**AN ATTACHMENT THEORY-INFORMED THEMATIC ANALYSIS
OF BEREAVED FAMILIES' NARRATIVES**

RACHEL SARAH WILLCOX

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Department of Psychology

Faculty of Health and Applied Sciences

University of the West of England, Bristol

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Exploring attachment incoherence in bereaved families' therapy narratives

Abstract

Attachment theory predicts that family bereavement leads even securely attached individuals to experience temporary attachment insecurity. This paper explores how incoherence, a narrative marker of attachment insecurity, is displayed in the talk of five families undergoing bereavement family therapy. An Attachment Theory-informed Thematic Analysis of therapy dialogue identified both markers of incoherence and the ways families and therapists co-created incoherence. Results support attachment theory assumptions about the impact of family bereavement on talk but also suggest the micro-processes that contribute to maintaining incoherence. The findings have relevance for bereavement therapy interventions, therapy training and research practice.

This study focusses on the coherence of dialogue that occurs in family bereavement therapy, using the lens of attachment theory to examine how family members talk about the loss of a parent/sibling/child and to explore how systemically some interactions between therapist and family members appear to hinder a clear and coherent dialogue. Through a microfocus on therapy process, the study provides support for attachment theory ideas about the psychological importance of (fostering) coherent speech as well as information about potentially helpful versus unhelpful therapist actions in family bereavement therapy.

Background

Twenty-four thousand children under the age of 16 experience the death of a parent each year in Britain (Office of National Statistics, 2011) which means 3.8% of children in the UK experience such bereavement by the time they are 16 (Fauth, Thompson & Penny, 2009). If one considers also the impact of sibling death (and this study includes both parental and child death) the number is likely even higher. Research suggests the death of a family member has a significant negative impact on both children and adults, including negative effects on physical and mental health, poorer educational and employment prospects, financial disadvantages, and secondary relational loss (Akerman & Statham, 2011; Dowdney, 2000; Worden, 1996). A focus on therapeutic interventions for family death is legitimised by the fact that while the majority impacted are able to, in time, come to terms with the loss, research suggests that between 10-20% of bereaved adults and children show evidence of 'chronic' grief (Bonnano & Kaltmann, 2001; McClatchey, Vonk, Lee & Bride, 2014; Meert et al., 2011; Melhem et al., 2007; Worden, 1996). Therapeutic interventions for this population are important yet the empirical support for grief interventions is equivocal (Larson & Hoyt, 2007; Neimeyer & Currier, 2009) and there is also a lack of research that is focussed on families (Hooghe, De Mol, Baetens & Zech, 2013; Stroebe, 2010).

The current study focusses on family bereavement therapy and the narrative clarity and coherence of the dialogue between therapist and family members engaged in a particular therapeutic intervention that involves telling the story of the family member's death. While research suggests coherence is an important marker of attachment security (Main, 1986) it is also argued to be important outcome of therapy in general (Singer & Rexhaj, 2006), being correlated with increased reports of psychological adjustment, wellbeing and positive therapy outcomes, while incoherence is a predictor of negative therapeutic outcomes (Gilbert, 2002, Lysaker et al., 2005, Moreira, Beutler & Goncalves, 2008). Research has also shown that narrative coherence is a valid marker of progress and the 'effectiveness' of bereavement therapy for clients (Neimeyer, Herrero & Botello, 2006).

In/coherence of speech is important in attachment theory as the organization of speech is understood to reflect the intrapsychic organization of a person's attachment schemas. George and Main's work with the Adult Attachment Interview (AAI), an interview-based assessment of attachment in adults in which participants are asked about their parental relationships and childhood experiences of loss, posits that coherence of speech is a key marker of attachment security (George, Kaplan & Main, 1985). The empirical support for the AAI is strong, for example the security of pregnant mothers as assessed by the AAI has been found to predict attachment status of their infants at age one (Benoit & Parker, 1994; Fonagy, Steele, Moran, Steele & Higgit, 1993; Fonagy, Steele, Steele, Moran & Higgit, 1991; Raval et al., 2001; Steele, Steele, & Fonagy,1996).

In/coherence of speech has also been found to be a key marker of a particular type of attachment insecurity, that related to loss. Attachment Theory suggests that when people experience the death of an attachment figure such as a close family member, their relational cognitive schema – what Bowlby termed Internal Working Model - for this relationship is disturbed (Bowlby, 1980). Bowlby argued that coming to terms with a loss normatively requires reorganising this schema to accommodate the death

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and that this process takes time. Main's coding system for loss in the AAI posits that the disorganisation of attachment schemas following loss creates particular types of incoherence in talk about the deceased (Main, Kaplan & Cassidy, 1985). These types of disorganisation are catalogued in the coding system for what is termed 'unresolved loss' ('U'); key for this study is that the coding manual assumes that a bereaved person's narrative within a year of their loss would normatively display these markers of incoherence. Again the empirical support for the U-coding system is strong; for example, unresolved loss has been found to predict the 'disorganised' form of attachment insecurity in infants in further prospective research studies (Ainsworth & Eichberg, 1991; Main & Hesse, 1990), including one meta-analysis (Van IJzendoorn, 1995).

Importantly for the current study, it has been proposed that individuals classified as ''unresolved with respect to loss: U'' on the Adult Attachment Interview (AAI) demonstrate many of the same symptoms described in prolonged grief disorder/complex grief (Neimeyer, Holland & Currier, 2008; Thomson, 2010). However this connection has not been empirically examined. Thus the current study provides an examination of the links between Attachment Theory ideas about coherence and unresolved loss and the narratives created by families about the death of their family member. In doing so the study applies the AAI coding system not to AAI interviews in which an adult participant talks about their childhood experiences of loss to the AAI interviewer but to extracts from family bereavement therapy in which the story of the family member's death is recounted by the family to the therapist. Using the AAI codes on non-AAI data is not entirely without precedent (Thomson, 2010); however there are limited examples of the AAI codes being used outside of this context and specifically on therapy data (Muscetta, Dazzi, Decoro, Ortu, & Speranza, 1999; Thomson, 2010;). While some researchers would disagree that attachment patterns influence discourse outside of an AAI interview (e.g. Hughes, Hardy, & Kendrick, 2000); there is a small literature that does suggest that attachment processes impact on narrative

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formation in other contexts (e.g. Bishop, Stedmon & Dallos, 2015), which provides support for their use in this study.

The current study adds to the limited literature on bereavement process research and aims to demonstrate the usefulness of the 'U' loss codes for understanding incoherence in family therapy narratives. The Strange Situation Test (SST) (Ainsworth & Wittig, 1969) and the AAI (George, Kaplan & Main, 1985) deliberately both 'stress' the attachment system (e.g. separating babies from their parents (SST) and asking adults to talk about things like separations from parents when they were children (AAI)). The therapy data in this study is also focused on a similar (very) stressful point, families retelling the story of the death of their family member, and therefore it can be assumed that it is at these moments that the researcher will be able to see the attachment system most clearly in operation. Utilising the coding system of the AAI to examine the therapy data will make it possible to look for subtle linguistic markers of unresolved loss that Attachment Theory would predict should be present in the recent aftermath of bereavement.

It has been noted in the counselling and psychotherapy literature that there is little research based on directly analysing what happens in therapy sessions (Finlay, 2014) and there have been calls for further process research based on therapy data (Henton, 2012; Mallinckrodt, 2011, Scheel et al., 2011). Concurrent with a shift in assumptions about the 'best' way to measure the efficacy of grief interventions, there have been calls for researchers to adopt narrative qualitative methodologies to consider the bereavement experiences of young people and adults (Dowdney, 2000, Ribbens Mccarthy, 2007), as well as to increase understanding of the operational implementation of interventions (Currier, Holland, & Neimeyer (2007) and the critical mechanisms within interventions (Ahn & Wampold, 2001). Midgley (2004) correspondingly calls for greater use of qualitative methodologies in child therapy process research. The current study answers such calls for further research and asks the following research questions:

1. Is there evidence of incoherence (as described by the AAI) in the families' narratives?

2. Are there other ways that incoherence is demonstrated or systematically enacted in the family sessions?

Method

Design

This study employed a longitudinal qualitative design using recordings of the 'Telling the Story' intervention at the beginning and towards the end of family bereavement therapy. This involved the recording of 'naturalistic' therapeutic data.

Participants

Participants were recruited through Winston's Wish, a family bereavement charity based in the UK. The charity offers support to bereaved children, young people and their families on a local and

national level through helplines, literature, drop-in services as well as more formal therapeutic work. For families that engage with face-to-face work, there are various interventions offered. 'Telling the story', the focus of the current study, is a key intervention used with all families, usually in their first session. The aim of this intervention is to allow families to together tell the story of family life before the death, the death itself and how life is now, after the death. Families' stories inform the planning of further interventions and choice of support offered. Families repeat the story telling intervention within peer groups (adults and children) at a residential weekend if they chose to attend, and, additionally for this project, families re-told the story in an extra family session towards the end of the therapy contract.

Participant families were recruited between April 2014 and June 2015 by the team supporting families bereaved through illness or accidents. Families were excluded from recruitment if the therapeutic team felt that participation in the project would be detrimental to a family's therapeutic progress. Five families were recruited (a total of six adults and eight children) and 13.5 hours of audio-recorded data was collected over 10 interviews. All the families were White British. The average time between the death and the first recording was 9.4 months (range 6-18 months), and the average time between the two recordings was 7.2 months. The average time between the death and the final recording was 16.2 months (range 11-26 months).

Ethical approval for the study was obtained from the First Author's Health and Life Sciences Faculty Research and Ethics Committee in accordance with the ethical code of conduct published by the British Psychological Society (BPS, 2009).

After obtaining informed consent from the therapists, parents and children, the 'Telling the story' intervention was audio-recorded. The recordings were transcribed orthographically (Braun & Clarke, 2013); transcription also followed guidance from Main and Goldwyn (1984), who stated that AAI interview transcriptions should be transcribed 'verbatim' with all 'errors' and hesitations transcribed,

meaning that mispronunciations, gaps/silences or stutters are noted. Transcription followed these guidelines and prolonged silences were timed and noted.

Data Analysis

This study utilised a flexible and inductive approach to theory-informed TA which is quite different to more deductive theory-driven TA approaches (e.g. Boyatzis, 1998). Unlike other examples of theory-driven TA, this study was not framed by a positivist/quantitative epistemology which emphasizes coding reliability and aims to be a 'scientific method'– what has been referred to as the 'small q school' (Kidder & Fine, 1987) of qualitative methodologies. Instead this study aimed to develop a more fully qualitative 'deductive' approach to TA that prioritised researcher subjectivity and interpretation, as well as theoretical flexibility, and accessibility. This methodological approach also reflected the authors' values of inter-subjectivity and 'professional artistry' in research, values which are core to British Counselling Psychology (BPS, 2005).

The data was analysed using a theory-informed Thematic Analysis (Braun & Clarke, 2006, 2013) following the specified six phases of coding and theme development that begins with familiarising yourself with the data and identifying items of potential interest. The second phase of TA, 'generating initial codes', involved creating a 'codebook' in two stages. First, codes were developed directly from the unresolved loss codes from the AAI, and literally 'cut and pasted' into a codebook. This first version of the codebook was used as the initial coding guide, and the transcripts were read and coded using these AAI codes. AAI coding was developed for single-person research interviews and as such the coding does not capture systemic aspects of the family bereavement session. Thus in an iterative analysis process further codes were created through 'inductive-deductive' coding that was data-driven but informed by attachment theory and these codes were added to the coding book (see Table 1).

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To illustrate the process of code development, the creation of the code "Therapist co-constructing disorganised narrative" was informed by one of the original deductive AAI codes "Indication of disbelief that the person is dead". This new code "Therapist co-constructing disorganised narrative" shows the importance of the therapist using the right words, e.g. "Daddy's body" rather than "Daddy" (which suggests that Dad may still be alive) to avoid perpetuating incoherence in the narrative. Further examples of the data are shown in the analysis section tagged by family number/recording number (1 or 2)/line number for example: *Family 2/1 Line 832*.

Analysis

Two themes were identified in the data: Evidence of unresolved loss and creating incoherence.

It's all a bit of a blur: Evidence of Incoherence

This theme describes the way that unresolved loss, as defined by the AAI codes, is demonstrated in the families' stories through incoherence. This theme reflects the results of the deductive analysis with most of the data codes captured by this theme having been taken directly from the AAI. There were signs of unresolved loss in all of the family's stories, both at first and second tellings, and the signs took three forms, which are reflected in the titles of the three subthemes.

Disbelief that the person is dead: Lapses in the monitoring of reason. Most of the families' stories evidenced 'indications of disbelief that the person is dead'. Examples of this can be seen throughout the families' stories in both first and second tellings, reflecting the codes found in the AAI. Firstly there were 'slips of the tongue to the present tense'. An example of this is shown in Family Two, when Andrew talked about his wife who died of cancer six months previously: *"The first pain (.) her worst pain is always in the morning" (Family 2/1 Line 832).* Two further indicators of 'disbelief that the person is dead' seen in the data were talking as if 'the deceased is living a parallel life in the present' and

'being dead is an activity' (which involves referring to a dead loved one as having animate living characteristics in the present). Examples of both of these codes were evident in the stories, particularly when families were describing seeing their loved one's body for the first time after the death. In Family One, Katie described her partner's body: *"He was quite cold and different wasn't he? So we put him in the blanket to keep him warm" (Family 1/2 Line 78).* The idea that Katie's partner could feel the cold and needed to be kept warm even though he was dead illustrates the attribution of living characteristics to a dead body. In Family Three, when the Dad's body was returned from the hospital to the undertakers, Mum used language that creates the impression that he is still alive, and perhaps coming back from being away on a trip rather than having died:

> *Mum: I was working on the Thursday and I just thought I just got this feeling (.) it was going to be the Thursday he's going to come back and I really don't to be at work when he comes back and family will wanna go up and see his Dad (.) and Wednesday night I was thinking do I wanna phone up work and say I don't wanna come in because I know I just know that their Dad is going to come back tomorrow (.)*
>
> *(Family 3/1 Line 372-374)*

Other aspects of the lack of monitoring of reason expressed by the families were disorientation with respect to time and space: family members described days passing in a '*blur*' (Family 1 / 2 Line 245) and psychological confusion was seen in statements that were paradoxical or impossible, for example *"(.) I knew something was wrong but I didn't know"* (Family 4/1 Line 218).

A very common indicator of incoherence in all of the families' stories was confusion around the timeline of the death itself, and the timeline of events leading up to the death. Family members were confused about what happened when, children were confused as to how old they were at certain stages, particularly over longer illnesses, and confused about events surrounding the death itself. This was seen

throughout all the stories told, and lead to a sense of incoherence in the narratives. Here two children, aged 7 and 5, display confusion around the time of the death:

Steve: she was at the party

Brenda: we weren't at the party (.) we weren't at the party when mummy died

Steve: oh I forgot a bit

(Family 5/2 Lines 65-67)

The daughter in Family One, Alice (aged seven) displayed significant disruption in the timeline as she could not remember a time before her step-dad was ill. The illness and death had become uncontained and stretched across all of her memories of her step-dad and their life together, leading to a huge confusion about the timeline*: "I can't say how he was I can't say any think about how he came became before he came ill and died 'cause he was already ill (.) even though I met him before" (Family 1/1 Line 18-19).*

Confusion about the timeline was also displayed through events that were forgotten or partially remembered. Events and details being forgotten left gaps in the timeline and resulted in a lack of detail and depth to the stories of the family members' death, creating uncertainty and confusion. Episodic memories are important in creating clear and coherent timelines (Ehlers & Clark 2000), so missing details such as these are also important markers of incoherence.

Sense of being overwhelmed: Lapses in the Monitoring of Discourse. The second subtheme is illustrated by examples of the families finding it difficult to monitor how they are forming their narrative. A common sign of incoherence in the stories was unfinished sentences and prolonged silences. Unfinished sentences are understood in the AAI to be evidence of the speaker being overwhelmed by the thought of the death and unable to monitor or repair their speech (Main, Goldwyn, & Hesse, 2003). Prolonged silences can be understood as moments of preoccupation with the death, and part of the

'freeze' mechanism that is triggered when talking about distressing material (Hesse & Main, 1999, 2006).

In this study, silences longer than 6 seconds were coded and considered to be indicators of incoherence,

in contrast with the 20-30 second silences coded in the AAI. The rationale for this was based on

interpretive judgement after listening to all the recordings and noting silences that seemed 'appropriate'

in terms of turn taking and the natural flow of talk between individuals. These contrasted with silences

that were mid-sentence or were disruptive to the flow of talk. These silences were timed and found to

be all six seconds or longer, so this became the criteria for coding. This is in line with other findings that

silences over five seconds can be considered problematic in conversation (Jefferson, 1988) and that the

'usual' length for silences in psychotherapy conversation is two seconds (Berger, 2011). Unfinished

sentences and prolonged silences were spread throughout the narratives, but concentrated in

particularly difficult parts of the story as demonstrated below in this extract from Family One:

> *Mum: They were just in hospital (.) umm ((long pause 6 seconds)) just checking on his body (.)*
>
> *making sure everything is working as it should have been (.)*
>
> *(Family 1/1 Lines 281-282)*

Unfinished sentences were also common in the stories, both in adults and children's

contributions. When Rosie described her children visiting their Dad's body, she found it difficult to

monitor her speech and there was disruption as sentences were left unfinished*: "and then they went to*

see- I think he'd- I was at work when he- when he came back (.) and I-" (Family 3/2 Line 314). In Family

One, when Mum (Katie) was talking about the cause of her partner's death, she was also unable to finish

her sentence, which led to an incoherence in the story as important detail was not given:

> *Alice: um is this what Darren happened (.) is it where he had his lungs and they stopped (.) and his*
>
> *kidneys*
>
> *Mum: yeh his body jus-*

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Alice: yeh

Mum: yeh

(Family 1/1 Lines 218-221)

Family members also displayed incoherence by going 'off topic' mid-story-telling. An example of this came in Family Five's first recording that takes place at the therapists' office at a point where the family were talking about the Mum's funeral and the details of how her body was dressed and put into the coffin:

Dad: no no you dress her outside the box and then put her in

Brenda: so outside the box

Dad: uh huh (.) and then place Mummy in nice and cosy and comfy

Brenda: why is there poo on the window

Therapist: because there are some birds that fly by that window that's why there's poo on that window

Brenda: is that Saint Greg's church

Therapist: ah I'm not sure (.) I think it's Saint Martins (.) so after mummy died you went to (.) she was at

(Family 5/1 Lines 935-938)

Brenda is unable to maintain the conversation about her Mum's body and she switches off topic, literally 'out of the room', to the bird droppings on the window. Main and Goldwyn (1984) consider that when a speaker wanders to irrelevant topics or suddenly changes topic when creating a narrative, this is due to a lack of monitoring of their own speech, something that results from the speaker losing touch with the present context because of its the distressing content. This diversion away from the distressing

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content can be understood as a small dissociative act, regulating the affect of the speaker by changing topic to something less distressing and manageable (Parkinson & Totterdell, 1999).

Trying to see things in a normal light: Behavioural Reactions. This theme was developed through th inductive-deductive coding processes and focusses on how the family members tolerated and expressed emotion in the course of the story telling. There were moments of appropriate laughter and humour as families told their stories, such as when mother and daughter laughed about their experiences of Zumba (Family 3/2 Lines 455-462). However, there were times when there were giggles and laughter when talking about the death and these instances of inappropriate laughter were coupled with evidence of incongruous emotion. Mum from Family 1 demonstrated this incoherence when describing who came to the house as soon as the Dad's body was found*: "(.) yeh (.) Jane came (.) Aunty Steph came (.) (Laugh) then luckily everyone went home. It was quite a (.) I mean cos everything was fine" (Mum, Family 1/1 Lines 374-375).* She then continues to describe the Dad's funeral saying: *"(Laughs) I've never seen so many people in one place (Laughs) ha-ha" (Line 448).* This laughter paired with incongruous emotion creates a confusing mismatch between events and emotion. As found in other research, laughter when talking about a death is a sign of incoherence and unresolved aspects of the loss (Dimaggio & Sermerai, 2004; Lyons-Ruth, Yellin, Melnick, & Atwood 2005; Marvin & Pianta 1996; Salvatore, Conti Fiore, Carcione, Dimaggio & Semerari 2006).

