Est. 1841 | YORK ST JOHN UNIVERSITY

Gabriel, Lynne, Wilson, John and Stiles, Bill (2023) Assimilation in Bereavement: Charting the process of grief recovery in the case of Sophie. British Journal of Guidance and Counselling, 51 (3). pp. 367-380.

Downloaded from: https://ray.yorksj.ac.uk/id/eprint/5562/

The version presented here may differ from the published version or version of record. If you intend to cite from the work you are advised to consult the publisher's version: https://doi.org/10.1080/03069885.2021.1983154

Research at York St John (RaY) is an institutional repository. It supports the principles of open access by making the research outputs of the University available in digital form. Copyright of the items stored in RaY reside with the authors and/or other copyright owners. Users may access full text items free of charge, and may download a copy for private study or non-commercial research. For further reuse terms, see licence terms governing individual outputs. Institutional Repositories Policy Statement

RaY

Research at the University of York St John

For more information please contact RaY at ray@yorksj.ac.uk

Assimilation in Bereavement: Charting the process of grief recovery in the case of Sophie

John F. Wilson

York St John University

Lynne Gabriel

York St John University

William B. Stiles

Miami University, Appalachian State University, and Metanoia Institute

Address correspondence to
John Wilson
Department of Psychology
York St John University
York, United Kingdom
Email: j.wilson2@yorksj.ac.uk

Abstract

This theory-building case study examined an application of the Assimilation of Grief Experiences Scale (AGES), a conceptual account of a bereaved person's process of change in grief recovery, in a case study of a 40-year old woman in bereavement counselling. An assessment session and 44 counselling sessions were analysed intensively, comparing the description provided by the AGES with the details of the case. Results showed how the AGES tracked and described details of Sophie's recovery.

Key words

assimilation, schema, bereavement, loss, grief trajectory.

word count, including abstract, references, and table: 8707

A central principle of bereavement counselling is that bereaved people are able to adapt to loss if they can identify and articulate the changes to their assumptive world after the loss (Attig, 2004; Neimeyer, 2006), which comes from the disruption of life circumstances and of norms previously taken for granted (Parkes, 1971). Janoff-Bulman (1992) likened the meaning-making process in grieving to Piagetian theories of assimilation and accommodation in the ontogenesis of intellect. In this theory-building case study, we examined the applicability of a theoretical account of psychological change of offered by the assimilation model (Stiles, 2001, 2011) to a bereaved person's process of change in grief recovery using a new tool for tracking individual grief trajectories.

The Assimilation Model

The Assimilation Model (Stiles, 2001, 2011) views a client in therapy as a community of voices confronted with some initially disconnected and disorganised voices. The term voice is a metaphor for traces of the person's experiences; it emphasizes the active, agentic nature of information in people. The disconnected voices represent experiences that were traumatic, unacceptable, or somehow incompatible with the community of voices, which is the person's usual self. The disconnected voices become increasingly ordered, coherent, and assimilated into the community over the duration of a successful clinical intervention.

The death of one's spouse, partner, child, parent, or other loved one can be traumatic and incompatible with a person's usual self, which may encompass voices representing years of experiences involving them. Assimilating the bereavement means coming to terms with the death, the events surrounding the death, the effects of the loss, and the new meanings of that large part of the community of self--a new relationship with the deceased. In complicated cases, this can be a very protracted and emotionally painful process. The assimilation model seemed to us to offer an approach to understanding and describing that process.

To assess the assimilation of problematic voices in psychotherapy, assimilation researchers typically analyse client transcripts of therapy sessions, and assess observations of the change process. Observations from each case permeate the model so that they become part of the theory. If aspects of a case study fail to fit the theory, this can point to something in the theory that needs changing. The model is modified to fit new observations, with the requirement that it remain consistent with previous observations. Thus, as the theory is applied to each case, successive case observations are applied to the theory, leading to gradual improvements in generality, precision, and realism (Stiles, 2007, 2009).

Although assimilation has been studied most commonly in cases of adult psychotherapy for depression and anxiety (e.g., Caro Gabalda & Stiles, in press; Gray & Stiles, 2011; Honos-Webb, Stiles, & Greenberg, 2003; Kivikkokangas, Leiman, Laitila, & Stiles, 2020; Mosher, Goldsmith, Stiles, & Greenberg, 2008). However, the assimilation model has been applied to many other sorts of cases, including, for example, psychoanalytic therapy of a traumatised political refugee (Varvin & Stiles, 1999), clients with intellectual disability (Shepherd, 2015), psychological change in a student in counselling training (Folkes-Skinner, 2016), use of digital game-like software in counselling adolescents (van Rijn, Chryssafidou, Falconer, & Stiles, 2019), professional supervision dealing with personal issues that arise in therapists' practice (van Rijn, Agar, Sills, Pearce, & Stiles, submitted), adults who have received a dementia diagnosis (Lishman, Cheston, & Smithson, 2016), executives' development in coaching (Osatuke, Yanovsky, & Ramsel, 2017), immigrants adjustment to their host culture (Henry et al., 2009), and organizational change in a Veterans Administration medical centre (Moore, Osatuke, & Howe, 2014). In this study, we extended the model to the study of bereavement counselling.

Recovery from bereavement involves both a homeostatic rebalancing of the negative affect due to the distress of broken attachment, and the adaptation to a changed assumptive

world. Successful adaptation requires people to find new meanings concerning the loss and their idiosyncratic response to it. We see the mechanism of this as the assimilation of the experiences into schemas that better fit the bereaved person's changed circumstances.

