting Amsterdams Sociologisch Tijdschrift.

Wouters, C. (2002). The quest for new rituals in dying and mourning: Changes in the We-I balance. *Body and Society*, 8 (1): 1-27.

Wouters, C. (2011). How civilizing processes continued: Towards an informalization of manners and a third nature personality. *The Sociological Review*, 59 (1): 140-159.

Yamba, C. (1999). Cosmologies in turmoil: Witch finding and AIDS in Chiawa, Zambia, Africa: *Journal of the International African Institute*, 67 (2): 200-223.

Young, C. (2009). The CORE-OM intake norms of students attending a South African university counselling service: A comparison with UK counselling service data. *British Journal of Guidance and Counselling*, 37 (4): 473 - 483.