The final and very powerful example of evidence of unresolved loss seen in the data is the code 'family member physically leaves the room'. There are examples of family members disconnecting from the story telling by moving out of the room in three of the families, all of these examples taking place in the first family therapy session. The first recording of Family Four takes place in the family's home. At the point in the story when the Dad is talking about finding his son's body, the Mum leaves the room, taking the pet dogs outside. She gives no verbal indication for her reason for leaving the room. Later on in the

session when the youngest son is talking about events that may have contributed to his brother's death, the Dad is heard on the recording getting up from his chair and can be heard moving things and banging in the distance. He then returns a couple of minutes later. There is again no explanation given or permission sought from other family members or the therapist, nor does the therapist comment on either of these 'breaks' from the session. This physical response to distressing content can be understood as intolerance of difficult emotions and having to disconnect from the narrative as it is too overwhelming (Parkinson & Totterdell, 1999).

Obstacles and mismatches: Creating Incoherence

The second theme reflects the actions of family members and therapists that maintain the incoherence that is already present in the stories. This theme was developed through the processed on inductive-deductive coding and is focussed systemically, on the impact of the interactions between those present in the session. This theme thus describes what family members and the therapists do in the sessions that thwarts the creation of a coherent and collaborative story. This includes non-collaboration between family members as well as therapists' contributions to creating incoherence.

A clear example of non-collaboration was parental resistance to providing clear and full information to their children, which leaves their children with gaps in their timeline of the death or vague about the details of the death. Research shows that appropriate details and clear understanding of events are vital for a coherent story (Ehlers & Clark, 2000) and that stories with fuller detail and a clearer timeline structure lead to better outcomes for families (Figley & Kiser, 2013), so resistance from parents to giving their children information is significant. One example of this was the lack of clarity around details seen in Family One with the use of non-specific language and words by the mother, such as *'horrible things' (line 365) and 'nasty stuff' (line 342)* to describe medical equipment and the failed

attempts at resuscitation. Although this may be understood as a mother's attempt to protect her

daughter from details about the death, the daughter is left confused and without a clear story of her

own. In Family Four, there is an example of a family not sharing information with a son. In this family, the

older son died and following the death a Coroner's report was made. However, as his surviving brother

stated: *"I've never read the report (.) I've never um well actually I was never offered it really (.) I was*

never given the chance to (.)" (Family 4/2 Lines 713-714). Not giving children full details of events in an

age-appropriate way perpetuates mystery for them, and does not allow them to create a coherent

account of what happened. Children need accurate information about the death so they can

avoid 'magical thinking' or filling in the gaps with misinformation that may lead to self-blame for the loss

(Howarth, 2011; Lampton & Cremeans, 2002). Withholding details also results in the creation of a story

where a family member has exclusive insight or understanding about events, meaning there cannot be a

co-created story as details are not shared.

In most of the families' stories there were disjunctures between the children's and the adult's

memories of the death, which is not surprising perhaps as family members remember different versions

of the events. However, there were also examples of disagreement between the members of the family

as they told their story of the loss, over both factual events and interpretations of the events. This is to

be expected to some extent within a family group, however it is potentially the resistance to allowing all

parts of the story to be told that creates incoherence. For example in Family Four, a significant factor

contributing to incoherence was resistance from the Dad to the inclusion of both parts of the son's

narrative in the family story and the son's perspective on events leading up to his brother's death. The

son Mike's search for meaning and sense making is disrupted by Dad's disallowing of this part of the

narrative. Research shows that concurrence between family members and having a congruence in the

family story may be more important for adjustment and wellbeing than the interpretation given to the

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event, even if this is a positive one (Davis, Harasymchuk & Wohl, 2012). A family's ability to allow a variety of perspectives in a story is disrupted by trauma and loss (Kiser, Baumgardner, & Dorado, 2010), so by continuing to disallow a 'full' story, even if this includes negative interpretations of the events, the incoherence is perpetuated.

Another feature of this theme of creating incoherence is parents' reshaping the child's story to match their own understanding. In Family Five, the children have been talking about seeing their Mum's body in the open casket, and Steve (age 5) had already described his sister Brenda (age 7) as being scared and not wanting to kiss the body, and Brenda agreed this was right, she had been scared and had been slower to kiss Mum's body than her brother. However, Dad then goes on to tell this part of the story differently: "*Dad: the kids got to go and say their goodbyes and they weren't a bit scared and they were constantly kissing her" (Family 5/1 Lines 822-823).* This 'rewriting' of the story denies the children validity in their emotions around a particularly difficult point and creates dissonance between their experience and what is being told as the family story. This can be understood as a display of 'misattunement' (Fonagy, Gergely, & Jurist, 2002) from the Dad to his children's story and emotional state.

Dissonance is also created by parents not tolerating distress or being emotionally dismissive towards their children in sessions. One parent (Family Four) uses the phrase 'anyway 'repeatedly to start sentences, typically to redirect away from emotive material such as whether the son had financial difficulties at the time of his death. In Family One, Lucy the youngest daughter (age 3), although not actively engaged in creating the verbal narrative, is still present for the session and impacts on the story telling process. There are some really chaotic passages in the session where Lucy is clearly very distressed, but her tears are not acknowledged and she is not involved in the story telling. For example, at one point Alice (age 7) has to shout to make herself heard above Lucy's noise when clarifying with her

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Mum the actual date that Dad died. At another point Lucy asks *"Where my Daddy?" (Family 1/1 Line 64),* and her question is not answered or addressed by anyone, including the therapist. Mum's response to Lucy is anger and discipline rather than comfort or involvement in the story in an appropriate way, which perhaps demonstrates Mum's lack of ability to engage emotionally with her children at this time and to empathise with their distress in an appropriate way. Mum has to leave the session with Lucy and this adds to the incoherence as they are no longer present for a part of the story telling. Overall across the session there is a strong sense of emotional disconnection Mum and her children and there are no instances of Mum offering comfort to either child, nor offering sense making to them. Although there is evidence of Mum actively encouraging Alice to engage in the process, Mum is emotionally withdrawn and passive in response to both current distress and accounts of distress.

This theme of creating incoherence also describes actions taken by adults: the therapists, parents or sometimes parents and therapists together. In some stories, parents use exclusive adult language which leaves the child out of the story, for example, medical terminology that is not understandable by the child, such as specific names of drugs or treatments. Other instances of adult exclusivity are using phrases that create 'in-jokes' between parent and therapist. In Family Two, the Dad is talking about a cruise holiday the family took together before the death of his wife that had been recommended by his father-in-law. He says:

Dad: Sarah's father was (.) for want of a better phrase (.) a serial cruiser

Therapist 1: Ha-ha

(Family 2/1 Lines 273-274)

Although this may be understood as a harmless joke between adults, or even strengthening the therapeutic relationship, it has the possibility of disengaging the child from the process of story-telling as the language used is not understandable by them, nor co-created.

In two of the families' stories, the therapist is involved in the co-creation and maintenance of a disorganised narrative. This is primarily through the use of unclear language when talking about the dead body. In Family One, the level of incoherence in the first story is high, and at points the therapist is party to creating the incoherence. In this extract, Alice and her Mum are talking about what happened to the step-dad's body once he had died:

Mum: And that was before, no that was after Daddy had gone

Alice: yeh

Therapist: And where did Daddy go to?

Alice: hospital

Therapist: ah so the ambulance took him?

Alice: yeh

Therapist: ah ok

Mum: it was (.) it wasn't the ambulance that took him, was it?

Alice: what was did it?

Mum: it was the funeral people, wasn't it?

(Family 1/1 Lines 144-153)

The language used gives a sense of 'aliveness' to the Dad and we could easily believe they are referring to him going to hospital because he is unwell until the Mum mentions 'funeral people'. The therapist is pulled into this incoherence and instead of using a phrase such as 'Daddy's body', which would clearly indicate that he was dead, she continued to use language such as 'him' that perpetuates the incoherence and disbelief he is dead. This resembles Salvatore, Dimaggio and Semerari's (2004) findings regarding the impact of disorganised narratives on therapists: that they too experience feelings of confusion and chaos and at worst are pulled into behaviours that become anti-therapeutic.

The final way in which families created incoherence in their story telling was omissions in the second telling of the story, such as having different starting points (and therefore missing out significant events) or having significant details missing (such as the Grandma being in the house when the son died (Family Four)), or a notable reduction in the emotional richness and expressivity in the story. When significant details are missing, this creates distinct differences between the first and second telling which potentially foster incoherence.

Discussion

The aim of this study was to utilise the framework of Attachment Theory and specifically the unresolved loss codes of the AAI to explore how incoherence is expressed in bereaved family's therapy narratives. The findings suggest that the AAI 'U' coding can be productively used to analyse narratives of the death of a family member that are extracted from family bereavement therapy sessions and that use of these codes do pick up the narrative incoherence that would be, within attachment theory, expected within about a year of a family loss. The findings also suggest the value of inductive-deductive coding to show how incoherence is systemically created by family members and therapists in the process of telling the narrative.

The relevance of the findings for Attachment Theory. Previous research has also shown that unresolved loss codes can be identified in transcripts of an individual's clinical treatment sessions (Thomson, 2010), therefore the findings from this study add to the body of evidence demonstrating the value of AAI coding outside of the AAI interviewing process. This is important not only methodologically but also theoretically as it suggests that attachment theory describes processes that occur not just in the AAI interview and thus provides some evidence for these ideas.

The study findings are also relevant for attachment theory because they suggest that not only is incoherence demonstrated through individual narratives, but also, as can be seen from the analysis, incoherence is manifested in behaviour and seen interactionally between family members, providing evidence of the microprocesses involved in the co-creation of attachment in families. Baradon and Steele (2008) identify behaviours (as well as narrative) in infant-parent psychotherapy that they understand as demonstrating representational knowledge (i.e. IWMs) through "action and enactment" (p. 209) in therapy sessions. These include Frightening Behaviours (FR)/parental anomalous behaviours such as moving away from the infant without cause and dissociative 'blind moments'. The findings of the current study show parallel examples of incoherence enacted between family members such as: adults resisting giving further information or resistance to hearing or discussing certain parts of the story, adults reshaping the story or being emotionally dismissive. The behaviours that are demonstrated in these sessions can be likened to the FR behaviours (or parental anomalous behaviours) identified by Abrams, Rifkin and Hesse (2006) that are proposed to 'transmit' unresolved loss from parent to child. Some of the interactive patterns found in the families' narratives are also subtle, brief and unmonitored by the parents, such as the prolonged silences or unfinished sentences (parallels with the FR dissociative 'blind' moments). However, some are more overt, such as disagreement about the facts or leaving the room during the session (parallels with FR backing away from a child). Whether subtle or overt, these actions

all create further incoherence. Moreover, these are aspects of incoherence that could not be present in an individual narrative (such as the AAI) as they are interpersonal manifestations of incoherence. Using an attachment-informed analysis of therapy data has thus allowed these broader aspects of incoherence to be recognised and understood within the context of a family's bereavement narrative. The findings have implications for Attachment Theory as they suggest ways that those in attachment systems can collaboratively create incoherence and perpetuate lack of resolution by resisting the process of resolution.

Implications for therapeutic practice with bereaved families

The findings show the importance of both speech and behaviours within the therapy session to indicate lack of resolution of loss. The markers of incoherence found in the narratives can be 'red flags' to therapists that could 'cue' them to a lack of resolution and incoherence in the story and suggest the things to listen for, and where they are clustered, where they might need to focus work in terms of clarifying, adding detail, reflecting or sense making. This is similar to the idea of 'hot spots' in trauma work (Ehlers & Clark, 2000).

Additionally, the findings may directly influence practice through therapists using the markers to guide the choice of intervention. This study highlights the importance of the interactions between family members and this awareness can directly inform practice. For example, if one family member's perspective is regularly dismissed this will add to the formulation and understanding of the family's unhelpful dynamics and resistance to creating a more coherent family story.

Implications for therapeutic training

There are two more specific training suggestions that arise from this study. First, that therapists can be trained to listen for incoherence markers. There have been calls for including study of the "fine-grained moment-by-moment interactional processes" (Gross, 2014, p. 512) in therapeutic training

courses (Gross, 2014; Rey, 1994). Training therapists to focus on the subtleties of talk when training and practicing would lead to increased awareness of the importance of the way a story is told and of the micro-moments in sessions. We suggest that therapists can be trained to 'hear' the markers of incoherence in stories told by clients.

Second, the findings of this study give examples of the impact a therapist has on therapy, for example co-constructing disorganisation in the narrative. This shows the need for self-awareness and awareness of interpersonal dynamics in the therapy room to be developed through training as well as supervision and reflective practice.

Implications for Research practice

The methodology of this study offers a new way of conducting research on therapy data: inductive-deductive theory-informed TA provides an easy and accessible method of using 'live' therapy data and engaging in theory-informed process research, which is less complex and time-consuming than methodologies such as Conversational and Discourse Analysis (Foucault, 1984; Sacks, Schegloff, & Jefferson, 1974). Further, this methodology permits a unique combination of theory and analysis. TA is often (particularly outside of the US) associated with inductive non-theory informed research, so this project is unusual in that it is explicitly informed by Attachment Theory. The analytic process promotes both exploration of the data and the practical application of the theory to the data – in other words analysis that is both deductive and inductive, theory-driven, top-down and data-driven, bottom-up analysis of the data. As such, it clearly seeks to link theories (of change, that is, increasing/decreasing coherence) to actual practice in the room. While being flexible and exploratory, it also involves theoretical rigor and the systematic use of a six-phase process of analysis that helps ensure quality and rigour. This methodology thus opens up opportunities for researchers to use this method to examine how practice-relevant theory can be understood at the level of therapy microprocesses. For example

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possibilities include a person-centred (Rogers, 1959) theory-informed TA focusing on a therapist

evidences and a client experiences congruence, or perhaps a psychodynamic theory (Freud, 1912)

informed TA focusing on defences as they are demonstrated within session.

Limitations and suggestions for further research

There are limitations related to the methodology used in this study. Audio recordings of the

therapy sessions were used for this project, rather than video recordings, which limited the amount of

information and data available for transcription and coding. There were elements of behaviour that

could be picked up on the recordings, such as family members leaving the room, but some behavioural

aspect of sessions was not accessible. Although the AAI coding is based solely on verbal narrative, other

methods of measuring attachment status (e.g. the Strange Situation Test, Ainsworth & Wittig, 1969)

place importance on physical proximity and positioning (proximity seeking), as well as touch and giving

of comfort between parent and child. Using only audio recording, this study only captured a limited part

of this data, which perhaps could be partly overcome with a contemporaneous note-taking of such

interactions during the session or (if ethically appropriate) with a video record of the session. To address

these limitations, further research could include using video taping of therapy sessions, which would

allow for a wider analysis of the behavioural aspects that are important in Attachment Theory. Such

analysis could draw on the Child Attachment Interview (2003) developed by Target, Fonagy and Shmueli-

Goetz, which incorporates behavioural as well as linguistic markers of incoherence.

Conclusions

The study demonstrates the value of using Attachment Theory as a paradigm for understanding

bereavement narratives and the therapeutic encounter in family bereavement therapy. The study

highlights processes which occur in family bereavement work and contributes new understanding about

bereavement narrative processes, in particular how incoherence, a marker of attachment security, appears to manifest dialogically, and interactionally. This new understanding has direct application for practitioners and trainers and can guide further research and practice. The study also offers a new way of conducting research on therapy data that is accessible and offers future researchers ways of integrating theory into process therapy research.

Table 1: Examples of codes from the codebook

Codes taken directly from AAI	Codes created through inductive-deductive process
Indications of disbelief that the person is dead eg slip of the tongue to present tense (is/was)	Giggles/laughter/incongruous emotion when talking about the death/difficult event
Deceased and speaker living parallel lives in the present	Family member physically leaves the room or goes significantly off topic during distressing content
Being dead is an activity	Therapist co-constructing disorganised narrative eg using 'Daddy' instead of 'Daddy's body' after the death
Change of pronouns/attributing deceased actions to self	Disjuncture between child and adult memory of death
Timeline confusion – dates/events leading up to death/own age/when death occurred	Children left vague about details or with gaps in timeline

References:

Abrams, K. Y., Rifkin, A., & Hesse, E. (2006). Examining the role of parental frightened/frightening subtypes in predicting disorganized attachment within a brief observational procedure. *Development and Psychopathology*, *18*(2), 345-361.

Ahn, H. N., & Wampold, B. E. (2001). Where oh where are the specific ingredients? A meta-analysis of component studies in counseling and psychotherapy. *Journal of Counseling Psychology*, *48*(3), 251.

Ainsworth, M. D. S., & Eichberg, C. (1991). Effects on infant-mother attachment of mother's unresolved loss of an attachment figure, or other traumatic experience. *Attachment Across the Life Cycle*, *3*, 160-183.

Ainsworth, M. D. S. & Wittig, B. A. (1969). Attachment and exploratory behavior of 1-year-olds in a strange situation. In B. M. Foss (ed.), *Determinants of Infant Behavior, IV* (pp. 111–136). London: Methuen.

Akerman, R., & Statham, J. (2011). Childhood bereavement: A rapid literature review. London: Child Wellbeing Research Centre.

Baradon, T., & Steele, M. (2008). Integrating the AAI in the clinical process of psychoanalytic parent-infant psychotherapy in a case of relational trauma. In Steele, H., & Steele, M. (Eds.). (2008). *Clinical applications of the adult attachment interview*. (p. 195-212). New York: Guilford Press.

Benoit, D., & Parker, K. C. (1994). Stability and transmission of attachment across three generations. *Child Development*, *65*(5), 1444-1456.

Berger, I. (2011). Support and evidence for considering local contingencies in studying and transcribing silence in conversation. *Pragmatics*, *21*(3), 291-306.

Bishop, S., Stedmon, J., & Dallos, R. (2015). Mothers' narratives about having a child with cancer: A view through the attachment lens. *Clinical Child Psychology and Psychiatry*, *20*(4), 611-625.

Bonanno, G. A., & Kaltman, S. (2001). The varieties of grief experience. *Clinical psychology review*, *21*(5), 705-734.

Bowlby, J. (1980). Attachment and loss: Volume 3. Loss. *New York: Basic*.

Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. Thousand Oaks, CA: Sage.

British Psychological Society, D. o. C. P. (2005*). Guidelines for Professional Practice in Counselling Psychology*. Retrieved from: http://www.bps.org.uk/sites/default/files/documents/professional_practice_guidelines_-division_of_counselling_psychology.pdf

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101.

Braun, V., & Clarke, V. (2013) *Successful qualitative research: A practical guide for beginners.* London: Sage.

Currier, J. M., Holland, J. M., & Neimeyer, R. A. (2007). The effectiveness of bereavement interventions with children: A meta-analytic review of controlled outcome research. *Journal of Clinical Child and Adolescent Psychology, 36*, 253–259.

Davis, C. G., Harasymchuk, C., & Wohl, M. J. (2012). Finding meaning in a traumatic loss: A families

approach. *Journal of traumatic stress*, *25*(2), 142-149.

Dimaggio, G., & Semerari, A. (2004). Disorganized narratives: The psychological condition and its treatment. In Angus, L. E., & McLeod, J. (2004). *The handbook of narrative and psychotherapy: Practice, theory and research*. (p.263-282) Thousand Oaks. CA: Sage.

Dowdney, L. (2000). Annotation: Childhood bereavement following parental death. *Journal of Child Psychology and Psychiatry*, *41*(07), 819-830.

Ehlers, A., & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour research and therapy*, *38*(4), 319-345.

Fauth, B., Thompson, M. & Penny, A. (2009) *Associations between childhood bereavement and children's background, experiences and outcomes. Secondary analysis of the 2004 Mental Health of Children and Young People in Great Britain data.* London: NCB

Figley, C. R., & Kiser, L. J. (2013). *Helping traumatized families*. New York: Routledge.

Finlay, L (2014) Qualitative Methodologies in Vossler, A., & Moller, N. (Eds.). (2014). *The Counselling and Psychotherapy Research Handbook*. (p. 164-183) London: SAGE.