Tools for Tracking Assimilation Progress

The main analytic tool used in previous assimilation studies has been the Assimilation of Problematic Experiences Scale (APES; Stiles & Angus, 2001). The APES describes the relation of a target problematic experience or voice to the community of voices in a sequence of eight stages or levels. The APES is more than a descriptive scale; it is an evolving theoretical model of the sequence of therapeutic change, developed and refined by successive case studies. Across multiple studies, the APES has been altered to reflect new understandings and special applications. Some versions have been renamed, for example the Assimilation of Problematic Voices Scale (Honos-Webb, Stiles, & Greenberg, 2003), the Assimilation of Problematic and Overwhelming Experiences Scale (Varvin, 2003), the Heidelberg Structural Change Scale (Rudolf, Grande, & Oberbracht, 2000), and the Markers of Assimilation of Problematic Experiences in Dementia (Cheston, Gatting, Marshall, Coleman, & Spreadbury, 2017; Lishman, Cheston, & Smithson, 2016).

A new adaptation of the APES has been developed for measuring individual grief trajectories. This adaptation was named the Assimilation of Grief Experiences Scale (AGES; see Table 1; Wilson, 2017). The AGES assesses progress on three tasks that seemed clinically integral to the assimilation of a significant bereavement: 1) Managing the pain of grief, 2) Coming to terms with the circumstances of the loss, and 3) Accepting a new relationship with the deceased. It was constructed using a theory-building approach in a series of case studies of bereaved clients (Wilson, 2017). The present case study applied the AGES in a further case.

Like the APES, the AGES includes eight stages (see Table 1). This may recall previous stage models of grief (e.g., Bowlby & Parkes, 1970; Kübler-Ross, 1969), the value of which has been questioned (Stroebe, Schut, & Boerner, 2017). However, unlike the stages in those previous models, the APES and AGES stages represent anchor points on a developmental continuum rather than discrete stages (Stiles, 2001, 2011). They depict a sequential process of adaptation to grief as a problematic experience. To some extent, the sequence is a logical necessity: a person must be aware of (AGES 2) and state a problem (AGES 3) before he or she can understand it (AGES 4) or solve it (AGES 6). But the AGES is also an evolving summary of empirical case observations, building assimilation theory as applied to problematic grief.

Goal of This Study

The goal of this theory-building case study was to assess and elaborate the assimilation model as it applies to bereavement. It was at the same time an evaluation of the AGES as a clinical and research tool for assessing the grief trajectory of a client in bereavement counselling and as a conceptualization of assimilation progress in counselling for bereavement. That is, we sought to remain open to the failings of the model as well as its achievements.

Method

Client and counsellor

Sophie (a pseudonym) was a 40-year old woman who was seen in bereavement counselling at a bereavement counselling service in the North of England. Sophie was bereaved of her husband, David (pseudonym), through cancer. Rather than the peaceful death in a hospice, as had been anticipated, David died suddenly and traumatically from a haemorrhage, at home with his family present. Sophie was left with three children: two at

school and one at university. Her counselling began 14 weeks after her bereavement and lasted until the second anniversary of her husband's death. In the first year the sessions were usually weekly, but by the end, only needed at wider, usually monthly intervals. Sophie received 45 sessions, including an initial assessment session. We took advantage of this longer-than-usual treatment to study the details of assimilating a complicated bereavement.

The counsellor was a 67-year old man with 15 years of experience in bereavement counselling and in training others in grief theory and in bereavement counselling. He had a University Diploma in therapeutic counselling, awarded 1997. He used a person-centred approach (Rogers, 1957, 1961, 1963). This entailed working closely with each client, in a collaborative endeavour which sought to meet the needs of their unique situation. He was the first author of this paper.

Sophie was the tenth and final case in a series, the first nine of which used to construct the AGES (Wilson, 2017). Thus, Sophie's case was analyzed after the AGES was in its final (present) form.

Ethics

Ethical permission for the study was granted by York St John University and by the bereavement counselling service in the North of England where Sophie was seen. At the beginning of the research, Sophie was provided with a written explanation of the design of the study and the use of the data, and she gave her written permission. It was made clear in writing that she could withdraw permission if she changed her mind.

Assimilation of Grief Experiences Scale (AGES)

The AGES was constructed to assess how individual bereaved clients adapt to loss during their counselling (Wilson, 2017). As shown in Table 1, the AGES describes the

changing relation of the problematic bereavement to the self in eight stages, numbered 0 to 7: (0) Warded off, (1) Unwanted thoughts, (2) Vague awareness, (3) Problem statement/clarification, (4) Understanding/insight, (5) Application/working through, (6) Problem solution, and (7) Mastery. For each stage, distinguishing signs are listed in three categories: managing the pain of grief, coming to terms with the circumstances of the loss, and accepting a new relationship with the deceased.

The AGES can be applied to each expression of a focal theme to assess the degree to which the death was assimilated into a meaning-making schema within the usual self. It can also be applied to longer stretches of dialogue to describe the predominant level of assimilation evidenced in that stretch. Theoretically, degree of assimilation of the bereavement, represented in the AGES level, represents the client's recognition of and adaptation to her or his post-loss world. The scale is understood as a continuum, and intermediate ratings (e.g., 2.7, 4.2) are allowed. Clients may enter counselling at any stage, and any movement along the continuum may be construed as progress.

Procedure

Sophie's 45 sessions were transcribed verbatim, and a qualitative assimilation analysis (Stiles & Angus, 2001) was performed by this paper's first author. This involved four steps: 1) gaining familiarity with the case by repeated close reading of the transcripts, 2) identifying the focal themes addressed in Sophie's counselling, which included her husband's death and adapting to her changing parental role, 3) extracting passages that dealt with these themes and examining them as they changed across sessions, and 4) interpreting them within the assimilation theory as elaborated for dealing with bereavement. Step 4 included assigning an AGES rating to each of Sophie's 45 sessions (including the assessment session).

As a check on the reliability of these AGES ratings, 20 randomly-selected passages from the transcripts of Sophie's sessions were rated independently by 18 experienced

bereavement counsellors. The counsellors were each given the AGES (Table 1) and asked to use it to rate the 20 transcript extracts. No additional training was given to the raters. The passages were set in the context of a written summary of the case, with the selected passages highlighted, so the passages were in temporal order rather than random order. There was close agreement between the AGES ratings by the first author and the means of the counsellors' ratings (ICC = .966) (McGraw & Wong, 1996).

Results

Sophie's grief trajectory

There was a strong positive correlation of Sophie's AGES scores with the number of weeks since her bereavement. This was true both for the session level ratings by the first author ($r = .96$, $N = 45$ sessions) and for the mean AGES values of the 20 randomly selected passages from the transcripts of Sophie's counselling, as scored by the 18 clinicians ($r = .93$, $N = 20$ passages). This steady increase, from a mean of AGES 2.0 across her first five sessions to a mean of AGES 6.2 across her last five sessions, showed Sophie's gradual but successful assimilation of her pain, loss, and new relationship with her deceased husband.

Sophie's progress in counselling

When Sophie arrived at her assessment session, session 1, she was clearly distressed. Her grief was compounded by feelings of guilt. She had talked to a friend about the stress of looking after her husband and in conversation had wondered, with some resentment, how long this phase of her life might last. The following day he died suddenly. In the assessment session, 14 weeks after his death, she explained:

> *Sophie*: Then I felt awful saying that cos the next day he died (sobs). I feel bad saying that. It's almost like somebody heard me say that and then though 'Oh well, we'll just take him away then.'

Counsellor: As if you made it happen?

Sophie: Yes (sobs). Sometimes I think things like that happen when I think things.

In session 5, Sophie described feeling comforted by finding a white feather in the room where David died. She said she noticed how white feathers kept appearing in her life, although she recognised the irrationality of her behaviour. In the assessment session, Sophie interpreted an inexplicably opened wardrobe door as a sign of his presence. Magical thinking, which conjures the deceased's presence, plays a part in the experience of many clients, and has been included in the sequence of descriptors as AGES 2 working towards 3.

In session 6 Sophie spoke of sometimes finding herself searching for signs of David. She had entered his name into a Google search and had gone over hospital letters which discussed his diagnosis and prognosis. Searching behaviour has frequently been observed by the author in client work and is also included as an AGES descriptor. She was scored as being between AGES 2 and 3.

In session 8, as she thought of the circumstances surrounding David's death, Sophie reported poor sleep and rumination. She talked about how difficult it had been to stay with him after his death and described his eyes not being fully closed and his hands thin and blue. She reflected that she did try to protect her youngest son from her emotions, for example, crying in the shower where he could not hear her. We scored this as AGES 2.0

In session 11 Sophie described meeting for coffee with another widowed mother. They compared notes, and Sophie said that it helped to know others had gone through a similar experience. She noted that they had both got upset, "and it was fine." It had also helped to meet somebody further on with their grief, and to know that things did get easier:

Sophie: She's not all doom and gloom. It was quite light-hearted, some of the stuff.

In her ability to gain respite from her negative affect, we scored her as approaching AGES 3

In session 15 Sophie was able to state one of her greatest concerns: the responsibility of bringing up her children alone. Her focus was on being able to help with homework:

Sophie: I always used to say to (daughter's name), 'Go and ask your dad, he'll know'. They used to say, 'Daddy knows everything' (laughs), and he generally did. Yes, you know I just feel like I won't be able to fill those boots. In clearly being able to state a problematic feature of her loss, we scored this as AGES 3

By session 20, eleven months after David's death, Sophie had begun to recognise the value of taking control of her life.

Sophie: I have begun to keep a memo book in place of post-it notes.

This was a moment of positivity which raised her AGES score to 4.4, although it was not maintained in the context of other strands of her grief (cf. Caro Gabalda & Stiles, 2013, 2018).

Theoretically, when problematic voices emerge prior to stage 4, they are in opposition to the dominant community of voices (the usual self). Early in her grief, Sophie experienced opposing voices of guilt if she did anything to enjoy herself or allowed herself moments of happiness. In Session 23 she reported that she had been out with some girlfriends. It had been an enjoyable evening but when she got home, she felt guilty at having enjoyed herself.

Sophie: I felt so guilty, I felt really guilty and horrible and it made me cry.

Despite the distressing guilt, however, Sophie said that as bad as the "meltdown" had been, it allowed her to vent pent-up emotions. She questioned whether she had been ready to go out with friends but answered her own question with opposing voices that showed signs of coming together.

Sophie: I think, 'Maybe I wasn't ready for going out, but then I think 'If I wasn't, I wouldn't have gone.

Our descriptors of this stage in the sequence put Sophie at AGES 3, working towards 4. This was technically a setback, reflecting important work on a different strand from the taking control of her life addressed in the extract from session 20. Sophie's coming to terms with guilt appeared to be part of building a meaning bridge, a semiotic link (Stiles, 2011), between David's death and her usual self. Other manifestations included an acceptance of the reality of the death and the regaining of an element of control (cf. Wilson, 2017).

Session 26 was two days after the anniversary of David's death. Sophie had "slobbed around the house" and had taken flowers to the graveyard. The following day she had felt angry with her situation. Part of her frustration was with family and friends not responding to her needs.

> *Sophie*: I just feel like everybody should know. You know, some people won't know it's the anniversary and I feel like shouting and saying 'Look it's the anniversary today, don't you know?' and I just feel really angry like (becomes tearful) 'You should *know* what today is,' And people don't, cos they're just getting on with everything (sighs, pause). Why don't they know? Why don't they care?

She said that even good friends were starting to close down the conversation when she talked about David. She had found a widow's blog online and said it was helpful because it expressed exactly what she was feeling. Given Sophie's need to talk about David, albeit shut down by others, we scored this as AGES 3, working towards 4.