Fonagy, P., Gergely, G., & Jurist, E. L. (Eds.). (2002). *Affect regulation, mentalization and the development of the self*. New York, US: Karnac Books

Fonagy, P., Steele, M., Steele, H., Moran, G. S., & Higgitt, A. C. (1991). The capacity for understanding mental states: The reflective self in parent and child and its significance for security of attachment. *Infant mental health journal*, *12*(3), 201-218

Fonagy, P., Steele, M., Moran, G., Steele, H., & Higgitt, A. (1993). Measuring the ghost in the nursery: An empirical study of the relation between parents' mental representations of childhood experiences and their infants' security of attachment. *Journal of the American Psychoanalytic Association*, *41*(4), 957-989.

Foucault, M. (1984). *The Foucault reader*. Rabinow, P. (Ed.) London: Pantheon.

Freud, S., (1917). *Mourning and Melancholia*. In: Strachey, J., (Ed. & Trans). The Standard Edition of the Complete Psychological Works of Sigmund Freud. Vol. 14 1917. Reprint, London: Hogarth Press; 1957

George, C., Kaplan, N., & Main, M. (1985). Adult Attachment interview protocol (2nd ed.) *Unpublished manuscript, University of California, Berkeley*.

Gilbert, K. R. (2002). Taking a narrative approach to grief research: Finding meaning in stories. *Death studies*, *26*(3), 223-239.

Gross, C. (2014). Couple narratives and adult attachment using conversation analysis in assessment. *British Journal of Psychotherapy,* 30 (4), 499- 516.

Henton, I. (2012). Practice-based research and counselling psychology: A critical review and proposal. *Counselling Psychology Review*, *27*(3), 11-28.

Hooghe, A., De Mol, J., Baetens, I., & Zech, E. (2013). The measurement of couple and family interactions and relationship quality in bereavement research. *Family Science*, *4*(1), 66-78.

Howarth, R. A. (2011). Promoting the adjustment of parentally bereaved children. *Journal of Mental Health Counseling*, *33*(1), 21-32.

Hughes, J., Hardy, G., & Kendrick, D. (2000). Assessing adult attachment status with clinically-orientated interviews: A brief report. *British Journal of Medical Psychology*, *73*(2), 279-283.

Jefferson, G. (1988) Notes on a possible metric which provides for a 'standard maximum' silence of approximately one second in conversation. In D. Roger and P. Bull (eds.), *Conversation: An*

interdisciplinary perspective. (p. 167-196.) Clevedon, UK: Multilingual Matters

Kiser, L. J., Baumgardner, B., & Dorado, J. (2010). Who are we, but for the stories we tell: Family stories and healing. *Psychological Trauma: Theory, Research, Practice, and Policy*, *2*(3), 243.

Lampton, C. C., & Cremeans, K. J. (2002). Recent advances in the understanding of childhood grief and mourning*. Marriage and Family, (5)* 467-476.

Larson, D. G., & Hoyt, W. T. (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.

Lyons-Ruth, K., Yellin, C., Melnick, S., & Atwood, G. (2005). Expanding the concept of unresolved mental states: Hostile/helpless states of mind on the Adult Attachment Interview are associated with disrupted mother–infant communication and infant disorganization. *Development and psychopathology*, *17*(01), 1-23.

Lysaker, P. H., Carcione, A., Dimaggio, G., Johannesen, J. K., Nicolò, G., Procacci, M., & Semerari, A. (2005). Metacognition amidst narratives of self and illness in schizophrenia: associations with neurocognition, symptoms, insight and quality of life. *Acta Psychiatrica Scandinavica*, *112*(1), 64-71.

Main, M., & Goldwyn, R. (1984a) *Adult attachment scoring and classification system.* Unpublished manuscript, University of California at Berkeley.

Main, M., Goldwyn, R., & Hesse, E. (2003). The adult attachment interview: Scoring and classification system, version 7.2. *Unpublished manuscript, University of California at Berkeley*.

Main, M. and Hesse, E. D. (1990). Parents' unresolved traumatic experiences are related to infant Disorganized attachment status: Is frightened and/or frightening parental behavior the linking mechanism? In M. Greenberg, D. Cichetti, and M. Cummings, (Eds), *Attachment in the Preschool Years*.(p161-182) Chicago: Chicago University Press.

Main, M., Kaplan, N., & Cassidy, J. (1985). Security in infancy, childhood, and adulthood: A move to the level of representation. In I. Bretherton & E.Waters (Eds.), Growing points of attachment theory and research. *Monographs of the Society for Research in Child Development* (p. 66-107) 50 (1-2, Serial No. 203).

Mallinckrodt, B. (2011). Addressing the decline in counseling and supervision process and outcome research in the Journal of Counseling Psychology. *The Counseling Psychologist*, *39*(5), 701-714.

Marvin, R. S., & Pianta, R. C. (1996). Mothers' reactions to their child's diagnosis: Relations with security of attachment. *Journal of Clinical Child Psychology*, *25*(4), 436-445.

McClatchey, I. S., Vonk, M. E., Lee, J., & Bride, B. (2014). Traumatic and complicated grief among children: One or two constructs?. *Death studies*, *38*(2), 69-78.

Meert, K. L., Shear, K., Newth, C. J., Harrison, R., Berger, J., Zimmerman, J., & Willson, D. F. (2011). Follow-up study of complicated grief among parents eighteen months after a child's death in the pediatric intensive care unit. *Journal of palliative medicine*, *14*(2), 207-214.

Melhem, N., Brent, D., Ziegler, M., Iyengar, S., Kolko, D., Oquendo, M., & Mann, J. (2007). Familial pathways to early-onset suicidal behavior: familial and individual antecedents of suicidal behavior. *American Journal of Psychiatry*, *164*(9), 1364-1370.

Melhem, N., Brent, D., Ziegler, M., Iyengar, S., Kolko, D., Oquendo, M., & Mann, J. (2007). Familial pathways to early-onset suicidal behavior: familial and individual antecedents of suicidal behavior. *American Journal of Psychiatry*, *164*(9), 1364-1370.

Midgley, N. (2004). Sailing between Scylla and Charybdis 1: Incorporating qualitative approaches into

child psychotherapy research. *Journal of Child Psychotherapy*, *30*(1), 89-111.

Moreira, P., Beutler, L. E., & Gonçalves, Ó. F. (2008). Narrative change in psychotherapy: differences between good and bad outcome cases in cognitive, narrative, and prescriptive therapies. *Journal of clinical psychology*, *64*(10), 1181-1194.

Muscetta, S., Dazzi, N., Decoro, A., Ortu, F., & Speranza, A. M. (1999). "States of mind with respect to attachment" and change in a psychotherapeutic relationship: A study of the coherence of transcript in a short-term psychotherapy with an adolescent. *Psychoanalytic Inquiry*, *19*(5), 885-921.

Neimeyer, R. A., Holland, J. M., & Currier, J. M. (2008). *Meaning reconstruction in later life: Toward a cognitive-constructivist approach to grief therapy.* In D. Gallagher-Thompson, A. Steffan, & L. Thompson (Eds.), Handbook of behavioral and cognitive therapies with older adults (pp. 264–277). New York: Springer and Verlag.

Neimeyer, R. A., & Currier, J. M. (2009). Grief therapy evidence of efficacy and emerging directions. *Current Directions in Psychological Science*, *18*(6), 352-356.

Office of National Statistics Death Registrations by Single Year of Age - United Kingdom, 2011 http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-240174

Parkinson, B., & Totterdell, P. (1999). Classifying affect-regulation strategies. *Cognition & Emotion*, *13*(3), 277-303.

Raval, V., Goldberg, S., Atkinson, L., Benoit, D., Myhal, N., Poulton, L., & Zwiers, M. (2001). Maternal attachment, maternal responsiveness and infant attachment. *Infant Behavior and Development*, *24*(3), 281-304.

Rey, H. (1994) *Universals of Psychoanalysis in the Treatment of Psychotic and Borderline States*. London: Free Association Books.

Ribbens Mccarthy, J. (2007). 'They all look as if they're coping, but I'm not': The Relational Power/lessness of 'Youth' in Responding to Experiences of Bereavement. *Journal of Youth Studies*, *10*(3), 285-303.

Rogers, C. R. (1959). A theory of therapy, personality, and interpersonal relationships, as developed in the client-centered framework. In S. Koch (Ed.), *Psychology: A Study of a Science: Vol. 3* (pp. 184-256). New York, NY: McGraw-Hill.

Sacks, H., Schegloff, E. A., & Jefferson, G. (1974). A simplest systematics for the organization of turn-taking for conversation. *Language*, 696-735.

Salvatore, G., Conti, L., Fiore, D., Carcione, A., Dimaggio, G., & Semerari, A. (2006). Disorganized narratives: Problems in treatment and therapist intervention hierarchy. *Journal of Constructivist Psychology*, *19*(2), 191-207.

Salvatore, G., Dimaggio, G., & Semerari, A. (2004). A model of narrative development: Implications for understanding psychopathology and guiding therapy. *Psychology and Psychotherapy: Theory, Research and Practice*, *77*(2), 231-254.

Scheel, M. J., Berman, M., Friedlander, M. L., Conoley, C. W., Duan, C., & Whiston, S. C. (2011). Counseling-related research in counseling psychology: Creating bricks, not edifices. *The Counseling Psychologist*, *39*(5), 719-734.

Singer, J. A., & Rexhaj, B. (2006). Narrative coherence and psychotherapy: A commentary. *Journal of Constructivist Psychology*, *19*(2), 209-217.

Steele, H., Steele, M., & Fonagy, P. (1996). Associations among attachment classifications of mothers,

fathers, and their infants. *Child Development*, *67*(2), 541-555.

Stroebe, M. S. (2010). Bereavement in family context: Coping with the loss of a loved one 1. *Family Science*, *1*(3-4), 144-151.

Target, M., Fonagy, P., & Shmueli-Goetz, Y. (2003). Attachment representations in school-age children: the development of the child attachment interview (CAI). *Journal of child psychotherapy*, *29*(2), 171-186.

Thomson, P. (2010). Loss and disorganization from an attachment perspective. *Death studies*, *34*(10), 893-914.

Van IJzendoorn, M. (1995). Adult attachment representations, parental responsiveness, and infant attachment: a meta-analysis on the predictive validity of the Adult Attachment Interview. *Psychological bulletin*, *117*(3), 387.

Worden, J. W. (1996). *Children and grief: When a parent dies*. London: Guilford Press.

ABSTRACT

Attachment theory predicts that family bereavement leads even securely attached individuals to experience temporary attachment insecurity. Attachment in/security is displayed through the way narratives are constructed, and the Adult Attachment Interview posits particular indices of 'narrative incoherence' for narratives related to experiences of bereavement. This thesis explores bereaved families' therapy narratives to see if they display signs of narrative incoherence or evidence of lack of resolution as predicted by attachment theory. The thesis also examines whether there is evidence of shifts and changes changes in the stories over time that could be understood as reflecting a move towards greater coherence. Families are dynamic systems and the stories told in family therapy are co-creations between family members and the therapists: the impact of the actions of family members and therapists on narrative coherence are also analysed. Five bereaved families' narratives were recorded during the therapy intervention 'Telling the Story', at the beginning and towards the end of their family bereavement therapy. An Attachment Theory informed Thematic Analysis was carried out on the transcripts and identified four themes: Evidence of Unresolved Loss, Creating Incoherence, Creating Coherence and Evidence of Coherence. Results show that there is, as predicted by the Adult Attachment Interview, evidence of narrative incoherence, and additionally there are behavioural and systemic features that create further incoherence in the narratives. The results also show how coherence can be created and what features a more coherent family story includes. The findings have implications for bereavement therapy interventions, therapist training and methodological development. Limitations and suggestions for further research are also discussed.

INTRODUCTION

I will start by providing a brief introduction to my research and overviewing the material discussed in the literature review that follows. The empirical work in this thesis is focussed on an intervention utilised in grief therapy for families who have experienced the death of a family member (parent or sibling). The intervention aims to encourage the families to together tell a 'coherent' story of the death and facilitates them doing so by inviting them to tell and re-tell the story of the death at different points in their therapy; the assumption is that achievement of a coherent family narrative of the loss is therapeutically beneficial for the family. This therapeutic intervention is justified by ideas from two theoretical domains: Attachment Theory and theories around complex grief. Yet while the theoretical justification for this way of working with bereaved families is strong, there is as yet no empirical evidence for this particular intervention (though there is some broad support as will be discussed). This thesis thus set out to provide a detailed examination of the narratives of loss from five families at the beginning and towards the end of therapy in order to examine whether theoretical assumptions about grief and mourning appear to explain both how the stories are told and the nature of any changes in the narratives across therapy. In doing so, the thesis provided support for ideas within both Attachment Theory and theories of complex grief, and provided preliminary support for the value of the therapeutic intervention under study.

Research suggests that that the death of a family member has a significant impact on both children and adults: negative effects on physical and mental health; poorer educational and employment prospects; financial disadvantages; and secondary relational loss (Akerman & Statham, 2011; Dowdney, 2000; Worden, 1996). This long-lasting impact of loss provides a strong argument for searching for effective interventions for bereaved families. Both the long-lasting impact of family bereavement and the intervention studied in this research can be more fully understood in the context of Attachment Theory.

Bowlby's Attachment Theory (1980) posited an evolutionary motivation for an infant to establish an attachment to significant caretakers. However, Bowlby argued that attachment functions from "cradle to grave" (p.129) and maintaining access to an attachment figure continues to be the set goal of the attachment system from infancy through adulthood (Bowlby, 1969, 1973, 1979, 1980). Bowlby was concerned not only with the formation and maintenance of attachment bonds but also what happens

when they are lost – some of his earliest work was with World War Two war widows (Holmes, 1993). Bowlby's theories of adult and child responses to loss rest on his model of relational cognition; he used the term 'Internal working models' (IWM) to describe this internal representational world (Bowlby, 1969). Bowlby's attachment theory suggests that when people experience the loss of someone who has been an attachment figure, their IWM needs to be reorganised to recognise or accommodate the change in relationship; the assumption is that if the IWM is not appropriately updated a person will struggle to recover from the loss (Bowlby, 1980).

In order to test and explore the existence of relational templates in adults, George, Kaplan and Main (1985) developed the Adult Attachment Interview (AAI). Interviewees are asked about their relationships with their parents, as a way of assessing these IWMs and understanding how an individual organises themselves in context of relationships. In research utilising the AAI, individuals are given attachment security codes (to denote that they are securely or various types of insecurely attached) according to how they answer questions in the AAI. A key theoretical assumption is that insecure attachment status is associated with 'incoherent' narratives (further defined below); in addition, AAI theory also posits particular indices of 'narrative incoherence' for the narratives related to experiences of bereavement.

It is important to note that Bowlby assumed that individuals who had experienced loss would be 'unresolved' with respect to that loss for some period after it occurred; he did however think that over time loss should be 'resolved' or the attachment system of the individual should return to equilibrium. Bowlby was also convinced that the response of the 'adult world' to a child's distress had a decisive influence on children's ability to achieve resolution following death of a family member (Holmes, 1993).

Empirical evidence for the theoretically-predicted impact of attachment security/insecurity (and narrative incoherence) is strong. Research has evidenced cross-generational effects, with attachment of mothers to their own parents consistently predicting the attachment security of their infants (Ainsworth & Wittig, 1969, van IJzendoorn, 1995), and even with this impact extending across three generations (Benoit & Parker, 1994). With respect to the category of insecurity related to unresolved bereavement or trauma, 53% of mothers with unresolved states of mind (U) have infants classified as the type of attachment insecurity termed 'disorganised' or 'D' (van IJzendoorn, 1995). This is important because a 'D' attachment style has significant predictive power for troubled mental health and relational difficulties

both in childhood and further into adulthood (Adam, Sheldon-Keller, & West, 1996; Allen, Hauser, & Borman-Spurrell, 1996). In other words, there is empirical evidence of the generational impact of unresolved loss, both to second and third generations (Beniot & Parker, 1994; Steele, Steele, & Fonagy, 1996). Furthermore, research shows that this 'U' state does not appear to change over time, suggesting intervention may be required (Hughes, Turton, McGauley & Fonagy, 2006).

Attachment Theory provides one theoretical framework for this project; another is theories around 'complex,' or 'chronic' grief. Both frameworks are utilised because it has been suggested that 'unresolved' loss as understood by the AAI has overlap with the symptoms of 'chronic grief' (Neimeyer, Holland, & Currier, 2008; Stroebe, Schut & van den Bout, 2013). Research into chronic grief has documented its deleterious impacts and sought effective interventions. To date, research into interventions and treatment for chronic grief for children and adults has focussed mainly on relief of 'pathological and behavioural symptoms' rather than looking at changes in the narrative around the death (Currier, Holland & Neimeyer, 2007). This is beginning to change however as narrative coherence becomes better understood as a positive outcome of therapy, which is suggestive of resolution of loss (Singer & Rexhaj, 2006). The recognition that how someone talks about a death might be a therapeutically important indicator in the context of grief therapy has clear echoes of the assumptions in the AAI that narrative incoherence in the context of talk about a death is similarly a sign of the extent to which a loss has been 'resolved'.

Thus, in this study, analysis of the narratives of bereaved families will be informed by the 'unresolved' loss codes from the AAI. Analysis of the therapy transcripts of family sessions (from Winston's Wish) will allow three questions to be examined:

1. Do family narratives at the beginning of therapy show signs of narrative incoherence/lack of resolution as predicted by Attachment Theory?

2. Is there evidence of shifts and changes in the stories over time that could be understood as reflecting a move towards greater coherence?

3. What actions by family members or therapists create coherence or incoherence?

LITERATURE REVIEW

In this literature review I will start by examining the research concerning the impact of bereavement on children and families, exploring how grief theory has developed, and reviewing the types of grief therapy available. I will then go onto discuss the theoretical understanding of loss and grief proposed by John Bowlby in Attachment Theory and how this has been drawn on and developed by later researchers leading to the development of the Adult Attachment Interview. I will then focus on the Unresolved Loss codes from the AAI and discuss generational patterns and impact of unresolved loss on infants and children. Finally, I will review the literature around the therapeutic value of narratives in bereavement work and the theoretical justification for a story-of-death intervention in grief therapy. I will conclude by discussing and justifying the methodological approach used in this study: theory-driven thematic analysis.

Impact of bereavement on adults and children and types of grief

Bereavement and loss is a near universal human event. The word 'grief' is used to connote the emotional, physiological, cognitive, and behavioural reactions of a person to the death of someone significant (Stroebe, 2002). Grief is often viewed as an individual experience, and less commonly understood as a family process, in which each family member's grief processes interrelate and impact on each other (Shapiro, 1994; Stroebe, 2010). The family experience of grief is important because the experience of a child losing a parent or sibling is more common than is often assumed. Twenty-four thousand children under the age of 16 experience the death of a parent each year in Britain (Office of National Statistics, 2011), which means 3.8% of children in the UK experience such bereavement by the time they are 16 (Fauth, Thompson & Penny, 2009). This is nearly 1 in 25 children; or at least one child in every classroom in the UK. If one considers also the impact of sibling death (and this study includes both parental and child death) the number is likely even higher. The experience of how families understand and tell the story of their loss is thus an important focus for research.

Research suggests that there are detrimental effects of a bereavement on children's acute and medium-term adjustment including heightened feelings of fear and dysphoria (Weller, Weller, Fristad & Bowes, 1991), somatic complaints (Kalter et al., 2002), difficulties with learning and concentrating in school (Worden, 1996), and an inability to maintain healthy levels of self-esteem or a sense of connectedness to

their remaining social network (Silverman & Worden, 1992). One in five children who lose a parent are likely to be diagnosed with a psychiatric disorder in childhood, and longer term impacts on employment, obtaining qualifications, depression levels and likelihood of smoking have been evidenced (Dowdney, 2000; Akerman & Statham, 2011). The loss of a sibling is thought to result in rates of problems equivalent to the loss of a parent (Worden, 1999). Parents who have experienced the death of a child have also been found to suffer varied negative mental and physical health sequelae, as well as secondary losses such as financial, job and relational losses. The deterioration of the marital relationship may be among these negative outcomes (Oliver, 1999; Rogers, Floyd, Seltzer, Greenberg & Hong, 2008). Therefore, the experience of the death of a family member can be seen to effect both adults and children in a number of ways.