Slowly, Sophie negotiated a new relationship with her deceased husband. In the second year she continued to feel close to him, but her magical thinking was diminishing, and she was able to relocate him symbolically. She said that she felt close to him in the bedroom where he died but that she still could not sleep in that room. Each time she left the bedroom she always shouted back upstairs.

Sophie: **'**See you later' sort of thing. And I don't shut the door, cos he hated being shut in. So I kind of feel like he's there.

Noting this change from magical thinking to a more realistic, symbolic relationship, we scored this moment in Sophie's assimilation process as AGES 3.9.

In session 38, Sophie reported being able to enjoy a night out with friends without guilt, whereas seven months earlier (session 23), the guilt had been very distressing. She noticed too that she could enjoy happy memories with just a slight tinge of sadness. Thoughts and memories around David's illness and death were not as intense, and the image of him collapsing was fading. We observed this ability to oscillate to and from periods of respite, as AGES 4, moving towards 5. In spite of this she was still unsure about ever returning to sleep in the marital bed.

Sophie: It's just the thought of being in that big bed I think, and him not being there. I think it's maybe that. It's scary.

In the same session (37), Sophie reflected that her recent pattern of monthly counselling appointments seemed to be adequate for her needs. She said that although "I may have my moments", compared to the first year, which had been a "horrible blur", she now accepted that "that's how it is and that's how it will be." Schemas such as this, which identify a degree of acceptance of the post-loss world, bring the community of voices together and construct a meaning bridge, such as a word or a story that serves as a conduit for shared meaning between interlocutors or between the internal voices of one individual (Brinegar, Salvi, Stiles, & Greenberg, 2006; Stiles & Brinegar, 2007). This confirmed our score of between AGES 4 and 5 for this session.

Session 44 marked the second anniversary of David's death. Sophie reflected, as she had on previous occasions, that "the build-up was worse than the actual day." Others in the family had been 'teary', although she had, not, which she found puzzling. She described it as

"a bit annoying" that some friends had remembered the significance of the date, but others had forgotten. She reflected on the experience of a friend also bereaved of a husband but who has recently got engaged.

> *Sophie*: I'm really happy for her, *really* happy for her (pause) but it's almost, I almost feel like we're in a different category now. And I almost feel a little bit abandoned, I don't know if 'abandoned' I don't know what the right word is, I just feel like I'm the only one in that situation now sort of thing, whereas before I thought, 'Oh yes she's like a little ally.

She said that she felt she needed other friends, and was considering joining the WAY Foundation, a UK organisation for young widows. In the final session (45) she reported that she had joined it. Based on this move to seek out new opportunities we scored AGES 5.5.

In the final session Sophie described her mood as "a little bit up and down." She found herself thinking about David "absolutely loads, like not purposely, just thinking about him loads, all the time then that weans off a bit."

> *Sophie*: I just feel like I'm in this (pause) plateau of nothingness really. And then sometimes I think I miss David *more* now than, (pause). Obviously, I miss him all the time, but I feel like I'm missing him more now because I want to be able to do things, everyday things with him and things like that. It's weird really, but I feel I've just got to get on with it, can't do anything about it.

With her counsellor Sophie reviewed the work done together, and there was mutual agreement that the counselling could come to an end. Sophie recognised that although her grief would continue, she now had an understanding of the nature of her grief and emotional resources to cope without professional support: we scored AGES 5, approaching 6.

Progress on bereavement tasks

The three categories of tasks in bereavement, used as subheadings for each AGES stage (Table 1), offer a way to organize case observations. Here we use them to describe Sophie's progress on the AGES. Sophie's gradual but successful assimilation was manifested in all three categories.

1) Managing the pain of grief

Soon after her husband died, Sophie had returned to work in a part-time job. Her employer had noticed her distress and numbness and had persuaded her to seek professional help. When her counselling began, Sophie was still able to ward off her grief by avoiding the reality:

> *Sophie*: When I think about it in my head it's like it's a film and it's not really real. [Session 1, assessment].

The AGES sequence describes a client's move from AGES 0: warding off the grief, to AGES 1: vague awareness of the reality.

With a large family to care for, it was unlikely that Sophie would feel that her life had no purpose. There were always opportunities to keep busy. There were, however, times when she was alone and she found herself dwelling on the loss:

> *Sophie*: Stuff has been popping into my head. Also, I have not been sleeping well and my mind has been racing. [Session 8].

By Session 13 Sophie was becoming aware both of triggers to her sadness and of ways to gain some relief. She recognised the constraints of living in a small, insular community, and put her feelings down to "cabin fever". She was also aware of worrying about the sole responsibility for home and children. On the positive side, she spoke of friends she met for coffee whom she could talk to, and she was able to discriminate between those who listened and understood from their own experiences and those who could be

“overpowering” and “bossy” in the advice they gave. We scored Sophie's management of the pain of bereavement at AGES 3, working towards 4.

By Session 35, Sophie could say that she was continuing to “go with the flow”. She still found herself returning to the day of David’s death, although it was generally not upsetting, and she felt she could cope with it. However, the previous week she had spoken to somebody about his sudden death, although she “didn’t want to go too far into it”. She talked about planning a time out with friends. She anticipated that unlike the feelings of guilt on enjoying herself that see had expressed in Session 23, it would be okay this time although she was still not ready to be away from home overnight because this would feel like abandoning David. Her AGES score was 4, working towards 5.

In session 43 Sophie was able to report feeling positive, and more in control of her life and health. She said that she was now comfortable thinking about things that they had done as a family. For example, she and her daughter had been into a television shop and had talked about how Dad would have liked one of the big screens. This ability to be able to discuss the deceased with minimal negative affect is an identified point on the AGES sequence (See Table 1). Sophie's assimilation was at AGES 5, close to 6.

2) Understanding the circumstances of the death

Concurrently with her need to establish a new sense of identity, Sophie was working on understanding the circumstances of her husband’s diagnosis, prognosis and death. This was a protracted process. She arranged to meet the oncologist who had cared for him. In session 6 she said that she needed to know whether the embolism from which he died was caused by his cancer or by the chemotherapy. In the event, meeting the oncologist with her questions was in Sophie’s view unhelpful. In session 21 Sophie said that she had experienced him as defensive and she had not got the answers she needed. She did not feel he had listened to her. During the meeting she said that she could hear David’s voice asking her why she was

doing this. However, she concluded that it was something that had to be done. As early as session 11, Sophie was able to reflect that as traumatic as David's death had been for the family, to die suddenly, rather from a long debilitating illness, was the end he would have chosen for himself.

> *Sophie*: He wouldn't have liked to have lingered but he wouldn't have wanted us to go through any of it really. But definitely that way for him.

This is typical of clients attempting to construct meaning from the death: AGES 6.

In making sense of David's cancer, Sophie kept returning to events surrounding his death. In session 27 she reflected,

> *Sophie*: I keep thinking that I could have, and I know I've said it loads of times, that I could have done something else or changed something, done something on that day (3 second pause). It just seems like (sighs) I'm putting this pressure on myself thinking that, I mean I'm not medically, I can't, you know, but I just feel as though that (pause) I might have been able to do something that nobody else could have done. I know that sounds really stupid, I could have changed the outcome.

By AGES 6 the reality is accepted, and the circumstances are assimilated.

3) Establishing a new sense of identity: changing relationship with the deceased

In the middle period of her counselling Sophie identified the problems of single parenting, as in the example above: helping with homework. In almost every session Sophie addressed her struggle as a widowed mother. By session 31, she was beginning to question her sense of identity as a person in her own right.

> *Sophie*: I know I'm a mum and everything, but what's the other bit of me doing? Do you know what I mean? Where do I go from here? (sobs). Don't know, don't know. I can't see a plan. People that I don't really know, you know, they see a wedding ring and they you know, assume you're married.

At the school gate another parent had referred to her as a single mum.

Sophie: I don't think of myself as being single parent. Do you know what I mean? I'm not divorced, and I find that a bit annoying. But she lumped me in as a single parent. I don't feel like that. Yes. Is that weird? I don't like being lumped as a single parent. Then I realise I don't like being thought of as a widow either.

She said that ticking the 'widow' box on forms was horrible.

Sophie: That's the sort of box I should be ticking when I'm in my seventies. I feel I'm just, I'm not just a mum but I'm a mum and then there's the other box; What else am I? I just feel like is every week just going to feel like this now?

In session 33, a year after David's death, Sophie was aware of her need for a sense of personal identity:

Sophie: It does feel like there's nothing out there for me. I feel a bit selfish really. I feel selfish just thinking that I could be happy again. You know?

Counsellor: Why would it be selfish to be happy again?

Sophie: Well I just, maybe it is, maybe it is that I don't deserve, deserve it. I don't know.

She said there were "silly" resentments in her life, for example,

Sophie: It's always me that has to drive.

And two minutes later:

Sophie: Maybe I think that I can't move on until Michael's older. Then then I'm thinking maybe 'Am I going to feel like this for the next 10 years or something?' And then I can start living. It's not like I want to be party animal. I don't want to be going out and things like that. It's not that I want something, I don't know. It's really hard to explain. It's just feels all like (3 second pause) is this it? (laughs)"

In the AGES sequence from 5 to 6 the bereaved person begins to establish a sense of identity which is independent of the past relationship with the deceased. Fully accomplishing a new, post-loss sense of identity is a long process which may continue after counselling has ended.

Discussion

Our observations in Sophie's case seemed consistent with the elaborated theory of assimilation in the resolution of grief as described by the AGES (Table 1). The tasks of bereavement detailed in the AGES subheadings at each stage provide a means organizing observations of a client's grieving process. The details of the Sophie case show how the AGES concepts can be applied to clinical details. Thus, the study justifies a small increment of confidence in the theory and at the same time suggests that the AGES has potential for clinical and research applications in charting the grief trajectory of bereaved clients.

Sophie's scores over two years showed a positive trend, though they fluctuated with the vicissitudes of daily life as well as across strands of her bereavement. Theoretically, although strands of a problem tend to be assimilated together, they may get out of synchrony during treatment as work focuses on some strands and others fall behind temporarily (Caro Gabalda & Stiles, 2013, 2018). This pattern is consistent with grief trajectories typical in normal grief in non-resilient individuals (Bonanno, Boerner, & Wortman, 2008). Although Sophie had a resilient personality, we suggest that the circumstances of the death, her relationship to the deceased, and the stress of adapting to single parenthood compromised this resilience.

The consistent pattern of AGES scores assigned by bereavement counsellors to the 20 randomly selected transcript extracts suggests that the AGES is an acceptable and accessible tool for clinicians and practitioners, as well as a reliable index of progress in grieving. There are, however, methodological limitations to this demonstration. The counsellors who rated

the 20 extracts were shown them in temporal sequence, so they may reasonably have expected an upward trend in the AGES scores. This is a confound for interpreting the ICC score as a reliability of independent ratings. In general, AGES levels often cannot be judged in isolation from their context (raters must accurately understand the meanings of references), so from a psychometric perspective, this confound is a limitation of the instrument, not just of this study's procedure.

The AGES elaborates assimilation theory by focusing on a specific population and category of problematic experience. Clients assimilating the experience of bereavement have some things in common with all clients, but many more things in common with other bereaved clients, and the AGES elaborates assimilation theory of the latter.