The long-term and serious potential consequences of a family bereavement for, in particular, children, are in contrast with what research suggests is the outcome of other types of loss; these more typical grief reactions have sometimes been termed in the literature 'normal grief' (Penman, Breen, Hewitt & Prigerson, 2014). Grief has been understood as a 'normal' affective response to the loss of a loved person which, if it follows the 'normal' course, does not require therapeutic intervention (Stroebe & Stroebe, 1987). Research suggests that bereaved individuals typically experience a gradual decrease in grief symptoms and eventually reinvest in relationships and activities (Lichtenthal, Cruess, & Prigerson, 2004). Bonnano and Kaltmann's (2001) review of the bereavement literature reported that between 50-85% of bereaved adults exhibit a 'common grief pattern,' with most bereaved individuals returned to normal (baseline) levels of functioning by the end of the first year. However, a relatively small subset of approximately 15% of bereaved individuals tended to show serious disruptions to functioning beyond the 1-2 year point thereby suggesting some form of 'chronic grief'. More recent research shows that 'complicated grief' has a prevalence of approximately 10 to 20% after the death of a romantic partner and an even higher incidence among parents who have lost children (Meert et al., 2011).

Although the majority of the research on complex grief focusses on adults, there is research evidence showing that children and adolescents can also experience a form of 'chronic grief'. Despite the fact that most bereaved children will show resilience in adjusting to loss, a sizable contingent (between 15%–20%) is still expected to display significant emotional and behaviour difficulties at 2 years post-loss (Worden, 1996). 'Prolonged grief disorder', traumatic grief and complicated grief has been evidenced among

parentally bereaved children aged 7 to 18 (Melhem et al., 2007; McClatchey, Vonk, Lee & Bride, 2014). Taken together the research on complex and chronic grief suggests that for both children and adults loss within the family is associated with chronic or complex grief reactions; potentially these grief reactions may partly explain the serious potential outcomes of family loss outlined above.

There have been different labels and definitions for this 'chronic grief' reaction throughout the bereavement literature, such as delayed grief (Parkes, 1965), inhibited grief (Parkes, 1965), traumatic grief, (Jacobs, 1999), distorted grief (Belitsky & Jacobs, 1986), complicated grief (Shear, Frank, Houck, & Reynolds, 2005), and prolonged grief disorder (Prigerson et al., 2009). The debate continues as to whether these are distinct and separate types of grief or interchangeable terms for similar patterns of adaptation and symptomology (McClatchey, Vonk, Lee, & Bride 2014). However, these terms all have in common a reference to a pattern of adaptation to bereavement that involves the presentation of certain grief-related symptoms at a time beyond that which is considered adaptive, describing a context in which the acute grief symptoms have become more developed and prolonged. These symptoms include preoccupation with thoughts about the dead person, a sense of purposelessness about the future, numbness, bitterness, difficulties accepting the loss, and difficulty moving on with life without the dead person (Prigerson et al., 2009; Shear, 2011).

It is important to note that theoretical understandings of grief are debated and that different perspectives exist. Shifting understandings of grief reaction (including the idea that there are 'normal' and 'abnormal' grief reactions) reflect shifting understandings about human responses to loss both within the discipline of psychology and in the wider socio-cultural context. One important current context is the recent increasing medicalisation of grief with 'Complicated Grief' now included in the DSM-V (APA, 2013). Although not included as a diagnosable disorder, the newest edition refers to Persistent Complex Bereavement Disorder under the Disorders for Further Study section of the manual. The diagnostic criteria are applicable to adults 12 months after the death, and to children 6 months after the death. The possible pathologising of a common human process is controversial, potentially leading to "unnecessary treatment, stigmatisation, and other negative discriminatory effects" (First, 2011, p.9). The DMS-V has also removed the bereavement exclusion on the diagnostic criteria of a Major Depressive Episode. Previously, the aim of the bereavement exclusion was to identify and avoid misdiagnosis of individuals who are experiencing normal grief reactions to a loved one's death, but now there is no time

exclusion.

Critics of the medical model argue that there is no such a thing as 'essential grief' (Rosenblatt, 2000, p.11) and that by defining it with diagnostic criteria, we are 'self-defeating' as we limit our understanding of this complex experience (Rosenblatt, 2000). Others take a more moderate view, emphasising the continuum on which both normal and 'pathological' grief lie by characterising the latter as an intensification or prolongation of the norm (Holland, Neimeyer, Boelen, & Prigerson, 2009; Horowitz, Bonnano, & Holen, 1993). They suggest there is a continuum from those who need basic support or information after a loss, to those who need more formal or in-depth therapeutic work where there are issues of complex grief presentations (Mallon, 2008). For the purposes of the current study, the position taken is that – a position that could be viewed as a a more 'moderate' perspective - there may be those who need – or want – therapeutic help in the context of a family loss. It should be noted that one reason for this position is the acknowledgement that the loss of key attachment figures (e.g. for a child a parent, or for a parent a child) may be particularly difficult to 'resolve'.

Research on experience of family bereavement suggests that both children and adults may be vulnerable to complex grief reactions as well as a range of broader negative impacts. However, it has only recently become clearer about what predicts which people and families navigate grief without complication. In 2006, Stroebe, Folkman, Hansson and Schut published the 'Integrative risk factor framework for the prediction of bereavement outcome', which lays out different factors that may increase the likelihood of bereaved adults developing more complex grief reactions such as physical and mental health problems that may persist long after the loss has occurred. Burke and Neimeyer's (2012) systematic review of the risk factors for complicated grief has highlighted that there is strong support for the following risk factors in prolonged grief in adults: being female, being a spouse or parent of the deceased, low social support, violent death, younger or older age of the deceased, sudden death, avoidant coping styles, low income, and low levels of education (Burke & Neimeyer, 2012). Since Stroebe et al.,'s (2006) framework was published, researchers have been exploring these factors and looking at more specific types of bereavement (e.g. parental/spousal/child death) in an effort to understand what may lead to negative outcomes. For example, Harper, O'Connor and O'Carroll (2014) found that parents who had experienced the death of a child displayed more avoidant coping strategies and low levels of cognitive restructuring (less ability to find meaning) and this was correlated with prolonged grief.

Although risk factors associated with the death are less well understood among children than adults (Dyregrov & Dyregrov, 2013), several factors that may complicate a child's reactions following a loss have been identified. For example, the extent to which the death leads to significant changes in the child's daily environment such as changing school or moving house increases risk (Coffino, 2009); as do poor quality parenting and lack of support at home (Leucken, 2008; Tremblay & Israel, 1998). Likewise, the emotional reaction of the caregiver and the degree of sadness in the home (Brown et al., 2008), trauma related to witnessing the death, finding the body or having fantasies about what happened can lead to complicated grief reactions in children (Dyregrov & Dryregrov, 2005). Intensified grief reactions may also result when facts are not communicated, information is kept from the child or the emotional climate is restricted or parents are unresponsive to their child's needs (Lin, Sandler, Ayers, Wolchik & Leucken, 2004). These family dynamics may be understood in a systemic framework as a family having an 'open' or 'closed' emotional style with the patterns of relationships within the family affecting the child's experience of grief (Dallos & Vetere, 2009). Dyregrov and Dyregrov (2013) describe families with poor informational climates as an 'understudied area' (p. 73) and have suggested it would be 'fruitful to enhance the focus on these dynamics because children with such living conditions become especially vulnerable' (p.73).

In summary, research currently suggests that there are risk factors over and above _who_ is lost that can lead to more complicated and prolonged grief both in adults and children and that the context within which the child or adult grieves may also impact on the grief process. In particular, the research base has identified avoidant coping in bereaved parents as important for parents and the communication styles in the bereaved family and communication around the death in particular as potentially important in predicting outcomes for children. The aim of this research project is to add to this literature through a direct focus on active family communication about the family death (the story of loss); the aim in doing so it to increase understanding as to what may help families move towards recovery and avoid complications in their grieving.

Having outlined the impact of family loss on children and adults in bereaved families, and outlined the understandings of grief being drawn on in this study, I now go on to examine the field of grief therapy, as the data for this study is drawn from a family grief therapy intervention.

Grief Therapy
Part 1: Broad Background to Grief Therapy

As noted above, grief theory suggests that many achieve resolution of bereavement without intervention, but the evidence of complex grief reactions in both adults and children suggests the need for interventions for some bereaved individuals and families. I shall now discuss a brief history of grief therapy, and the rationale for narrative interventions and evidence for 'treatments' that have been found to be effective with individuals, children and adolescents and families.

Practitioners have been offering counselling and psychotherapy to those who are mourning since Freud coined the phrase 'grief work' in *Mourning and Melancholia* (Freud 1917/1957) and spawned the notion of the 'talking therapy', which essentially argues that talking about loss is beneficial to bereavement resolution (Walter, 1994). Lindemann's (1944) paper on 'Symptomatology and management of acute grief' documented a pattern of acute grief-related symptomology and began the process of being able to distinguish between 'normal' and 'pathological' grief reactions (Leick & Davidsen-Neilsen, 1991). Lindemann (1944) was the first to suggest that the bereaved could be routinely assisted in resolving difficulties through 'grief work' with a professional. Lindeman believed that the "uncomplicated and undistorted grief" (1944, p. 192) could be resolved within 4 to 6 weeks, but the more complex grief would take longer to resolve.

Further theories of grief developed over time, each with accompanying suggestions as to how grief is best resolved, providing therapists with specific tools for guiding the therapeutic process (Doughty & Hoskins, 2011). These theories took the form of phase and stage models, and included those presented by Kubler-Ross (1969), Bowlby (1980) (which I will discuss in further detail below), Rando (1984), and others (Sanders, 1989; Worden, 1991). In the 1990s, new research introduced the idea of narratives being of importance in bereavement. A biographical perspective on grief was proposed in 1996 by a British sociologist Tony Walter that "challenged the dominant model of grief in contemporary bereavement literature" (Stroebe, 1997, p.255). His paper, 'A new model of grief: Bereavement and biography' stated that, "The purpose of grief is the construction of a durable biography that enables the living to integrate the memory of the dead into their ongoing lives" (p.7). This purpose was accomplished through "conversation with other survivors" (p.7). His 'novel perspective' (Stroebe, 1997, p.261)

challenged the traditional ideas of purpose and process of grief, and was important in the beginning of successive developments in theory and practice that led to changes in therapeutic interventions. A move away from the rigid phase/stage models had begun, with the, "emphasis turning towards the concept of co-facilitation of a process, with the client's perspective taking the lead" (Humphrey & Zimpher, 2007, p.5).

Another important part of the move towards more process-focussed and client-led treatment, which acknowledged the importance of the loss narrative, was the development of the Dual Process Model (DPM) by Stroebe and Schut (1999). The DPM considers other processes in addition to the earlier grief work hypothesis. DPM proposes that the bereaved individual oscillates between two processes focussed on different issues: loss-oriented issues (grief work – expressing grief and reconnecting with the memory of the loved one, including restructuring the relationship with the deceased in an adaptive way) (Continuing bonds theory, Klass, Silverman, & Nickman, 1996), and restoration-oriented experiences (attending to life changes – re-engaging relationships/work and new life roles). Complicated Grief Treatment (CTG) is based on this model and includes a component focussed on the story of the death told by the bereaved (Shear, Frank, Houck, & Reynolds, 2005). The rationale for including a piece of narrative work is that revisiting the story of the death is essential in overcoming avoidance (known to be detrimental to recovery) and engaging with the implications and consequences of the death. This is understood as part of the loss-oriented processes (Shear, 2010).

A further development in the focus on narrative in bereavement theory was Neimeyer's (2000) theory that meaning reconstruction is a core process in grief resolution. Drawing on constructivist theory, Neimeyer proposed that bereaved individuals search for personal narratives in order to make sense of their changed realities. He states that significant loss presents a challenge to a person's sense of narrative coherence as well as to their sense of identity (Neimeyer, 2000). Therefore, bereaved individuals need to be able to create new narratives that meaningfully integrate the loss into the story of their lives as well as preserving narrative coherence. Neimeyer puts forward several interventions for those engaged in grief therapy from a 'Constructionist' perspective, including 'Narrative Retelling'. He proposed that retelling the story of the death under conditions of safety, and focussing on the hardest parts of the experience and "staying with them" (p.76) until the associated images and meanings can be held with less anguish, are "pivotal" (p.76) factors in working with grief and promoting meaning making

and coherence (Neimeyer, Burke, Mackay & van Dyke Stringer, 2010). This theoretical perspective echoes with previous findings that narratives help individuals make sense of their experiences, and this is particularly true for people trying to make sense of difficult or traumatic experiences (Koenig Kellas, & Trees, 2006).

Increasingly, narrative clarity and coherence have been seen as important outcomes of not only grief therapy, but therapy in general (Singer & Rexhaj, 2006) and correlated with increased reports of psychological adjustment, wellbeing and positive therapy outcomes (Gilbert, 2002; Lysaker et al., 2005; Moreira, Beutler, & Goncalves, 2008). There has been a historical tradition in grief therapy of using narratives, and an accepted wisdom that talking about the bereavement has been found to be helpful, providing relief (Bosticco & Thompson, 2005; Valentine, 2008). However, these more recent theoretical developments give a stronger rationale for this specific intervention. This is important for the current study because it focuses on analysing a therapeutic intervention that involves families doing exactly that.

Historically, research has shown that helping a bereaved child construct a coherent story of the death is valuable (Lichter, Mooney & Boyd, 1993; McIntyre & Hogwood, 2006) and Stokes (2009) states that one of the ten priorities for bereavement practitioners is to: "Enable a child to construct a coherent narrative (story) that they can tell with emotional integrity throughout their lives as this has been shown to help children in their bereavement process" (p.14). So it can be seen that there are theoretical premises for the importance of working with the narratives of bereaved clients, both individual adults and children. I shall now go on to discuss the efficacy of grief 'treatments', examining what elements of grief therapy research suggests are more helpful than others.

Part 2: Evaluation of Adult Interventions

The effectiveness of grief therapy has come under increasing scrutiny in recent years, with reviews providing conclusions that range from scepticism to cautious endorsement of this form of therapy (Neimeyer & Currier, 2009). Researchers describe the difficulty involved in establishing the effectiveness of grief therapy due to a "dearth of well controlled studies" (p.119) on which to base discussions (Haine, Ayers, Sandler & Wolchik, 2008). Despite this 'new pessimism' (Larson & Hoyt, 2007) in the bereavement research community, there are some indications as to what makes grief therapy effective.

First, Neimeyer and Currier (2009) found in their meta-analysis of over 60 studies, that adults who had "less oppressive and sustained symptoms" (p. 355) did not benefit significantly from grief interventions. However, those adults who were "contending with substantial clinical distress" (p. 353) on referral did experience some benefits from engaging in treatment. The researchers thus recommended that grief therapy should only be offered to individuals who are struggling with complex grief reactions, and they call for "carefully crafted therapies" (p. 355) for the subset of bereaved individuals who struggle to adjust to life after the death of their loved one. A second concern is what form the therapy should take. Neimeyer and Currier (2009) describe some models of therapy that have been found to be more effective than others. One model of 'carefully crafted theory-guided' therapy for grief amongst adults they highlight is Complicated Grief Treatment (CGT) developed by Katherine Shear and her team at the University of Pittsburg (2005). This model of treatment is guided by the dual-process model of bereavement (Stroebe & Schut, 1999), which posits that adaptation after the death of a loved one entails oscillating between orientation to the loss and restoration of contact with a changed world. Other types of therapy Neimeyer and Currier (2009) discuss as effective focus on using techniques to help the bereaved create a biography that includes the death of the loved one, integrating the loss into their own life story rather than avoiding it, and promoting more constructive thinking about the loss. The two therapies highlighted use written (Wagner, Knaevelsrud, & Maercker, 2006) or oral procedures (Boelen, de Keijser, van den Hout, & van den Bout, 2007) to accomplish this. Both of these therapies have outperformed control conditions. The key element that the oral and written procedures and CGT have in common is "repeated and experientially intense 'retelling' of the circumstances of the death with associated feelings and reactions" (p.355). Neimeyer and Currier (2009) state that: "As more evidence accrues regarding the role of these cognitive, attachment-oriented, and meaning-making processes in adjustment to bereavement, we are hopeful that such theory based models will contribute to an expanded toolbox of effective methods for grief therapists." (p.256). The significance of these findings for this study is that the intervention that will be analysed is exactly that which has been found to be effective; a retelling of the story of the death.

Part 3: Evaluation of Child Interventions

There have also been calls for more work to be done on the development and evaluation of grief interventions for children and adolescents to help understand and improve outcomes and treatment efficacy for this group (Humphrey & Zimpfer, 2007). A similar meta-analysis to Neimeyer and Currier

(2009) was carried out on bereavement therapy with children and adolescents by Rosner, Kruse and Hagl in 2010. Of the 27 studies they examined they found two types of therapy to be the most successful in terms of symptom reduction. The first was music therapy interventions (Dalton & Krout, 2006; Hilliard, 2007). The second was a trauma/grief-focused school-based brief psychotherapy (Goenjian et al., 1997). However, when analysing all the different variables within the 27 examples of grief therapy, they identified one moderator they called 'therapeutic confrontation' as showing the most promising results. They defined therapeutic confrontation as, "sessions or exercises on especially painful aspects related to the bereavement, such as talking about the circumstances when the loved one died and or the situation at the funeral." (p. 103). This is (again) exactly the intervention that this study focusses on; a style of intervention that Rosner et al. describe as "worth exploring" (p.103).

Since Rosner et al.'s (2010) meta-analysis there have been further positive findings. For example, recent studies have shown that CBT-based therapy (which focusses on cognitions and how these influence emotional response) led to reductions in immediate as well as long-term grief problems in children confronted with parental and sibling loss (Sandler et al., 2010; Spuij et al., 2012; Spuij, Dekovic & Boelen, 2015). Directed written exposure therapy, 'Writing for Recovery', has also been shown to be effective with bereaved adolescents reducing traumatic grief symptoms (Kalantari, Yuly, Dyregrov, Neshatdoost, & Ahmadi, 2012). However, the area of therapeutic interventions with bereaved children needs further development and empirical support (Rosner et al., 2010) and the current study aims to add to the body of evidence in this area.

The tentative evidence for the efficacy of some forms of grief intervention must be balanced by the fact that, to date, due to the population studied, the results may not generalise to a UK context. Many of the studies in this field have originated from the United States and the focus on adaptability and return to function found in that culture may be less suited for understanding grief in children in different societal and historical contexts (Dyregrov & Dyregrov, 2013). This study thus aims to add to the broader discussion to this topic by focussing on a different cultural context (England) and by taking a less 'outcome' focussed approach, instead focussing on coherence and family processes.

Thinking about the UK context it is important to note that there have been calls for a universal support service for bereaved children in the UK (Stokes, 2004), and that there is a growing network of charities

that are meeting this need, under the umbrella organisation the Child Bereavement Network. In Rolls and Payne's (2004) review, 91 different childhood bereavement services in Britain were identified. These organisations offered a range of services focussing on bereaved children and their families. These services offered both group and individual work but most services used a combination of these two approaches, and included family work as part of their provision. This demonstrates that there is a history in the UK in working with families after a bereavement, as well as a funding and policy context that is broadly supportive of such work. This context is important for the current study as it suggests the potential value of the study findings for the existing network of UK providers.

One of these UK services is the charity Winston's Wish, which was established in 1992, originally to meet the needs of bereaved children in Gloucestershire. In 2015, the organisation supported over 40,000 bereaved children and young people through a variety of support services. This research project was carried out in partnership with Winston's Wish, and focussed on an intervention used in their family work (which is further explained in the method section). I will now go on to evaluate family bereavement interventions and assess what evidence is available for their efficacy.

Part 4: Evaluation of Family Interventions

As well as working with groups or one to one, grief therapy can take place within families. A potential criticism of the outcome research on grief interventions to date is that it is predominantly focussed on individual outcomes rather than family outcomes. Stroebe (2010) stated that within the bereavement literature, "the family context of grief and grieving is neglected" (p.144) and more recently Hooghe, De Mol, Baetens and Zech (2013) said, "The main body of literature in the scholarly grief field concerns the bereaved individual, detached from his or her family network" (p.66). Another criticism of research in this field is that it tends to treat the impact of a bereavement as a one off event (Shapiro, 1994). However, the impact of a bereavement on a family is not static. As a dynamic system, families adapt to change, and new ways of behaving and making sense of the loss develop over time (Bowlby-West, 1983). Thus, the current research offers the advantage of both a family-level examination and also a focus on shifts over time and throughout the therapeutic journey.

Historically, there has been evidence that working with the whole family is the most effective way of helping bereaved children (Herbert, 1991; Parkes & Weiss, 1983) with recent developments creating

specific approaches and treatment models designed to work with families. One of these, Family Focussed Grief Therapy (Kissane & Lichtenthal, 2008) is designed for use with children dying of cancer and their families. This model "prioritises the family as the natural context in which distress due to illness and loss is expressed and metabolised" (p. 118) and has been shown to have considerable success in reducing distress of bereaved families. Another treatment programme is the Family Bereavement Program Approach (Sandler, Wolchik, Ayers, Tein & Leucken, 2013), which works with parentally bereaved children and their remaining parent. Although this program works with children and adults in peer-groups, rather than as whole family units, it emphasises the importance of working with all members of the family to strengthen their coping and resilience strategies.

Other research has examined what attributes within families can help to promote an easier adaptation to loss, and findings have included more openness and frequency of communication (Hope & Hodge, 2006). This is associated with less depression and anxiety in bereaved children and better adjustment to the loss (Hope & Hodge, 2006; Nickman, Silverman, & Normand, 1998). One of the findings of Fletcher's (2002) qualitative research with families who had lost a child was the theme of 'reconfiguration'; the reorganisation of the family unit after the death. Fletcher calls for further research to explore this process of how families reorder themselves as a system and make sense of the loss within that system. The current research answers Fletcher's call as it explores how the family describes life after the death, and how they tell the story together of their 'reconfiguration'.

In summary, the literature on efficacy of grief interventions suggests that one uniting factor in 'effective' grief therapy with adults, children and adolescents is the use of 'therapeutic confrontation,' or focussing on the repeated telling of the story of the death. Research also suggests that working with family units rather than with individuals can lead to better outcomes. This research project combines these two important findings and focuses on the telling of the story of the death within families.

I will now discuss the theoretical background to loss and bereavement responses as proposed by John Bowlby, which is fundamental to informing the analysis of this research project, as well as to understanding why repeatedly telling the story of the death may be an important thing for bereaved families to do. As Daniel (2009) states, "Though attachment theory is only one of several possible

perspectives on narrative organisation and interaction that may be valuable to psychotherapists, it holds special promise because of its links with a rich and rapidly evolving empirical literature within both clinical, developmental, social, and personality psychology" (p.302).

Bowlby and Attachment Theory

John Bowlby was a British psychiatrist, psychologist and psychoanalyst who began working with London's evacuated children and widows after World War Two. His work in developing and then applying Attachment Theory to adult grief extended the adult bereavement literature to include developmental and relational perspectives (Shapiro, 1994). The relational perspective, understanding people's behaviour within the context of their current and past relationships, stood in contrast to the earlier more individualised theories of grief proposed by Freud (1917), Lindemann (1944) and Caplan (1964). Bowlby's Attachment Theory (1980) posits an evolutionary motivation for an infant to establish an attachment to significant caretakers. When this bond is threatened by a separation, the child responds with a series of characteristic behaviours including crying, protest, and a concerted search for the loss attachment figure (Bowlby, 1980). Bowlby suggested that adulthood attachment bonds to their partner and children are derived from the same emotional system underlying attachment in children and he argued that maintaining access to an attachment figure continues to be the set goal of the attachment system from infancy and throughout adulthood (Bowlby, 1969, 1973, 1980). This means that when an adult is separated from their attachment figure(s) through death, the grief that follows resembles many elements of the childhood attachment and separation sequence – sadness, anger and a preoccupation with the lost person. Healthy mourning is identified by Bowlby (1980) as, "the successful effort of an individual to accept both that a change has occurred in his (sic) external world and that he (sic) is required to make corresponding changes in his internal, representational world and to reorganise, and perhaps to reorient, his (sic) attachment behaviour accordingly" (p. 18). In contrast to healthy mourning, Bowlby suggested that 'disordered mourning' could follow the failure to resolve a loss. He stated additionally that such unresolved loss may impact on relationships such that 'disordered mourning' could result in "a bereaved person's capacity to make and to maintain love relationships becoming more or less seriously impaired" (Bowlby, 1980, p.137).

Internal Working Models

Bowlby's Attachment Theory, including his theories of adult and child responses to loss, rests on his

model of relational cognition. Bowlby used the term 'Internal Working Models' (IWM) to describe this internal representational world (Bowlby, 1969). Forming from infancy, initially even before language, IWM are theorised to be based on each person's actual experiences, in particular, on their relationships with significant attachment figures. Bowlby held that over time each person's IWM function as cognitive-interpersonal blueprints that dictate how new interpersonal interactions are to be processed and interpreted. Thus, IWM of relationships are beliefs and expectations about how a primary carer (parent) or other significant person may be expected to behave, as well as how a person themselves may respond in relationships. Critically, based on their experiences in relationships, individuals can develop globalised IWM that are indicative of 'secure' attachment (as a result of what Winnicott termed 'good enough' mothering, [Winnicott, 1953], or one of several categories of 'insecure' attachment [Main, 1985]).

In the context of the loss of an attachment figure, Bowlby theorised that the bereaved person's IWM has to adapt and change to represent the world without the presence of the person who has died (Bowlby, 1980). IWM were termed 'working' models because they remain open to correction and revision. Bowlby (1980) proposes that when IWM are not corresponding to external reality, they are inadequate and interfere with effective coping and optimal development. Therefore, the death of an attachment figure presents a decisive and temporarily irreconcilable mismatch between an unrevised mental representation of a loved one and a dramatic change in the ongoing relationship with that person (Shear et al., 2007). Although this theory remained 'untested', the idea was generally accepted as a useful and practical model for understanding how individuals deal with the trauma of bereavement (Hughes et al., 2006). IWM cannot be seen in the brain, just as other psychological concepts and theories cannot (e.g. understanding of core beliefs in Cognitive Behavioural Therapy [Beck, 1979], psychodynamic theories of transference [Freud, 1912] and Rogerian ideas of 'conditions of worth' [Rogers, 1959]). However, these concepts are still acknowledged to be useful. Nonetheless, there was a question about how to assess or measure IWM. This question was answered by attachment researcher Mary Main, who developed a structured coding system to assess adults' attachment narratives and thus their IWM called the Adult Attachment Interview (AAI) (George, Kaplan, & Main, 1985). Originally developed to categorise speaker's attachment status (e.g. secure or insecure), the Adult Attachment Interview (AAI; George, 1984, 1985, 1996) also assesses the way in which an adult has coped with a loss or bereavement either in childhood or adulthood. For infants, the corresponding measure of attachment was The Strange Situation Test (SST) (Ainsworth & Wittig, 1969).

Since these original methods were created, further measures of child and adult attachment have developed, such as the self-report Kerns Security Scale (Kerns, Klepac & Cole, 1996), Secure Base Script Assessments through story creation (Bosmans & Kerns, 2015) and puppets (Cassidy, 1988) and story completion methods (Bretherton, Prentiss & Ridgeway, 1990) (see below for further discussion of Attachment Measures used with Children). There is also a separate literature from social psychology based on quantitative self-report measures to assess attachment status (e.g Self-report measure of Adult Romantic Attachment [Hazan & Shaver,1987]; Experiences in Close Relationships Scale [Brennan, Clark, & Shaver, 1998]). However, it has been contested that self-report measures may not correspond with narrative/play based methods as they are assessing differing processes, conscious versus unconscious (Jacobvitz, Curran, & Moller, 2002) and not focussed on narrative formation. The AAI is key to the current project both theoretically and methodologically, and is discussed further below.

The Adult Attachment Interview

The Adult Attachment Interview (AAI) is an interview in which adults are asked about their experience of their parents in childhood (George, Kaplan & Main 1985). The 20 interview questions require interviewees to retrieve and evaluate attachment related autobiographical memories. The AAI scoring and classification system developed by Main and her team focuses on the patterns of speech that emerge when an individual is interviewed. In addition to questions concerning childhood experiences with primary caregivers, including experiences of separation and childhood illness episodes, there are four questions regarding major loss experiences and any overwhelmingly frightening or traumatic experiences occurring throughout the individual's lifetime. These questions taken from the AAI (George et al., 1985) are below:

> *13. Did you experience the loss of a parent or other close loved one while you were a young child-- for example, a sibling, or a close family member?*
>
> *13a. Did you lose any other important persons during your childhood?*
>
> *13b. Have you lost other close persons, in adult years?*
>
> *14. Other than any difficult experiences you've already described, have you had any other experiences which you should regard as potentially traumatic?*

Coding of the AAI results in the interviewees being given a generalised attachment category based on the AAI coding results for the whole of the AAI; these adult secure/insecure attachment classifications are detailed in Table 1 below.

Table 1: Adult attachment categories (summarised from Main et al., 1985/2003)

Adult Responses to AAI	Adult categorisation
Coherent, collaborative discourse. Valuing of attachment, but seems objective regarding any particular event or relationship.	Autonomous (F) [Secure]
Not coherent. Dismissing of attachment-related experiences and relationships.	Dismissing (D) [Insecure]
Not coherent. Preoccupied with or by past attachment relationships or experiences, speaker appears angry, passive or fearful.	Preoccupied (E) [Insecure]
Contradictory strategies in discourse.	Cannot Classify (CC)
During discussions of loss or abuse, individual shows striking lapse in the monitoring of reasoning or discourse.	Unresolved (U)

It should be noted that a person who is categorised as 'U' or unresolved with respect to loss or trauma, will also be classified as F, D or E; this distinguishes between incoherence related to a difficult loss or trauma and the overall attachment classification. Unresolved status is secondary to the major organised states of mind and may co-occur with secure as well as insecure (dismissing or preoccupied) states of mind, so an individual can have secure attachment categorisation and still be unresolved with respect to loss.

As well as being distinct constructs identifiable through narrative as proposed by George et al. (1985), attachment patterns can be regarded as containing phenomenological aspects of people's experience. An individual's early experiences of care giving and soothing in times of distress forms their 'internal working model'. This model informs their understanding of themselves in relation to care givers and others, and informs how they manage distress and separation. I will now briefly describe the experience of each different type of attachment pattern for individuals and how this impacts on close relationships as well as in therapy.

Collins and Read (1994) developed a theory around the structure and function of working models. They have proposed a model with components that vary across the major attachment groups and describe the relational experiences of individuals with varying attachment patterns. They proposed that for a securely attached individual, there is generally a desire for intimate relationships and they seek a balance of closeness and autonomy in relationships. A securely attached individual is able to acknowledge their own emotional distress when it arises and are able to modulate their negative affect in a constructive way. They have fewer self-doubts and are generally high in self-worth. They are generally liked by others and believe others to be generally well intentioned and good hearted. Overall others are believed to be trustworthy, dependable and altruistic. Further research has shown that secure attachment has been found to be inversely related to depression, anxiety, social isolation, and family conflict avoidance (Leveridge, Stoltenberg & Beesley, 2005). When grieving, securely attached individuals may be able to find a balance between continuing to be able to experience memories of the deceased as positive sources of joy, and able to tolerate the pain of the loss. Secure individuals can stay connected and hold memories of the deceased in mind, and also are able to engage with other activities necessary to continue with their own life and safety (Dallos & Vetere, 2009).

For individuals with a dismissive attachment pattern, Collins and Read (1994) proposed that they need to maintain emotional distance with others, and will limit intimacy to satisfy their own need for autonomy. They generally manage their emotional distress by cutting off anger and minimising distress-related emotional displays. Individuals with avoidant patterns often perceive others as not trustworthy or dependable and doubt the honesty and integrity of others. Leveridge, Stoltenberg and Beesley (2005) examined family interaction patterns and found that avoidant attachment style was associated with defensiveness, somatic complaints, social isolation, family disengagement, and family conflict avoidance. With regards to grief reactions, dismissively attached people may attempt to push away memories, images or conversations had with the deceased as these may be too painful to tolerate (Dallos & Vetere, 2009).

Collins and Read (1994) stated that for a preoccupied individual there is generally a desire for extreme intimacy, and lower levels of autonomy are sought within relationships. They experience a fear of rejection and often have heightened displays of distress and anger. They may find others complex and difficult to understand and believe that people have little control over their own lives. Leveridge,

Stoltenberg and Beesley (2005) found that anxious attachment style was associated with depression and anxiety, linking this style to an inability to repress negative affect when responding to emotional memories and an inability to inhibit the spread of negative affect to other activities. When grieving, preoccupied individuals may be overwhelmed by memories of the deceased and these may shape and disrupt relationships with new friends or potential partners (Dallos & Vetere, 2009)

These relational patterns have implications for interpersonal relationships – both within intimate and family settings as well as social and work settings. These patterns also have an impact on the therapy relationship, and are mediating factors in outcomes in therapy. Levy, Ellison, Scott and Bernecker (2011) conducted a meta-analysis of research on attachment style and therapy outcomes and found that higher attachment security predicted more favourable outcomes in psychotherapy and higher attachment anxiety predicted worse outcomes after therapy.

Importantly for the current study, it has been proposed that individuals classified as unresolved with respect to loss (U) on the Adult Attachment Interview (AAI) demonstrate many of the same symptoms described in prolonged grief disorder/complex grief (Neimeyer et al., 2008; Thomson, 2010). For example, 'symptoms' such as inability to accept the death or feeling responsible for or causal in the death of a loved one can be seen as lapses in monitoring of reasoning (see below for detailed discussion of how 'U' is coded); 'symptoms' of preoccupation with the circumstances of the death can be seen as lapses in monitoring of discourse; and changes in behavior or impairments in functioning can be seen as lapses in monitoring of behaviour. Understanding the 'U' categorisation as a form of complex or prolonged grief allows conceptual links to be draw between the theory and research in the two areas, and legitimises the decision to use the AAI coding system in this project.

The Significance of Attachment Disruptions in Families: Empirical Evidence

Attachment researchers have sought for ways to assess IWM or to classify individuals' attachment status as ways to empirically test and extend the assumptions in Bowlby's Attachment Theory. Attachment IWM are assessed in adults through the AAI; in infants IWM are assessed behaviourally through the Ainsworth Strange Situation Test (Ainsworth & Wittig, 1969), which codes an infant as securely or insecurely attached by observing and coding their behaviour in a lab-based paradigm that involves brief separations from the infant's key attachment figures (e.g. mother or father). As predicted by Attachment

Theory, an empirical link has been found between a parent's attachment status (including whether they have unresolved loss 'U') and their child's attachment security as assessed by the Strange Situation Test.

In the first study combining the Strange Situation and AAI, Main and Cassidy (1988) revisited the infants' parents from the first Strange Situation Study several years later. The children were then 6 years old, and both parents were interviewed using the AAI. Main found that the parents' accounts could be systematically placed into one of three basic and relatively organised ways of recounting life history with respect to attachment: secure-autonomous, dismissing and preoccupied categories. These three categories formed the original "organised" categories for adults; these were associated with the infant's categories in the Strange Situation Test. The CC and U categories were associated with predicting the infant category 'D' (disorganised category) at a later date by Ainsworth and Eichberg (1991), with 89% correspondence.

Table 2: Predictive links between parental AAI category and infant SSP behaviour (Main & Cassidy, 1988; Ainsworth & Eichberg, 1991)

Adult categorisation	Predicts:	Infant classification	Infant Strange Situation Behaviour
Autonomous (F)	Predicts	Secure (B)	*soothed by parent*
Dismissing (D)	Predicts	Avoidant (A)	*does not make contact with parent or express attachment needs*
Preoccupied (E)	Predicts	Resistant-Ambivalent (C)	*not comforted by parent*
Cannot Classify (CC)	Predicts	Disorganised (D)	*no coherent strategy*
Unresolved (U)	Predicts	Disorganised (D)	*no coherent strategy*

Further research has confirmed this relationship between adult 'U' and child 'D' states: a meta-analysis by van IJzendoorn, (1995) of 9 studies revealed a significant effect size for the relationship between child

disorganisation and parental unresolved status. It is now a replicated finding that disorganised infant attachment is associated with the parent having an unresolved loss or other trauma (Ainsworth & Eichberg, 1991; Main & Hesse, 1990; Van IJzendoorn, 1995). A growing number of research studies have used prospective research designs to assess maternal representations of attachment during pregnancy and infant-mother attachment at 1 year. These studies reported significant concordance between classifications (autonomous– secure, dismissing – avoidant, preoccupied–ambivalent, unresolved– disorganized), ranging from 49% to 81% (Benoit & Parker, 1994; Fonagy, Steele, Steele, Moran & Higgitt, 1991; Fonagy, Steele, Moran, Steele & Higgitt, 1993; Raval et al., 2001; Steele, Steele, & Fonagy,1996). These findings show an impressive correlation given the time lapse and also the different focus for measurement (narrative in the mothers and behaviour in the children) as well as differing relationships (mothers talking about their own parents, and babies responding to their mothers). Additionally, the AAI has also been shown to predict patterns of infant security across 3 generations, with AAI categories of grandmothers correctly predicting 75% of mothers AAI categories and these in turn predicting 77% of the Strange Situation categories of their infants (Hautamaki, Hautamaki, Neuvonen & Miliniemi-Piispanen, 2010; Benoit & Parker, 1994). Overall it is clear that there is strong evidence of transmission of attachment trans-generationally.

Hesse and Main (2000) argued that the odd, unpredictable and inexplicable narratives of 'unresolved' adults suggest that the speaker continues to experience unusual absorption regarding the trauma/loss, or that the narrative reflects sudden changes in states of consciousness. This implies that the speaker may involuntarily remember the loss of an important attachment figure and unexpectedly re-experience the fright involved in the loss. Expressions are triggered when traumatic memories intrude into a mother's awareness, producing contextually anomalous fearful or frightening expressions (FR) during interaction with their infant. These lapses in monitoring may be understood to be a form of dissociation (Hesse & Main 2006). Adults who are classified as 'U' on the AAI (due to demonstrating incoherent narratives) and are more likely to have infants that are classified as disorganized in the Strange Situation test (Ainsworth, Blehar, Waters & Wall, 1978). The 'transmission' of this disorganisation from parental narrative to infant behaviour has been an important area of study.

Researchers have focused on certain parental behaviours that are experienced as frightening by the infant, known as 'FR'. These 'FR' are subtle and brief, unmonitored by the parents and experienced as

inexplicable for the infant with respect to the surrounding environment (Abrams, Rifkin & Hesse, 2006). The FR behaviours are subdivided into 3 types: frightening, threatening, and dissociative parental behaviour (Hesse & Main, 2006). An example of a frightening behaviour would be a parent pulling back or backing away as an infant approaches without explanation (such as the infant having dirty hands or parent holding a dangerous object). An example of threatening behaviour would be 'looming', which is the sudden movement by the parent into, and violation, of the area immediately surrounding the infant's face and eyes. An example of dissociative behaviour would be when a parent may momentarily appear 'blind' both facially and by changes in movement pattern during a play session with their infant (Abrams et al., 2006). The infant is thought to be particularly frightened by these FR behaviours because they cannot perceive a connection between them and the interaction or the immediate environment, and it disrupts the ongoing dyadic interactions. This may lead to the development of a disorganized attachment relationship. As well as 'U' status leading to FR behaviour, further research on mothers suggests that the unusual absorption in the loss leads to insensitivity and unresponsiveness (to infants' needs for comfort and protection), which in turn leads to disorganised attachment (Raval et al., 2001). It is the same disorganised characteristics that predispose parents to unresolved lapses in the AAI narrative that substantially impair their interactions with their infants. This link between 'U' coding and 'disorganised' infant behaviour is important for this study, because if a parent experiences a loss, and their narrative remains unresolved, this can have significant distressing and long term impact on their children due to FR behaviour (Abrams et al., 2006).

The majority of research on 'U' to 'D' transmission has been with mothers and infant dyads, and there has been little research on the impact of 'U' parents on older than preschool children. However, research shows that it is not only the direct interaction with 'U' parents that has negative consequences, but also the systemic issues that arise due to the unresolved loss. As explained by Busch, Cowan and Cowan (2008), "Children of unresolved parents may be at particular risk for problems because of the negativity they are likely to experience from their parents and also because of the anger and conflict they are likely to observe between their parents" (p.733). Busch et al. (2008) suggest that the impact of the parent's unresolved loss may have negative implications for, "the next generation's ability to achieve positive close relationships" (p.733). These findings support the idea that loss has a systemic impact that may be observed and understood further through the application of 'U' coding and ideas.