Like any case study, this one is vulnerable to distortions based on the expectations and biases of its authors. The first author's special access afforded by being Sophie's counsellor offered both the opportunity for a unique, inside view of the process and the possibility of particular sorts of distortion (e.g., self-serving bias). We have tried to remain aware of this and avoid the distortion, but we recommended appropriate caution in considering our interpretations. We have tried to provide observational detail (the quoted passages) as qualitative evidence to support our interpretations, but of course it is desirable that others with different biases and expectations also conduct studies. Finally, like any case, this one has idiosyncratic features and cannot be considered as representative of any particular population. The goal of a theory-building case study, however, is not to generalize from the case. The theory specifies its own range of application, and it can be assessed for consistency and elaborated based on any case to which it applies (Stiles, 2007, 2009). The assimilation model and the AGES can learn from the case of any bereaved client.

Data availability statement

The data that support the findings of this study are openly available in White Rose eTheses Online, at http://etheses.whiterose.ac.uk/17661/.

References

Attig, T. (2004). Meanings of death seen through the lens of grieving. *Death Studies, 28,* 341-360.

Bonanno, G. A., Boerner, K., & Wortman, C. B. (2008). Trajectories of grieving. In M. S. Stroebe, R. O. Hansson, H. Schut & W. Stroebe (Eds.), *Handbook of Bereavement Research and Practice: Advances in Theory and Intervention* (pp. 287-307). Washington DC: American Psychological Association.

Bowlby, J., & Parkes, C. M. (1970). Separation and loss within the family. In E. J. Anthony & C. Koupernik (Eds.), *The child and his family* (pp. 197-216). New York: Wiley.

Brinegar, M. G., Salvi, L. M., Stiles, W. B., & Greenberg, L. S. (2006). Building a Meaning Bridge: Therapeutic Progress from Problem Formulation to Understanding. *Journal of Counseling Psychology, 53*(2), 165-180.

Caro Gabalda, I., & Stiles, W. B. (2018). Assimilation setbacks as switching strands: A theoretical and methodological conceptualization. *Journal of Contemporary Psychotherapy, 48,* 205-214. doi:10.1007/s10879-018-9385-z

Caro Gabalda, I., & Stiles, W. B. (in press). Why setbacks are compatible with progress in assimilating problematic themes: Illustrations from the case of Alicia. *Psychotherapy Research*, https://doi.org/10.1080/10503307.2020.1795292

Cheston, R., Gatting, L., Marshall, A., Coleman, P. and Spreadbury, J. (2017) Markers of assimilation of problematic experiences in dementia within the LivDem project. *Dementia, 16* (4), 443-460. ISSN 1471-3012

Folkes-Skinner, J. A. (2016). The assimilation of problematic experiences during full-time counsellor training: The case of Mandy. *Counselling and Psychotherapy Research, 16*(3), 161-170.

Gray, M. A., & Stiles, W. B. (2011). Employing a case study in building an assimilation theory account of generalized anxiety disorder and its treatment with cognitive-behavioral therapy. *Pragmatic Case Studies in Psychotherapy, 7*(4), 529-557.

Henry, H. M., Stiles, W. B., Biran, M. W., Mosher, J. K., Brinegar, M. G., & Banerjee, P. (2009). Immigrants' continuing bonds with their native culture: Assimilation analysis of three interviews. *Transcultural Psychiatry, 46,* 257-284.

Honos-Webb, L., Stiles, W. B., & Greenberg, L. S. (2003). A method of rating assimilation in psychotherapy based on markers of change. *Journal of Counseling Psychology, 50,* 189-198.

Janoff-Bulman, R. (1992). *Shattered Assumptions: Towards a New Psychology of Trauma*. New York: The Free Press.

Kelly, G. A. (1963). *A Theory of Personality: The Psychology of Personal Constructs*. New York: Norton & Company Inc.

Kivikkokangas, S., Leiman, M., Laitila, A., & Stiles, W. B. (2020). Hiding shame: A case study of developing agency. *Romanian Journal of Psychoanalysis, 13,* 85-116. https://doi.org/10.2478/rjp-2020-0008

Kübler-Ross, E. (1969). *On death and dying*. New York NY: Macmillan.

Lishman, E., Cheston, R., & Smithson, J. (2016). The paradox of dementia: Changes in assimilation after receiving a diagnosis of dementia. *Dementia, 15*(2), 181-203.

McGraw, K. O., & Wong, S. P. (1996). Forming inferences about some intraclass correlation coefficients. *Psychological methods, 1*(1), 30.

Moore, S. C., Osatuke, K., & Howe, S. R. (2014). Assimilation approach to measuring organizational change from pre- to post-intervention. World Journal of Psychiatry, 4, 13-29.

Mosher, J. K., Goldsmith, J. Z., Stiles, W. B., & Greenberg, L. S. (2008). Assimilation of Two Critic Voices in a Person-Centered Therapy for Depression/Assimilation zweier Kritikerstimmen in einer Personzentrierten Therapie bei einer Depression/Integración de dos voces críticas en una terapia centrada en la persona por depresión/L'assimilation de deux voix critiques dans la dépression au cours d'une thérapie centrée sur la personne/Assimilação de duas vozes críticas numa terapia centrada na pessoa para a depressão. *Person-Centered & Experiential Psychotherapies, 7*(1), 1-19.

Neimeyer, R. A. (2006). Complicated Grief and the Quest for Meaning: A Constructivist Contribution. *Omega: Journal of Death & Dying, 52*(1), 37-52.

Neimeyer, R. A. (2009). *Constructivist Psychotherapy*. Hove: Routledge.

Parkes, C. M. (1971). Psychosocial transitions: a field for study. *Social Science and Medicine, 5,* 101-115.

Parkes, C. M. (1972). *Bereavement, Studies of Grief in Adult Life* (3rd ed.). London: Penguin.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of consulting psychology, 21*(2), 95.

Rogers, C. R. (1961). *On Becoming a Person: A Therapist's View of Psychotherapy* (1967 ed.). London: Constable.

Rogers, C. R. (1963). Actualizing tendency in relation to" Motives" and to consciousness. In M. R. Jones (Ed.), *Nebraska symposium on motivation* (pp. 1-24). Oxford, England: University of Nebraska Press.