As noted above, initial research by Maine with the AAI was carried out with mothers and fathers from the Strange Situation Test (Ainsworth & Wittig, 1969), but subsequent research has focussed mainly on the mother's relationship with the infant (McFarland-Piazza, Hazen, Jacobvitz & Boyd-Soisson, 2012). However, as significant attachment figures, fathers have an impact on an infant's attachment patterns. McFarland-Piazza et al. (2012) demonstrated that a father's unresolved attachment had an impact on their caregiving and emotional engagement, which in turn affected their infant's attachment styles demonstrated in the Strange Situation Test. There is then, clear evidence that adult parent (both mother and father) IWM impact the IWM/attachment security of their children. Research has also found that if an adult's AAI interview score is a 'U' for unresolved loss, this will have a direct impact on their parenting and their children's attachment security (Main et al., 1990). In terms of parenting, Busch et al's (2008) research with mothers who had a 'U' score demonstrated this had a significant impact on family relationships and parenting styles. These mothers displayed less positive emotion and more anxiety and anger with both their husbands and children, and more authoritarian parenting styles (more negativity and controlling behaviour) with their children.

The impact of parent's IWM on children's attachment security is demonstrated by research with children who have experienced loss and then subsequently become parents themselves. Main and Hesse (1990) found that 56% of mothers who had lost a parent by death before they were 18 went on to have children who themselves had disorganised (D) attachments as demonstrated in the Strange Situation Test (Ainsworth & Wittig, 1969). This is important because of the evidence of poor outcomes for 'D' children. As 'disorganised' children develop, research suggests that this attachment pattern develops into a controlling pattern of relating (Cassidy & Marvin, 1992; Main & Cassidy, 1988) including hostile, coercive behaviours. Further research on 'D' children showed that controlling children were at highest risk for both externalising (increased aggression) and internalising problems (more anxious/depressive symptoms) (Moss, Cyr, & Dubois-Comtois, 2004).

Family bereavement affects children because of the impact of the loss on their parents and thus on the parenting that they receive. Children that experience the death of a sibling also experience a disruption in the attachment to primary caretakers, as they, too, cope with this major event (Charles & Charles, 2006). However, children are also directly themselves impacted by loss in family, in particular if they are unable to 'resolve' the loss. Research suggests that children who have experienced a direct loss and then

remain 'unresolved' (as classified by the AAI) are at risk of hospitalisation for psychiatric disorders during adolescence, and experience increased rates of suicidality and likelihood of a being diagnosed with an anxiety disorder in teenage years (Adams et al., 1996; Allen, Hauser, & Borman-Spurrell, 1996).

As families in this study will include children from a wide age range, it is important to understand how attachment and 'D' is measured across the age range. Currently there are four approaches to measuring attachment in middle childhood (age 7-12). Firstly, as with adults, there is a tradition of self-report measures where children respond to questions about their parent's behaviour towards them or their general approach to attachment relationships (e.g. Kerns Security Scale, Kerns et al., 1996). Secondly, projective assessments are used where children are asked to complete a series of stories involving emotion-eliciting and relationally-focused situations (Granot & Mayseless, 2001; Slough & Greenberg 1990). Thirdly, secure base script assessments are used, where children are asked to create stories from a list of words presented to them (Bosmans & Kerns, 2015). And the final approach to measuring attachment, and the one of most interest in this study, is use of interviews. An example of this is the Child Attachment Interview (CAI) developed by Target, Fonagy and Shmueli-Goetz (2003) that uses direct questioning of children in the middle years (age 7-12) concerning attachment-related experiences based on the AAI. The CAI uses the AAI coding system to code responses and assign attachment status. Target et al.'s (2003) findings show that responses of children in this age range "appear to reflect their internal attachment organisation" (p. 184). The use of middle years aged children's verbal narratives and the coding of these children's attachment interviews using the adult AAI coding system gives support to use of this coding system in the analysis of family stories (as told by both adults and children) in this study. Attachment status in adolescents is also measured using a modified version of the AAI. The coding of these interviews also relies on the coding system from the original adult AAI (Warmuth & Cummings, 2015).

In summary, research suggests that experience of loss in a family system can have – if it is not 'resolved' – potentially devastating and long-term impacts, lasting even into the next generation. Bereavement of a parent not only affects children of all ages though the disruption of parent-child attachment relationship, loss of a sibling is also loss of an attachment figure (Ponzetti & James, 1997). In addition, the adult-adult romantic partnership can also be understood as an attachment relationship (Hazan & Shaver, 1987) and therefore disruption of this relationship is equally seen as a hugely important loss in attachment terms.

Therefore, the loss of a family member is a major disruption of the family network of attachment bonds – akin to an 'assault' on the family system (Shapiro, 1994). Shapiro (1994) explained the global and pervasive effects of grief on the family, stating that: ''Grief is a crisis of both attachment and identity, disrupting family stability in the interrelated domains of emotions, interactions, social roles, and meanings'' (p.17).

It is in this context that the current research project is located – examining family narratives of loss in the aftermath of a family bereavement. The Strange Situation Test (Ainsworth & Wittig, 1969) and the AAI (George et al., 1985) deliberately both 'stress' the attachment system (e.g. separate babies from parents and asking adults to talk about difficult things like separations from parents when they were children). The therapy data in this study is also focussed on a similar (very) stressful point, and therefore it can be assumed that it is at these moments that the researcher can see the attachment system most clearly in operation. Utilising the coding system of the AAI to examine the therapy data will make it possible to look for subtle linguistic markers of unresolved loss that Attachment Theory would predict should be present in the recent aftermath of bereavement. Some researchers would disagree that attachment patterns influence discourse outside of an AAI interview (e.g. Hughes, Hardy, & Kendrick, 2000), however some studies have demonstrated that attachment processes impact on narrative formation in other contexts (e.g. Bishop, Steadmon & Dallos, 2015, I discuss this study in further detail below).

Examining the family narratives at two points in time allows any changes in the narrative to be explored. This will allow me to examine whether the markers of the U state and incoherence undergo a steady improvement as do the symptoms of grief, over time. As stated by Hughes et al. (2006), there is currently no systematically collected data looking at patterns of discourse in the AAI immediately after loss or trauma, so there is no firm evidence as to whether there is a natural progression and improvement from disorganised thinking or discussing of the loss/trauma to becoming (more) organised with the passage of time. The findings of Hughes et al.'s (2006) study on infant disorganisation with mothers who were classified as U in pregnancy, and who had no therapeutic input, were that mother's U state did not change as time passed; that U became a stable state of mind. In this study, analysis of the narrative changes over time may shed some light on what may help to move a story from unresolved to 'resolved'

and make the U/D outcomes less likely. These findings may help inform effective therapeutic interventions and have implications for therapy practice.

I will now discuss the coding system of the AAI in further detail, with particular attention to the Coherence codes and the Unresolved Loss codes, which will inform the analysis of the therapy transcripts.

Coherence Codes

The Coherence codes in the AAI draw on British language philosopher Paul Grice's work on the Co-operative Principle (1975). This is a general, over-riding principle of conversation that participants are expected to observe: "Make your contribution such as it is required, at the stage at which it occurs, by the accepted purpose or direction of the talk exchange in which you are engaged" (Grice, 1975, p.42). The Co-operative principle is intended as a description of how people normally behave in conversation and from this Grice derived four conversational maxims (Grice, 1975; see Table 3 below). The coding used with the AAI looks for instances where these maxims are violated throughout the whole transcripts, when answering all of the 20 questions; examples are given in the Table below.

Table 3: Grice's (1975) four conversational maxims

Grice's Maxim	Explanation	An example of 'incoherence' in AAI scoring
Quality	be truthful, and, have evidence for what you say	factual contradictions found in the story being told
Quantity	be succinct, yet complete	giving far more information than is required; alternatively failing to answer a question
Relation	be relevant or perspicacious, presenting what has to be said so that it is plainly understood	repeatedly discussing wrong person or wrong time period
Manner	be clear and orderly	not quoting from others unless making clear that a quotation is about to be offered

Unresolved Loss Codes

In the AAI, the unresolved indices of loss are used to find evidence for the continuing presence of

disorganising or disorienting processes when interviewees answer the specific questions about loss/ trauma. There are three central types of evidence of unresolved loss (Main & Hesse, 1990) and these are listed alongside the indicators and examples in Table 4 below.

Table 4: Unresolved Indices of Loss (Main, Goldwyn, & Hesse, 2003)

Type of lapse during discussion of a loss	Indicators	Examples
A. monitoring of reasoning	*Refer to things that cannot be true in the external world*	
	Indications of disbelief that the person is dead	Slip of the tongue to the present tense regarding a lost attachment figure (*is* not *was*).
	Sense of being causal where no material cause is present	A person feeling responsible for death through thoughts, forgotten prayers etc.
	Confusion between dead person and self	Slip of the tongue which cannot be attributed to invasion by habit (e.g. 'I died').
	Time disorientation	Naming several substantially different times when a loss may have occurred (e.g. parent died when speaker 10 and 15 years old).
	Space disorientation	Placing themselves at an event which they were clearly not present.
	Psychologically confused statements	Suggest efforts to manipulate the mind in order to partially undo or effectively erase a past or ongoing experience.
	Other	

B. monitoring of discourse	Indicators involving a kind of absorption which takes the speaker out of the immediate (appropriate) interview context	
	Unusual attention to detail	More detail than is necessary or more than a speaker would normally conceive of as being interesting to a listener.
	Poetic phrasing with a memorised quality (e.g. eulogistic)	"She was young, she was lovely, she was dearly beloved by all who knew her and who witnessed her as she was torn from us by that most dreaded of diseases, tuberculosis". A sense of it being 'rehearsed'.
	Prolonged silences	In the middle or at the end of sentences (not because the speaker is choosing to remember or silently reflecting or weeping) the analogy is to the freezing response seen in babies judged disorganised on that basis. Silences will be timed and recorded in the transcript.
	Weaker indices	
	unfinished sentences	"She died in a ski accident. Maybe... (Long pause). So, we went right down to the hospital when we heard about it. Of course, my father was pretty upset."
	sudden change or move away from topic	Suggests momentary absorption combined with an attempted avoidance

	other topics invaded by information regarding a death	"So as I was saying, my first day of kindergarten wasn't that bad. My sister died when I was 16."
	Other	
Extreme behavioural reactions	*Reports of disorganised or disorientated behavioural responses to a loss*	*Does the underlying disorganisation or disorientation remain – can the speaker show that changes have taken place?*
	Re-direction of distress following bereavement	Reports of numbness after death of father, yet extreme grief reaction at funeral of distant relative.
	Extreme responses at the time of bereavement	E.g. suicide attempts, depression requiring hospitalisation, onset of a serious continuing substance abuse problem.

In summary, a speaker is judged as unresolved with respect to loss or abuse experiences when, during discussion of these experiences:

(a) their speech loses its coherence and they speak in an unusual and/or disorientated way;

(b) they lose the sense of temporal sequences as they mix past and present; and

(c) they describe their excessively disturbed behaviour as a response to the loss.

Links between the AAI, Grief Narratives and Coherence

The codes that are traditionally used in the coding of the Attachment Interviews (both Adult and Child) will be used in this study to inform the analysis of the stories told by the families in therapy in this study. Their use creates a link between Attachment Theory, unresolved loss and the narratives created by families about the death of their family member. The view that interpersonal loss disrupts the coherence of one's self-story (Neimeyer et al., 2010), echoes Bowlby's theory that IWM of relationship to self and others must update and reorganise when a loss occurs because they have been disrupted. Correspondingly, theoretical attention is now being given to the importance of increasing narrative coherence in bereavement work because the grief narrative is viewed as a reflection of individual psychological processes, exactly as the AAI narrative is viewed as revealing individual's attachment

(in)security (Georgaca & Avdi, 2009).

The Current Study Rationale

There has been controversy in recent literature as to the efficacy of 'grief therapy' (Neimeyer, 2000; Larson & Hoyt, 2007). Quantitative research in the area however often focuses on the relief from 'symptomology' (depression, anxiety) as the prime measure of therapeutic outcome (Neimeyer, 2000; Currier, Neimeyer & Berman, 2008), rather than measuring outcomes in terms of grief adaptation. Further, this research is typically based on self-report measures which are themselves based on diagnostic criteria (e.g. Inventory of Complicated Grief, Prigerson et al., 1995). Increasingly narrative coherence and meaning making are being seen as potentially more valid markers of bereavement therapy being 'effective' for clients (Neimeyer et al., 2008), moving away from the medical model paradigm that could potentially be pathologising. Concurrent with this shift in assumptions about the 'best' way to measure the efficacy of grief interventions, there have been calls for researchers to adopt narrative qualitative methodologies to consider the bereavement experiences of young people and adults (Dowdney, 2000; Ribbens McCarthy, 2007), as well as to increase understanding of the operational implementation of interventions (Currier et al., 2007) and the critical mechanisms within interventions (Ahn & Wampold, 2001). Midgley (2004) correspondingly calls for greater use of qualitative methodologies in child therapy process research. The current project answers such calls, by examining the extent to which a narrative intervention with bereaved families (telling the story of the death) is associated with shifts in the family narrative of the death, using qualitative methods.

I will be drawing mainly on Attachment Theory (Bowlby, 1980) for this study as much empirical evidence of the value of narrative coherence comes from research drawn from Attachment Theory, IWM and the AAI, where narrative coherence is a critical marker of attachment security (George, Kaplan, & Main, 1985). If the loss of a family member is understood as a loss of an attachment figure, then the assumption is that the narratives of the loss will have a measure of incoherence as a result of this disruption. This study will explore how those disrupted attachments are presented in the narratives of bereaved family members and whether and if so how these stories change over time. As Dallos and Vetere (2009) argue, "Narratives are not a passive recording of the past but constitute an active process of continual construction, reconstruction and review" (p. 9).

The decision to utilise AAI codes in this qualitative study requires some justification as it is somewhat novel in the literature. However, the idea that awareness of attachment styles and processes can bring deeper understanding to the therapeutic encounter is not a new one. Existing research has shown a fairly substantial link between attachment patterns and such clinical variables as the therapeutic alliance (Diener & Monroe, 2011), therapeutic outcomes (Folke, Daniel, Poulsen, & Lunn, 2016; Levy, Ellison, Scott, & Bernecker, 2011), psychiatric diagnosis (Dozier, Stovall-McClough, & Albus, 2008; Fonagy et al., 1996), and many others (see Daniel, 2006; Obegi & Berant, 2010; Slade, 2008; Steele & Steele, 2008). It has been argued that little is known about aspects of in-treatment interpersonal behaviour and discourse that are specific to the different attachment classifications (Talia et al., 2014; Obegi & Berant, 2010), with attachment-informed clinical research being described as, "still in it's infancy" (Obegi & Berant, 2010, p.481). However, increasingly research is examining how differing attachment categorisations (e.g. dismissing, avoidant) affects the actual content of the sessions; in particular, the client's narrative and discourse style. For example, Daniel (2011) found that there is a verbal productivity difference between dismissing and preoccupied clients, which lends some support to this idea that attachment-related differences in discourse style are also detectable in psychotherapy sessions. Talia et al. (2014) state that "different attachment patterns may have distinctive manifestations in the psychotherapy process that can be tracked by external observers" (p.192). This premise is also held by systemic therapists who work in an attachment informed way, for example, using Attachment Narrative Therapy (Dallos, 2006). Those working with families within an attachment framework focus on how families: "comfort themselves and others in times of anxiety, distress and difficulties" (Dallos & Vetere, 2009, p.9) and how the process of telling of the narratives in therapy is impacted by the attachment self-protective strategies or defences people employ informed by their attachment styles.

These studies are focused on the impact of the attachment classification of individuals (e.g. secure/insecure) on their overall discourse and behaviour and outcomes in therapy. These studies give weight to the argument that attachment processes impact on the therapeutic encounter. The current research project however, is not focused on the attachment classification of the individuals involved but rather on subtle attachment processes as they appear in conversations taking place in a therapeutic context about the death of a family member. Instead of using the AAI to code participants, I will be analysing how the loss of a loved one impacts on the very specific intervention of 'Telling the Story' of the death, and whether the 'U' codes from the AAI will be evident or not in the narrative created by the

families. The theoretical justification for doing so is that, as discussed, it is assumed that _everyone_ has a period of lack of resolution, is 'unresolved' or 'incoherent' narratively, following a loss – for example, that we could expect to see indicators of being 'U' in the recent aftermath of family loss. Looking at these narratives both at the beginning and near the end of the therapeutic encounter provides a way to explore whether the grief intervention seems to be associated with positive shifts in the narratives of family loss, or whether the 'normal' lack of narrative resolution shifts at all.

Nonetheless, the study design entails using the codes of the AAI 'out of context'. The concept of using the AAI codes on non-AAI data is not a new one (Thomson, 2010); however there are limited examples of the AAI codes being used outside of this strict context and specifically on therapy data (Thomson, 2010). Muscetta, Dazzi, Decoro, Ortu & Speranza (1999) describe applying a coding system focussed upon dismissing and preoccupied violations of Grice's coherence maxims to the transcript from an adolescent patient's therapeutic sessions. Ammaniti, Dazzi and Muscetta (2008) described two further cases where they use parts of the AAI codebook to analyse therapy transcripts. More recently, Thomson (2010) describes using unresolved loss codes to inform clinical work and research with bereaved adults in the US, with therapists "trained to monitor the disorganised and disorienting lapses" (p. 910). However, there is little information in her paper as to how this was systematically carried out. There is, therefore, precedent for using the AAI coding outside of the context for which is was designed. However, Daniel (2009) identifies possible problems inherent in transferring elements of the AAI coding system directly to a therapy context, citing the findings of Westen, Nakash, Thomas & Bradley (2006) study where there was a mismatch between therapist and AAI coding; for example, therapists did not consider of idealisation of a parent in therapy as a dismissing strategy, whereas it is a key indicator in the AAI. Daniel (2009) suggests this may be due to context, and calls for more research to explore which AAI markers are valid in psychotherapy. This study begins to answer this call, by looking for evidence of narrative incoherence using the AAI Unresolved loss coding on therapy transcripts of bereaved families.

Another recent example of using AAI classifications and coding to inform data analysis is Bishop, Stedmon and Dallos' (2015) paper which examines at how mother's habitual attachment strategies (assessed using an Adult Attachment measure) influenced their narratives of their children's experience of cancer. The researchers coded the attachments style of their participants, then interviewed them about their experiences of having a child who experienced a 'threat to life' through cancer. The

researchers then analysed the narrative processes in the interview transcripts that were similar amongst those grouped with the corresponding attachment category (secure/insecure). Although a relatively small sample (6 mothers) they found that those with secure attachment strategies had clear, coherent narratives demonstrating balance and ability to reflect on their experiences. Mothers with insecure attachment strategies created narratives that were emotionally closed, used distancing language and had little evidence of reflection on their experiences. The two mothers in the sample who had a 'U' coding had the greatest difficulty creating coherent stories, with difficulties ordering events in a correct timeline, and giving very little details about events. This study provides some evidence for the thesis that attachment styles impact on narrative processes outside of the AAI itself and provides further precedent for using methods/coding from Attachment Theory measures to inform analysis of narratives created in other (non-AAI) contexts.

By analysing the bereavement narratives of families as told in therapy, this research will be able to examine both the content of the stories and the family communication patterns around the loss. The study will explore how the way the story is told and the communication patterns used are associated with the developing coherence of the family's story of the loss.

These interviews are 'snapshots' into the processes and experiences of a grieving family. This research is unable to ascertain how the families related to each other and created narratives before their loss, or indeed in the earlier months after the loss before therapy was undertaken. There is, therefore, much that is unknown about the family dynamics and the broader context within which these transcripts are situated. It may be that what is seen in the analysis are pre-existing relational and narrative patterns that may have been exacerbated or exaggerated by the loss; however, due to the aims of the research, it is the change in stories over time within the research project window that is of interest. It is impossible to know any further detail, without the family undertaking additional measures and tests. However, this 'snapshot' limitation is common to most research that is interview/session based as it is focussed on one specific time period. This research was solely focussed on exploring the idea of incoherence as understood by the AAI and change between two sessions, and a broader study of the family dynamics is beyond the scope of this study.