Rudolf, G., Grande, T., & Oberbracht, C. (2000). The Heidelberg restructuring scale. A model of changes in psychoanalytic therapies and its operationalization on an estimating scale. *Psychotherapeut, 45*, 237–246.

Shepherd, C. (2015). *The feasibility and acceptability of a therapist measure of assimilation of problematic experiences for clients with Intellectual Disability.* (DClinPsy), University of Sheffield.

Stiles, W. B. (2001). Assimilation of Problematic Experiences. *Psychotherapy, 38*(4), 462-465.

Stiles, W. B., & Angus, L. (2001). Qualitative research on clients' assimilation of problematic experiences in psychotherapy. In J. Frommer & D. L. Rennie (Eds), *Qualitative psychotherapy research: Methods and methodology* (pp. 112-127). Lengerich, Germany: Pabst Science Publishers. Also published in *Psychologische Beiträge, 43*, 570-585.

Stiles, W. B. (2003). When is a case study scientific research? *Psychotherapy Bulletin, 38*(1), 6-11.

Stiles, W. B. (2007). Theory-building case studies of counselling and psychotherapy. *Counselling and Psychotherapy Research, 7*(2), 122-127.

Stiles, W. B., & Brinegar, M. G. (2007). Insight as a Stage of Assimilation: A Theoretical Perspective. In L. G. Castonguay & C. E. Hill (Eds.), *Insight in Psychotherapy* (pp. 101-118). Washington DC: American Psychological Association.

Stiles, W. B. (2011). Coming to terms. *Psychotherapy Research, 21*, 367-384.

Stroebe, M., Schut, H., & Boerner, K. (2017). Cautioning health-care professionals: Bereaved persons are misguided through the stages of grief. *OMEGA-Journal of Death and Dying, 74*(4), 455-473.

van Rijn, B., Agar, J., Sills, C., Pearce, P., & Stiles, W. B., (submitted). Assimilating problematic life script themes in supervision. Manuscript submitted for publication.

van Rijn, B., Chryssafidou, E., Falconer, C. J. & Stiles, W. B. (2019). Digital images as meaning bridges: Case study of assimilation using avatar software in counselling with a 14-year-old boy. *Counselling and Psychotherapy Research*, 19, 252-263. https://doi.org/10.1002/capr.12230

Varvin, S., & Stiles, W. B. (1999). Emergence of Severe Traumatic Experiences: An Assimilation Analysis of Psychoanalytic Therapy with a Political Refugee. *Psychotherapy Research, 9*(3), 381-404.

Varvin, S. (2003). Mental survival strategies after extreme traumatisation. Copenhagen, Denmark: Multivers APS Publishers.

Wilson, J. F. (2017). *Moments of assimilation and accommodation in the bereavement counselling process*. PhD thesis, York St John University School of Psychological and Social Sciences, York, United Kingdom. Available: http://etheses.whiterose.ac.uk/17661/

Table 1: The Assimilation of Grief Experiences Scale (AGES)

Stage 0 Warded Off

Managing the pain of grief

The client is in a state of numbness; dissociating from grief and associated reminders of the deceased.

Circumstances

The client avoids the circumstances surrounding the death. Clients frequently refuse to talk about what has happened.

Relationship to the deceased

The client dissociates from the reality of a physically ended relationship. Clients report reluctance to leave the body, or wanting to prevent the burial/cremation from taking place. In some instances, the client may refuse to talk about the deceased, and reminders of the loved one, e.g. wardrobe contents, are hastily packed away or disposed of. Clients do not generally present for counselling at this stage, but may report these events retrospectively.

Stage 1: Unwanted thoughts

Managing the pain of grief

Reminders which intensify the grief are avoided. Some clients manage this by "keeping busy". The client is often unaware of the full extent of her grief, although it is obvious to friends and family, who may begin to worry and suggest professional help.

Circumstances

Client shows extreme difficulty in talking about the circumstances of the death. If pressed to do so, the account is short and brief. The client avoids reminders, e.g. music, photographs etc. As she approaches stage 2, she becomes more willing to talk about the events with others, but does not easily raise the topic. She may become upset and tearful.

Relationship to the deceased

Client clings to the pretence that the loved-one is still alive. They talk as if the loved one was still there, e.g. greeting them on returning home from being out. The house remains unchanged, including the possessions of the deceased. Places associated with the deceased are often avoided. The client may express difficulties with being away from home, because they feel they are abandoning their loved one. Client may cry out in anguish, calling to the deceased. There may be regular, even daily visits to the grave or place where ashes are scattered. The client sometimes displays searching behaviour which may be desperate and distressing.

Stage 2: Vague awareness

Managing the pain of grief

This is the most distressing stage, and counselling tends to hasten its onset; such that clients feel worse before they feel better. The client may talk of a loss of identity and purpose: "I am nothing without them. My life is over". She is likely to dwell on the loss.

Circumstances:

Client becomes able to introduce a conversation about the death although she is likely to become upset. Guilty feelings and unfinished business surrounding the death are discussed. Voices are often confused: 'I don't know what to think/feel/believe'. Reminders of the deceased become more tolerable.

Relationship to the deceased

Client 'knows' the loved one has died, but may still expect them to return. The client may look for signs and messages from the deceased – e.g. butterflies, white feathers, noises in the house and unexplained phenomena. They may contemplate (or even go through with) a visit to a medium at this time. The client may be drawn to places which remind her of the deceased, including the hospital /hospice ward where the loved one died. Thoughts about the lost loved one are seldom, if ever, far away. The client can feel guilty if she is distracted from her grief, or if she catches herself laughing. Anger towards the deceased is largely avoided. The client may spend significant amounts of time talking to the deceased. She may seek out the smell of the lost loved one, e.g. on a dressing gown or in the wardrobe. Frenetic searching behaviour begins to diminish.