The qualitative longitudinal analysis engaged in in this study will seek to explore what Saldana (2003)

refs to as change through time; illustrating the process of change and showing the journey of the family as they negotiate their narrative of the bereavement. As narratives at the beginning and towards the end of therapy will be analysed, this approach reflects the conceptual stance of families as flexible and dynamic systems that adapt to change and new ways of behaving and making sense of the loss over time (Bowlby-West, 1983). Although longitudinal studies are standard in developmental research and are seen as an extremely useful tool for measuring change over time (Gillibrand, Lam & O'Donnell, 2011), longitudinal qualitative studies are not commonplace in counselling psychology research, which usually focusses on one-off interviews (Thomson & McLeod, 2015). By utilising a longitudinal analysis, it is possible to look at the change in the formation of the narratives and themes over the course of therapy and to consider their "ongoing, processual sense-making about their lived experiences of life transition" (Shirani & Henwood, 2011, p.18).

In summary, there is substantial empirical evidence that family bereavement makes children and their parents vulnerable to complicated/complex grief reactions and long term serious negative outcomes, that may be transmitted to the next generation. Grief theory and Attachment Theory converge to suggest that being able to tell a coherent story around the death is important for fostering positive outcomes. This justifies using an Attachment Theory framework to study the 'Telling the Story of the Death' intervention, which aims to foster such narrative coherence in these stories. However, Attachment Theory suggests that incoherent narratives are to be expected (and are normal) in the aftermath of death, so the first step in this study is to examine, using methods drawn from Attachment Theory, whether, as predicted, linguistic indicators of lack of coherence can be seen in the narratives of bereaved families (who are between 6 and 18 months after their loss). The second step is to examine whether there are shifts and changes in these narratives between the first and second tellings towards narrative resolution and coherence. And the final step is to see if there are specific actions by family members or therapists that help with a move towards coherence, or actions that are unhelpful and created further incoherence.

Research Questions:

1. Do family narratives at the beginning of therapy show signs of narrative incoherence/lack of resolution as predicted by Attachment Theory?

2. Is there evidence of shifts and changes in the stories over time that could be understood as reflecting a move towards greater coherence?

3. What actions by family members or therapists create coherence or incoherence?

METHOD

Epistemological Stance and Approach to Data Analysis

Attachment theory's epistemological framework was never made explicit; Bowlby was an 'eclectic' and drew on theories from psychoanalysis, cognitive-developmental psychology, control systems theory and primate ethology (Shaver & Mukilincer, 2009). Bowlby's partnership with Ainsworth who was an "astute observer and laboratory researcher…resulted in measures and research paradigms that appealed to empirically oriented researchers" (Shaver & Mukilincer, 2009, p.18). There are, therefore, assumptions that underpin Attachment Theory and associated clinical work. One of these is that 'Attachment' is a concrete concept that can be measured and is a perspective-independent and objective 'truth' (see Tables 3 and 4); this perspective on attachment places the construct within a realist/positivist paradigm. However, at the same time, attachment is not a fixed concept as therapeutic interventions can open the possibilities of change in attachment status. This possibility of change suggests that there may be flexibility within this concept and that 'attachment' may not fit neatly in a realist/essentialist/positivist paradigm.

Whilst acknowledging that the AAI and Attachment theory is a widely validated and profoundly valuable theory that underpins therapeutic practice and research, I also believe that individuals (and families) make meaning of their experiences within broader social contexts (Neimeyer, 2000). In this study, narratives have been generated within the family group and with the therapist-in-the-therapeutic setting, and this meaning making process is something I as the researcher acknowledge and influences my analysis of the data. In the analysis, there are elements of 'discovery orientation' (Willig, 2013), but this is within a larger context of recognition of the inherent subjectivity in the production of knowledge (Madill, Jordan & Shirley, 2000) and my own role as researcher in creating meaning and understanding in the analysis. Therefore, the philosophical and epistemological assumptions that underpin my particular study are captured by a broadly critical realist perspective (Willig, 2013) in which I acknowledge the

attempt to not 'objectively measure' through my analysis, because I value the interpretive process and interpretive application of theory to data. This epistemological stance reflects the strong values of inter-subjectivity and 'professional artistry' in research that are core to Counselling Psychology, whilst have the flexibility to draw on this hugely important and influential body of work of Attachment Theory.

Design

This study employed a longitudinal qualitative design, involving the recording of 'naturalistic' therapeutic data. The time between the beginning of therapy and end of therapy narratives was on average seven months. This made it possible to explore the change in the formation of the narratives and in the way the family told the story as the therapy progressed.

Recording of therapy sessions within therapeutic family work has a long precedent in the family therapy field with both audio and video recording historically being used (Draper & Dallos, 2010). The use of therapy sessions as data for counselling research is also on the increase (Peräkylä, Antaki, Vehvilainen & Leudar, 2008), with examples of such research including conversation analysis of couples' therapy transcripts (Sutherland, Sametband, Silva, Couture, & Strong, 2013), investigating in-session change processes with adolescents (Higham, Friedlander, Escudero, & Diamond, 2012), and examining process and outcome in clients with long-term health conditions (McLeod, 2013). By using in-session data in this project, this study adds to the growing field of in-session based psychotherapy process research and answers the calls for more such research to be carried out (Henton, 2012; Mallinckrodt, 2011, Scheel et al., 2011).

Theory-informed Thematic Analysis

The process of choosing a method of analysis was one that took extensive thought and discussion. As the analysis was to be informed by Attachment Theory and the AAI codes, initially I was intending to undertake theory-driven thematic analysis as described by Boyatzis (1998). However, this method of Thematic Analysis (TA) reflects the values of a positivist/quantitative tradition with an emphasis on coding reliability and has strong echoes of 'the scientific method'. There is little regard for subjectivity or the role of the researcher in the process of analysis and this is a very resource heavy approach as more than one coder is required, which is not suitable for a student project. On the other hand, a fully inductive (data-driven) approach to TA (Braun & Clarke, 2006) is not influenced by pre-existing theory. In

this style of TA, the analysis is not 'in' the data waiting to be found, rather the analysis is created by the researcher and the subjectivity of the researcher is integral to the process of analysis. This form of TA has been described as "flexible, straightforward and accessible" (McLeod, 2011, p.146) and therefore very suitable for a student project. Mortl and Gelo (2015) place TA on their psychotherapy process research "data analysis methods map" (p.396), acknowledging it as a suitable analytic method for psychotherapy process research. However, a fully inductive approach would not allow me to draw on the AAI or Attachment Theory and use them to inform my analysis.

I thus wanted to develop a more fully qualitative 'deductive' approach to TA that prioritised research subjectivity and interpretation, as well as theoretically flexibility, and accessibility. I needed to stay congruent with the strong values of inter-subjectivity and 'professional artistry' in research that are core to Counselling Psychology (BPS, 2005), and have the flexibility to draw on the hugely important and influential body of work of Attachment Theory. Braun and Clarke (2006) argue that their approach can be used deductively, however there are currently very few instances of deductive applications of their approach. I decided to use the Braun and Clarke (2006) approach as a framework for developing a deductive analysis of therapy transcripts informed by Attachment Theory and the AAI. Further details on what this involved are provided below.

Organisational setting

Winston's Wish is a registered UK charity and describes itself in its literature as "the leading authority in childhood bereavement and the largest provider of services to bereaved families in the UK. The vision is that bereaved children, young people and their families will receive the support they need" (Winston's Wish, 2010). The charity provides information and support in the areas local to their offices in Gloucestershire, Sussex and Manchester and offers face-to-face therapeutic work with families who have been bereaved through an accident or illness. Winston's Wish also offers support nationally through literature, a website and a telephone/email helpline and a national therapeutic team that works specifically with families who have experienced a death through suicide, murder, manslaughter or military action.

Winston's Wish's therapeutic work is underpinned by an approach that is, "non-pathological, respectful of the unique mourning process of the individual and mindful of the individual as part of the family and

the wider community" (Winston's Wish, 2014, p.136). The practitioners at Winston's Wish draw on the theories of the 'Dual Processing Model' (Stroebe & Schut, 1999), recognising the two processes involved in grief (loss orientation and restoration orientation) and using interventions that address both processes. For example, the Winston's residential weekend offers opportunities to talk about the deceased (loss oriented) but also to meet with those who have experienced a similar experience and to try new experiences such as rock climbing (restoration focussed). Winston's Wish also incorporates the ideas proposed by Tonkin in her paper, 'Growing Around Grief' (1996) that grief does not 'go away' over time, but life "grows around it allowing the process of integrating the loss with their lives and moving forwards" (p.10). The theory of 'Continuing Bonds' (Klass et al., 1996) is also key to the work of Winston's Wish, and informs interventions such as 'Memory Boxes' and 'Memory Jars', which involve children intentionally gathering, storing and treasuring all kinds of things such as letters, photos and items that remind them of their relationship with the person who has died.

Through its myriad of services, Winston's Wish seeks to support and educate bereaved children and their families (Humphrey & Zimpher, 2007). As an organisation it has five clinical objectives that centre on increasing opportunities for:

1) support, information and education for children and families to understand death and what it means to them;

2) understanding and expressing grief – encouraging children and families to share and understand the feelings, thoughts and individual ways of coping with loss;

3) remembering the deceased;

4) communication – encouraging family members to talk openly with each other; and

5) meeting others – providing opportunities to meet other families with similar experiences.

For families that engage with face to face work, there are various interventions offered. 'Telling the story' (which this study is focussed on) is a key intervention that is used with all families, usually in their first session. The aim of this intervention is to allow families to tell the story together of life before the death, the death itself and how life is now after the death. Usually two therapists are involved in this intervention, one therapist is guiding and facilitating the story telling, and the other is listening and taking notes. These notes are used to guide further interventions and the choice of support offered to the family. Families repeat this story telling at the 'Winston's Weekend' if they chose to attend, and

additionally for this project, families re-told the story together in an extra family session. This extra family session was added for the purposes of the study in order to have an opportunity to hear the story for the second time told as a family group. This decision was made after extensive discussions with the therapeutic team at Winston's Wish and came as their suggestion. The second telling of the story by family members usually occurs in peer groups when away at the Weekend (further details given below), and using this as data would have been problematic. Family members would have told their story in a group session alongside other clients who wouldn't have been part of this study, this would have led to complicated issues around gaining extra consent for that recording. There were also concerns about the appropriateness and possible confusion of recording just one story told in a group. An extra family session was agreed to be the most straightforward way to enable a second opportunity for the story to be told and recorded.

This additional opportunity for a second telling of the story as a family may have had some impact on the therapy for families, as the intervention isn't usually repeated with the family as a whole and it lengthened the therapy by one session. However, Winston's Wish work flexibly in order to meet the needs of the families they work with and there may be times they do revisit the story with the family when they feel it needs more time to be told and clarified. Feedback from the therapists involved was positive, and some found it useful to hear the story a second time, additional to the Winston's Weekend.

The Winston's Weekend is a gathering of families who have experienced a bereavement. Parents and children engage in different activities, some together, some in peer sessions. These include balloon releases, 'Telling the story' in peer groups, memory jars, 'Ask the Doctor' sessions where children can have any medical questions about the death answered by a doctor, wilderness challenges (such as archery, climbing), and the 'Bearduation' ceremony where presentations acknowledging achievements over the weekend are made. Other interventions that may be used in therapeutic one to one work with families or individuals may include role-playing techniques, music/creative writing/poetry, visualisations, activity books, cognitive restructuring and memory work. One technique that is referred to by one of the families that participated in this study is 'Rocky Rocks'. In this intervention, family members chose a smooth pebble (representing ordinary, everyday memories), a rough-edged rock (representing difficult memories) and a polished gemstone (representing precious, bright-shining memories). This facilities memory making and engaging with both positive and difficult aspects of the death and memories.

This project focusses on the 'Telling the story' intervention, which is one (albeit core) therapeutic exercise out of many used by Winston's Wish to help children and families navigate their own unique mourning process.

Participant Information

Inclusion/Exclusion Criteria

Newly referred families who accessed support through the Accident and Illness team in the Cheltenham office of Winston's Wish between April 2014 and June 2015 were approached upon approval from the Team Leader. If the therapeutic team felt that participation in the project would be detrimental to a family's therapeutic progress, then the family group was excluded from being invited to participate in the project. The therapeutic team excluded families who had experienced deaths that were very traumatic (e.g. suicide or manslaughter) or involved unusual accidents (for example a child who died by accidently strangling themselves with a shoelace noose).

Number of Participants

Five families were recruited (a total of six adults and eight children) and 13.5 hours of audio-recorded data was collected over 10 sessions. This amount of data is broadly consistent with the amount of data generated from the number of interviews or focus groups recommended for UK professional doctorates using qualitative methods (e.g. the 10-15 interviews recommended by Braun & Clarke would typically generate up to around 15 hours of data depending on the length of the interviews, and the 3-6 focus groups they recommend would generate around 3-12 hours of data depending on the length of the groups) (Braun & Clarke, 2013). A summary of participant information is detailed below in Table 5.

Table 5: Family details

Family name	Members present in the therapy sessions	Family member that died and relationships	Type of referral	Months between death & recording 1	Time between recording 1 & 2

1. **The Jones**	Katie (35) Mum Lucy (3) Daughter Alice (7) Daughter	Darren (37) Step-dad and partner	Illness	7	4
2. **The Smiths**	Andrew (41) Dad Chloe (7) Daughter	Sarah (38) Mum and wife	Illness	6	14
3. **The Roberts**	Rosie (47) Mum Suzie (16) Daughter Bradley (24) Son	Ed (51) Dad and ex- husband	Illness	6	9
4. **The Evans**	Sue (48) Mum Daniel (52) Dad Mike (17) Son	Tim (21) Son and brother	Accident	18	8
5. **The Adams**	Kevin (35) Dad Brenda (7) Daughter Steve (5) Son	Suzie (33) Mum and wife	Accident	10	1

The range of family members that had died were representative of the families usually referred to this team. However, the sample included a greater number of deaths due to illness rather than accident relative to all families referred between September 2013 and March 2014 (88% accident, 12% illness); this was due to the exclusion of families who had experienced traumatic deaths as potential participants. All the families were White British. The average time between the death and the first recording was 9.4 months (range 6-18 months), and the average time between the two recordings was 7.2 months. The average time between the death and the final recording was 16.2 months. It should be noted that the first recording, with the exception of one family, took place within the first year following the death, in a period in which it is broadly acknowledged that individuals will be struggling to come to terms with a loss and create a coherent narrative. In all but one case the second recording occurred after the one year mark (the exception was for Family 5 where the second recording happened at 11 months).

Using existing therapy sessions as research data in the current project reduced the impact on bereaved clients as they did not need to be interviewed additionally (Hynson, Aroni, Bauld & Sawyer, 2006; Rosenblatt, 1995) and it has added value as in-session data rather than interview data. It should be noted that the methodology of this study was developed following discussion with Winston's Wish and was designed to minimise the impact of the research on the participant families. This is an important consideration in the context of a participant group that is experiencing considerable distress. In addition, the design enabled the research to focus on a core therapeutic technique used in the organisation, namely the 'Telling the story' task, and thus provide important feedback which can be used to improve client care.

Ethical approval for the study was obtained from the University of West of England Health and Life Sciences Faculty Research Ethics Committee in accordance with the ethical code of conduct published by the British Psychological Society (BPS, 2009). Official organisation approval from Winston's Wish was also obtained (see Appendix Two). Consent was gained from the family members by a member of staff (key worker) from Winston's Wish at the assessment stage of their referral. This person was not the family's therapist to avoid a conflict of interest or the possibility of the family feeling 'obliged' or pressured to take part in the study. The staff member talked through the participant information sheets (see Appendix Three and Four) with the families and consent was obtained if the families elected to take part. If the families had questions that the key workers are unable to answer, the researcher's contact details were on the participant information sheets and they were encouraged to contact the researcher, which none of the families did. The information sheet also outlined the potential risks of taking part in the study, and provided details of further sources of support, including a contact within the organisation with whom they could discuss any concerns. Parental consent was obtained for using the recordings, and informed consent was also obtained from school aged children. The study followed BPS guidelines for informed consent from children: both seeking consent from the child, where possible, and their parents on their behalf:

"For children under 16 years of age and for other persons where capacity to consent may be impaired the additional consent of parents or those with legal responsibility for the individual

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should normally also be sought." (BPS, 2010, p. 16)

There was both an adult consent form, and a family consent form that was designed in conjunction with Winston's Wish (see Appendix Six). All family members needed to consent for the family to take part in the study. Therapist consent for using the recordings was also obtained (see Appendix Eight).

Right to withdraw

Participants were informed that they had the ability to withdraw fully from the study at any time up to the start of the coding of their transcript. During the processes of analysis, data were used to form codes and categories and it may not have been possible to withdraw all influence of the participant data from this process if participants chose to withdraw later than this stage. However, no quotations from a family withdrawing after the start of their coding would be used to illustrate themes or discussions about the data. As explained at recruitment, if they did withdraw from the study, the family was still offered the extra family session that they would have had as part of the study. This was the case with one family that did agree to be involved in the study, however the child became so distressed during the initial session the recording was stopped. This family withdrew from the study and did not complete a second recording. The data from this family has not been included in this study.

Confidentiality and Data Security

It was explained to families that all data collected would be used in accordance with the Data Protection Act (1998). This means that personal data has not been disclosed to anyone or used for any other purpose than was agreed with participants and no unanonymised data would be retained after the study concluded. To maintain anonymity and confidentiality, each family group has been given a unique reference code and individual participants given pseudonyms. Families were given a chance to choose their own pseudonyms at the recruitment stage and for those that did not choose their own, the researcher chose pseudonyms. The transcripts are anonymised and only the researcher and supervisors have seen them. The transcript included in this thesis has been provided unbound separately and will be destroyed after the examination to protect the confidentiality of the family. My analysis protects anonymity in terms of names of people, places and any other potentially identifying information following guidance in Braun and Clarke (2013). For example, one family discuss a final holiday taken all together. This holiday location, as well as family members' names, have been changed in the transcript to protect anonymity.

Transcription

The 'telling the story' intervention was audio-recorded and the recordings were transcribed using a 'thorough orthographic technique' based on Braun and Clarke's (2013) adaptation of Jefferson's transcription notation system (2004) (see Appendix Nine for a detailed overview of this notation system), which captures both the words and sounds spoken and some prosodic features of speech. Main (1994) stated that AAI interview transcriptions are transcribed 'verbatim' with all 'errors' and hesitations transcribed, meaning that mispronunciations, gaps/silences or stutters are noted. Transcription followed these guidelines and prolonged silences were timed and noted. Mid-sentence and end of sentence silences were timed and recorded in the transcript following the Braun and Clarke (2013) notation system.

Data Analysis

As noted above, the data were analysed using a theory-informed Thematic Analysis (Braun & Clarke, 2006, 2013). I implemented six phases of coding and theme development:

1. Familiarising yourself with the data and identifying items of potential interest
2. Generating initial codes
3. Searching for themes
4. Reviewing potential themes
5. Defining and naming themes
6. Producing the report

I began with familiarisation with the data (Phase 1), listening to the recordings and transcribing them, reading the transcripts and making note of any initial analytic observations. After this, Phase 2 involved generating initial codes and developing a 'code-book' (see Appendix Ten), which is not a feature of Braun & Clarke's (2006) approach but enabled the initial coding to have a start point focussed on the original AAI codes. This then guided the next phase of coding and was used across all the transcripts, keeping the analysis Attachment theory informed. The codebook was a working document which was added to throughout the coding process and contained all the codes created in the analysis.

The challenge at this stage of the analysis was using the original AAI codebook, which was designed for

use with transcripts from interviews conducted with one participant only, and applying this to transcripts of family therapy sessions. The coding was divided into a two-stage process. First, I developed codes directly from the AAI (as discussed in literature review: Table 4), and second, I created codes through a process of 'inductive-deductive' coding. I will now describe this process in greater detail.