Stage 3: Problem statement/clarification

Managing the pain of grief

Early in stage 3 the client still spends much time centred on her grief. Tears and low mood appear as if from nowhere, fixating the client on the loss. For some clients this includes both extrinsic, environmental triggers, and intrinsic factors such as personality traits, e.g. resilience. As she moves through this stage she experiences periods of respite and she begins to notice the extrinsic triggers to her grief; including anticipating difficult times, e.g. anniversaries. Some talk of guilt at finding grief respite; interpreting it as a sign of 'not loving enough'. For these clients, ruminating on the grief may become a sign of loyalty to the deceased.

Circumstances

Events surrounding the death are described in an unhurried and detailed narrative. Client identifies areas of guilt and unfinished business they wish to work on. They may begin to recognise the irrationality of some of their guilt, as voices become less confused and begin to work together. Reminders, e.g. photographs, even if upsetting, begin to be an aid to healthy grieving.

Relationship to the deceased

Client's conversations with the deceased begin to lose aspects of magic and pretence and start become symbolic rituals. She articulates human feelings towards the deceased. Examples include, "I am angry with you for leaving me". and. "A fine mess you've left me in!" Client starts to become comfortable with some happy thoughts about the deceased. Searching behaviour becomes less frequent, and more symbolic, such as online searches for references to the deceased, e.g. social media pages.

Stage 4: Understanding/insight

Managing the pain of grief

Through this stage there is an increased acceptance of the grief. The client is able to "go with the flow". The client articulates an awareness of being able either to avoid grief or to contact tears when it feels appropriate. She has identified coping strategies; for example, restoration activities such as hobbies and social events. These may help the client to get temporary respite from the loss and grief. Client may seek out the experiences of other bereaved people in order to understand normal grief. This may include talking to others with similar experiences, reading internet pages and browsing online forums. Grief is embraced as fear diminishes, although feelings of guilt may be associated with successfully managing the grief.

Circumstances

Voices come together in accepting the cause of the death and discussing the events coherently. The client is generally comfortable with deliberately evoking memories of the deceased (for example, looking at photographs, listening to music). Searching behaviour diminishes. Negative affect may at times begin to decrease as pain gives way to a quieter sadness.

Relationship to the deceased

Talking about the deceased becomes sad rather than painful. Client begins to rationalise personal objects and becomes selective over which of the deceased's possessions hold significant meaning. Magical thinking such as finding white feathers becomes less important. Guilt at 'being happy' is diminishing. The client is able to gain comfort, even enjoyment from photographs and videos of the deceased and is comfortable with the memories they elicit. She is able to locate a symbolic place for the person they have lost. This may be a physical place ('I can feel them near when I am in my study'), and/or a spiritual/religious place ('Heaven'). Most clients develop a sense of holding the loved one within the self ('in my heart').

Stage 5: Application/working through

Managing the pain of grief

The client has learnt to oscillate comfortably between spending time dwelling on the loss and engaging in restorative activities. Thus periods of grief avoidance become helpful. The client becomes more accepting of her 'up and down' moods. Feeling 'down' becomes less frightening. Feelings of guilt at 'moving on' become successfully managed and sadness is no longer identified as essential for continued love loyalty towards the deceased. The interludes of grief and sadness become accepted and integrated into daily life: 'That is how it is, and how it will be for some time yet.' This stage can be summed up as 'Keep calm and carry on'.

Circumstances

Client begins to reach a new understanding and acceptance. She articulates, perhaps with prompts and open questioning, that she can make sense of the circumstances surrounding the death. She may articulate a religious or spiritual meaning in which the client says they find comfort. Examples include, 'She is at peace now' and 'He died so as to be there in heaven for his grandson'. At this stage there is often an acceptance that grief will be here to stay for a while, but pain is being replaced by sadness.

Relationship to the deceased

Visits to significant places, e.g. the graveside, become less important and have less significance. Client is increasingly comfortable about being happy in relation to the deceased. Relationship to the deceased is negotiated and renegotiated towards a symbolic form. 'Magical' expectations that they can ever physically return become increasingly rare and fleeting. Client can find meaning in the life of the deceased, including shared experiences. Examples of things the client says include, 'He had a good life', 'We did so much together' and 'She achieved so much in her life'.

Stage 6: Problem solution

Managing the pain of grief

Client finds new meaning in post-loss life. She begins to establish a new identity. She articulates future plans as part of post-loss adaptation. This may include new hobbies and interests, new (or rekindled) friendships, house moves and job changes. Guilt at moving forward diminishes. Painful memories fade and happier memories take their place, although anniversaries may continue to be difficult for many years. The client is able to return to engagement with everyday life and the need for either grief or grief avoidance fade away. The client may experience having grown as a person, sometimes reporting feeling more compassionate and understanding of others.

Circumstances

Client accepts the reality of the death and may even have found a meaning: e.g. "He would not have wanted to be disabled or dependent". Religious and spiritual meanings may comfort some clients at this stage. Affect becomes positive. Guilt and other unfinished business is largely or completely resolved. Where no meaning can be found, for example following the death of a child, the client articulates a conscious decision to cease searching for meaning.

Relationship to the deceased

Client has formed a symbolic continuing bond with the deceased through objects which they find comforting. This may include items of clothing, photographs, items of jewellery and personal possessions with imbued meaning. Sad memories are tempered with happier ones. The client may contemplate new close relationships.

Stage 7: Mastery

Managing the pain of grief

The client is able to use her experience of grief and the strategies acquired to better cope with future losses.

Circumstances

Loss is integrated into a past which can be talked about reflectively with minimal negative affect. Any search for meaning has ceased. Client acquires a resilience which prepares her for future losses.

Relationship to the deceased

A symbolic and lasting bond with the deceased becomes integrated into the life of the client and is free of negative affect for nearly all of the time. The client becomes open to new close relationships whilst holding their lost loved one in their heart.