In the first step of phase 2 (Generating initial codes) I used the 15 specific codes that capture instances of narrative incoherence from the loss/trauma coding section of the AAI. These were used as the 'deductive codes', and were largely 'cut and pasted' into the codebook from the AAI. I used my interpretative judgement to apply these codes to the data, for example coding silences of six seconds or more rather than 20-30 seconds as AAI coders would for individuals completing the AAI. The rationale for this developed as I listened through the recordings and noted silences that seemed 'appropriate' in terms of turn taking and the natural flow of talk between individuals. These contrasted with silences that were mid-sentence or were disruptive to the flow of talk. I timed these silences and found they were all six seconds or longer, so this became my criteria for coding. This is in line with other findings that silences over five seconds can be considered problematic in conversation (Jefferson, 1988) and that the 'usual' length for silences in psychotherapy conversation is two seconds (Berger, 2011). It was not my intention to code the transcripts as 'Unresolved' as would be the task of an AAI coder, but to use the codes to identify evidence of both coherence and incoherence in the narratives in line with my research questions. This stage of the analysis was discussed in detail with both my supervisors, one of whom is AAI trained, who were able to give feedback and guidance on the suitability of my coding.

The second step of phase 2 (Generating Initials codes) involved developing codes through a process of 'inductive-deductive' coding. These codes were grounded in the data but the interpretation of the data was informed by Attachment Theory and the Adult Attachment Interview codes. The flexibility of TA allowed me to create codes that captured therapeutic and family processes that the AAI was never designed to code, but which Attachment Theory gives extra weight to. An example of this is new code 'Therapist co-constructing disorganised narrative', which is informed by one of the original deductive AAI codes 'Indication of disbelief that the person is dead', but also captures the therapist's involvement in the story and the interaction, which co-creates the disorganisation. This new code shows the importance of the therapist using an appropriate wording when talking about the deceased. For example, in family one, when talking about the aftermath of the death, the therapist continues to talk about 'Daddy' going

from home to hospital rather than using the wording 'Daddy's body', which would be more helpful in terms of increasing the coherence of the narrative. This and similar examples are explained further in the analysis.

This second step of inductive-deductive coding in particular allowed me to identify and code the process of change across the sessions. I created codes such as 'Details missing from second telling', which reflect how stories may be retold in a more or less coherent way, in line with the aim to examine changes over time. I used the technique of 'story mapping' (Braun & Clarke, 2013) to map out the structure of the stories and the main events. I divided the stories into the 3 sections used in the Intervention: before the death, the death itself, and life after the death. I then summarised the story told about each section and the notable events and descriptions. This allowed me to take a broader view of the stories and to code if the structure or timeline between the first and second telling differed significantly, or if certain events or details were missing. These story maps can be seen in Appendix 11.

This method of a theory-led thematic analysis was robust enough to encompass the wide remit of this project. First, it allowed the use of an important and evidenced based theory (Attachment Theory) on different types of data. Second, the flexibility of inductive-deductive coding provided opportunities for the generation of new insights grounded in both the theory and the data. Third, the method acknowledged the role of the researcher in the analytic process, which, as noted above, is important for producing research that is of good quality and rigorous.

After the second stage of creating the codebook was complete, the codes and the corresponding data extracts were then examined for broader patters of meaning or 'candidate themes' (phase 3). After a process of review and refinement (phase 4 and 5), which included a full review of all the data, looking both within individual session transcripts and across the data corpus, four themes were generated. The writing of this report constitutes the final stage of analysis (Phase 6).

Reflexivity and Quality: Researcher as instrument

As a qualitative researcher, I am keen to engage in engage in what Wilkinson (1988) terms 'personal reflexivity'. This involves reflecting on my prior assumptions and motivations for engaging in the research

topic of my choice. I have not experienced the death of a close family member, so my motivation to pursue this research is not from an intimate personal experience. However, I have witnessed the impact of the death of a parent or sibling on friends and their families and felt some of the rippled effect of the traumatic event. This is coupled with my experience of clinical work with those who are bereaved, and an increasing awareness of the impact of disrupted attachment on my client's narratives and meaning-making in our work together. My interest in trauma and narratives was further developed during my second-year project on 'Father's experience of traumatic birth', where there was clear evidence of incoherence and disruption in the father's interview narratives resulting from the unresolved trauma related to the birth of their children. So all of these threads have come together, with an interest in trauma research and practice as well as a systemic perspective on family life (Stanton & Welsh, 2012).

My strong interest in the research area has helped me to be aware of my own values and assumptions in relation to the research questions. Although this research project was theory-informed, inductive thematic analysis was also part of the process of data analysis. As such, I acknowledge my role and part in the production of knowledge in this project. Alongside the analytic processes already described, I used the techniques of bracketing and journaling (Morrow, 2005) to keep the reflexive process at the forefront and help reflect upon the implications of the personal and epistemological assumptions that shaped the research. To ensure I have produced a good 'quality' thematic analysis I additionally carefully followed Braun and Clarke's 15-point checklist of criteria for good thematic analysis (Braun & Clarke, 2006). I discussed my findings with other researchers through various means, including research peer support and supervision. I also discussed my findings with the therapy team at Winston's Wish, providing a form of 'credibility check' (Elliott, Fischer & Rennie, 1999, p.222).

The process of writing up the research project was an interesting and demanding experience. Due to the distressing content of the sessions I have been particularly aware of my own process in terms of self-care and also in how I have felt whilst engaging with the data. In particular, I noticed during transcribing and coding certain parts of the stories, struggles to maintain concentration and finding myself getting up and leaving the room or distracting myself more than usual. I understand this now as a 'disconnection' due to the upsetting content, just as family members were seen to do in session. My own experience of research was paralleling the therapeutic process. Another experience of counter-transference was during one supervision meeting when we were reading through a transcript. Myself and my supervisors

all had a strong counter-transferential response of anger to a parent in the transcript which we expressed verbally to one another. This response mirrored one of the children in that family who was distressed but unable to use her words to express herself and was acting in a very angry and disruptive way during the session. I have judiciously allowed these highly subjective experiences to influence the research, allowing these 'highlighting' moments to focus my attention on particular aspects of the data during the analysis and these moments have therefore informed the coding process. In this process of remaining reflexive, I have thus recognised the impact of my role as researcher on the analysis and acknowledge my active participation in creating the analysis.

ANALYSIS

The final four key themes identified in the data were: 1) Evidence of unresolved loss; 2) Creating Incoherence; 3) Creating Coherence; and 4) Evidence of Coherence. In the following section the numbers after quotations refer to the family identifier and whether the quotation is from the first or second interview. For example, "Family 2/1" means Family 2 and the first interview. A line number from the transcript is also provided.

Theme 1: *It's all a bit of a blur:* Evidence of Unresolved Loss

This theme describes the way that unresolved loss, as defined by the AAI, is demonstrated in the families' stories. This theme reflects the results of the deductive analysis with most of the codes captured by this theme having been taken directly from the AAI and applied to the data. There were signs of unresolved loss in all of the family's stories, both first and second tellings, and the signs took three forms, which are reflected in the subthemes. Firstly there was evidence of incoherence in the monitoring of reasoning; for example, when family members referred to things that cannot be true in the external world (Main et al., 2003). Secondly, there was evidence of incoherence in the monitoring of discourse; this refers to a kind of absorption that takes the speaker out of the immediate and appropriate context (Main et al., 2003). The third subtheme captures the behavioural responses, such as how speakers expressed incongruous and inappropriate emotion and how they behaved during the sessions.

Most of the families' stories evidenced 'indications of disbelief that the person is dead'. Examples of this can be seen throughout the families' stories in both first and second tellings, reflecting the codes found in the AAI. Firstly there were 'slips of the tongue to the present tense'. This grammatical error in speech is evident in the transcripts when family members talk about the deceased. An example of this is shown in Family Two, when Dad (Andrew) talks about his wife who died of cancer six months previously: "The first pain (.) her worst pain is always in the morning" (Family 2/1 Line 832). This use of the present tense, rather than the past tense, to refer to the experience of pain is an illustration of a disbelief that his wife is dead and evidence of unresolved loss. In Family Three, Mum (name) also uses the present tense to describe the deceased Dad, and this gives the impression that he is still alive:

> Son: he was asleep on the sofa and he was making himself some soup and he wouldn't normally eat soup
>
> Mum: unless he's not well
>
> (Family 3/1 Lines 65-66)

Two further indicators of 'disbelief that the person is dead' seen in the data were talking as if 'the deceased is living a parallel life in the present' and 'being dead is an activity' (which involves referring to a dead loved one as having animate living characteristics in the present). Examples of both of these codes were evident in the stories, particularly when families were describing seeing their loved one's body for the first time after the death. In Family One, Mum (Katie) described her partner's body: "He was quite cold and different wasn't he so we put him in the blanket to keep him warm" (Family 1/2 Line 78). The idea that the Dad could feel the cold and needed to be kept warm even though he was dead illustrates the attribution of living characteristics to a dead body. In Family Three, when the Dad's body was returned from the hospital to the undertakers, Mum (name) uses language that creates the impression that he is still alive, and perhaps coming back from being away on a trip rather than having died:

> Mum: I was working on the Thursday and I just thought I just got this feeling (.) it was going to be the Thursday he's going to come back and I really don't to be at work when he comes back and family will wanna go up and see his Dad (.) and Wednesday night I was thinking do I wanna phone

up work and say I don't wanna come in because I know I just know that their Dad is going to

come back tomorrow (.)

(Family 3/1 Line 372-374)

Another element of lapses in the monitoring of reason in the families' stories was confusion in

separating self from the deceased. This is illustrated both by a change of pronouns and also attributing

actions of the dead person to oneself. One example of this is seen in a daughter's (Alice) description of a

poem her Dad had written before his death that a friend read at his funeral:

Alice: Um (.) this is a poem that he writ (.)

Therapist: Ooh

Alice: this is a poem that I writ about I knew my days would come at last that I would and he said

the person that was reading the poem said that "our Darren was a brave man because he knew

he was going to die someday really early" and he was only eighty thirty-eight

(Family 1/1 Lines 392-396)

This confusion between pronouns and authorship of the poem, although spoken by a seven-year-old, can

be understood as an example of incoherence and unresolved loss. Other aspects of the lack of

monitoring of reason expressed by the families were disorientation with respect to time and space:

family members described days passing in a "blur" (Family 1 / 2 Line 245). Psychological confusion was

seen in statements that were paradoxical or impossible such as: "I said 'it will be alright and you're going

to see this neurologist you'll be fine don't worry' and I knew he was- (.) I knew something was wrong but

I didn't know" (Family 4/1 Lines 217-218).

A very common indicator of incoherence in all of the families' stories was confusion around the timeline

of the death itself, and the timeline of events leading up to the death. Family members were confused

about what happened when, how old they were at certain stages particularly over longer illnesses, and

confused about events surrounding the death itself. This was seen throughout all the stories told, and

lead to a sense of incoherence in the narratives. Here two children, aged 7 and 5 (Steve and Brenda),

display confusion around the time of the death:

Steve: she was at the party

Brenda: we weren't at the party (.) we weren't at the party when mummy died

Steve: oh I forgot a bit

(Family 5/2 Lines 65-67)

In the following extract, Alice (aged seven) displays significant disruption in the timeline as she cannot remember a time before her step-dad was ill. The illness and death have become uncontained and stretched across all of her memories of her step-dad and their life together, leading to a huge confusion about the timeline: "I can't say how he was I can't say anythink about how he came became before he came ill and died 'cause he was already ill (.) even though I met him before" (Family 1/1 Line 18-19).

When Alice tells the story of the death for the second time, her story starts at the death itself, giving no story of life before her step-dad died. This confusion in the timeline leads to a very incoherent and incomplete story for her, cutting short her memories with her step-dad and providing only a very narrow and short story. As research has shown, placing the difficult events within a broader narrative of the 'rest of life' rather than being the focus is seen as a sign of coherence and important for future wellbeing (Tuval-Mashiach et al., 2004). Difficultly with this is thus an important marker of incoherence.

Confusion about the timeline was also displayed through events that were forgotten or partially remembered, as demonstrated by the following account told by the Mum in Family 3 of hearing the news of the death from a doctor on arrival at the hospital:

Mum: and he said 'unfortunately he didn't come through' (.) actually do you know what I can't even remember the exact words (.) I can't I can't remember what the doctor actually said (.) I remember the doctor sitting down and saying 'I'm really sorry he didn't make it-' or he might not even have told me that I cor- just- do you know what (.) I can't you know did he actually say anything

(Family 3/2 Lines 123-126).

Events and details being forgotten leave gaps in the timeline and result in a lack of detail and depth to the story, creating uncertainty and confusion. Episodic memories are important in creating clear and

coherent timelines (Ehlers & Clark 2000), so missing details such as these are also important markers of incoherence.

Subtheme 2: Sense of being overwhelmed: Lapses in the Monitoring of Discourse

The second subtheme is illustrated by examples of the families finding it difficult to monitor how they are forming their narrative. A common sign of incoherence in the stories was unfinished sentences and prolonged silences. Unfinished sentences are understood in the AAI to be evidence of the speaker being overwhelmed by the thought of the death and unable to monitor or repair their speech (Main, Goldwyn, & Hesse, 2003). Prolonged silences can be understood as moments of preoccupation with the death, and part of the 'freeze' mechanism that is triggered when talking about distressing material (Hesse & Main, 1999, 2006). In this study, as noted above, silences longer than 6 seconds were coded and considered to be indicators of incoherence. Unfinished sentences and prolonged silences were spread throughout the narratives, but concentrated on particularly difficult parts of the story as demonstrated below in these two extracts from Family One:

> Mum: They were just in hospital (.) umm ((long pause 6 seconds)) just checking on his body (.) making sure everything is working as it should have been (.)
> (Family 1/1 Lines 281-282)

> Alice: so I said 'is Daddy dead' and Mummy- (long pause 6 seconds)
> Therapist: Hum
> Alice: And Mummy nodded (.)
> (Family 1/2 Lines 73–77)

Unfinished sentences were also common in the stories, both in adults and children's contributions. When Mum (Rosie) in Family Three described her children visiting their Dad's body, she found it difficult to monitor her speech and there was disruption as sentences were left unfinished: "and then they went to see- I think he'd- I was at work when he- when he came back (.) and I-" (Family 3/2 Line 314). In Family One, when Mum is talking about the cause of her partner's death, she is also unable to finish her sentence, which leads to an incoherence in the story as the rest of the detail isn't given:

Alice: um is this what Darren happened (.) is it where he had his lungs and they stopped (.) and his kidneys

Mum: yeh his body jus-

Alice: yeh

Mum: yeh

(Family 1/1 Lines 218-221)

Family members also display incoherence by going 'off topic' mid-story-telling. An example of this from Family Five's first recording that takes place at the Winston's Wish office in Cheltenham. The family are talking about the Mum's funeral and the details of how her body was dressed and put into the coffin:

Dad: no no you dress her outside the box and then put her in

Brenda: so outside the box

Dad: uh huh (.) and then place Mummy in nice and cosy and comfy

Brenda: why is there poo on the window

Therapist: because there are some birds that fly by that window that's why there's poo on that window

Brenda: is that Saint Greg's church

Therapist: ah I'm not sure (.) I think it's Saint Martins (.) so after mummy died you went to (.) she was at

(Family 5/1 Lines 935-938)

It seems that Brenda is unable to maintain the conversation about her Mum's body and she switches off topic, literally 'out of the room', to the bird droppings on the window. Main et al., (2003) consider that when a speaker wanders to irrelevant topics or suddenly changes topic when creating a narrative, this is due to a lack of monitoring of one's own speech. This is caused by the speaker losing touch with the present context due to the distressing content. This diversion away from the distressing content can be understood as a small dissociative act, regulating the affect of the speaker by changing topic to something less distressing and manageable (Parkinson & Totterdell, 1999).

Other signs of incoherence through a lack of monitoring of discourse were the use of 'poetic phrasing', which has a eulogistic sense to it, or a feeling of words being rehearsed. In a couple of the narratives, the children acted out scenes from the story showing 'an unusual attention to detail'. In one session, which was taking place at home, the child moved to the actual chair her Dad died in and showed the therapist how her Dad was sitting when she found him dead (Family 1/1 Line 317). Another child makes the sounds of the machines used in the hospital, the MRI machine and the ventilator, these sounds interspersed the dialogue that continued between the other family members (Family 5/2 Line 231). Both of these examples can be understood to be evidence of the speaker giving unusual attention to details, no longer aware of the present context and reliving the past.

Subtheme 3: Trying to see things in a normal light: Behavioural Reactions

The inductive-deductive codes that form part of this subtheme are concerned with how family members tolerate and express emotion in the course of the story telling. There are moments of appropriate laughter and humour as families tell their stories such as when mother and daughter in Family Three are laughing about their experiences of Zumba (Family 3/2 Lines 455-462). However, there are times when there are giggles and laughter when talking about the death and these instances of laughter occurred when telling difficult parts of the story, and there was a feeling of mismatch between the content of the story and the emotion being displayed. Mum from Family 1 demonstrates this contrast when describing who came to the house as soon as the Dad's body was found: "(.) yeh (.) Jane came (.) Aunty Steph came (.) (Laugh) then luckily everyone went home. It was quite a (.) I mean cos everything was fine" (Family 1/1 Lines 374-375). She then continues to describe the Dad's funeral saying: "(Laughs) I've never seen so many people in one place (Laughs) ha-ha" (Line 448). This laughter paired with this content creates a confusing mismatch between the events described and emotion. As found in other research, laughter when talking about the death are signs of incoherence and unresolved aspects of the loss (Dimaggio & Sermerai, 2004; Lyons-Ruth, Yellin, Melnick, & Atwood,2005; Marvin & Pianta 1996; Salvatore et al., 2006).

The final and very powerful example of evidence of unresolved loss seen in the data is the code 'family member physically leaves the room'. There are examples of family members disconnecting from the story telling by moving out of the room in three of the families, all of these are in the first sessions. The

first recording of Family Four takes place in the family's home. At the point in the story when the Dad is talking about finding his son's body, the Mum leaves the room taking the pet dogs outside. She gives no verbal indication for her reason for leaving the room. Later on in the session when the youngest son is talking about events that may have contributed to his brother's death, the Dad is heard on the recording getting up from his chair and can be heard moving things and banging in the distance. He then returns a couple of minutes later. There is no explanation given or permission sought of other family members or the therapist, nor does the therapist comment on either of these 'breaks' from the session. This physical response to distressing content can be understood as intolerance of difficult emotions and having to disconnect from the narrative as it is too overwhelming (Parkinson & Totterdell, 1999).

The theme 'evidence of unresolved loss' combines examples of how the families' stories are formed in ways that provide a sense of incoherence and confusion. Given the context of these collaboratively told stories it would not be possible to formally code the family members as 'unresolved' with respect to loss, but the presence of a lack of resolution in the form of these narrative indices is important to recognise and evidences the idea that there is still therapeutic work to be done to enable these families to tell their story in a way that is more coherent and resolved.

Theme 2: *Obstacles and mismatches:* Creating Incoherence

Theme Two, Creating Incoherence, reflects the actions of family members and therapists that maintain the incoherence that is already present in the stories. This theme describes what family members and the therapists do in the sessions that makes the creation of a coherent and collaborative story more difficult. This includes non-collaboration between family members (through exclusivity insight or knowledge) and resistance as well as therapists' contributions to creating incoherence.

There are examples throughout the narratives of resistance by the parent to providing further information to their children, which leaves the children with gaps in their timeline of the death or vague about the details of the death. An example of this is in Family One, when Alice is talking about the date of the funeral:

    Alice: Wednesday sixteenth

Therapist: Oh yeh do you remember it was a Wednesday

Mum: (laughter) I can't remember

(Family 1/1 Lines 265 – 267)

The Mum's response resists giving further information or confirmation of the facts, which would arguably be appropriate here as her daughter is seeking clarification. The Mum's resistance gives Alice a message about the unimportance of details, and creates incoherence in the telling of the story of the death. Research shows that stories with fuller detail and a clearer timeline structure lead to better outcomes for families (Figley & Kiser, 2013), so resistance by parents to giving their children information is significant. Lack of clarity around details is also seen in Family One with the use of non-specific language and words such as '"horrible things" (line 365) and "nasty stuff" (line 342) to describe the medical equipment and the attempts at resuscitation. Appropriate details and clear understanding of events are vital for a coherent story (Ehlers & Clark 2000). Although this may be understood as a mother's attempt to protect her daughter from details about the death, and telling her children that their step-dad was just asleep, the mother has left her daughter confused and without a clear story of her own. She then resists giving further information when asked directly by her daughter:

Mum: I mean it was weird for me because I couldn't panic (.) I just had to make sure didn't see what I call the horrible things

Alice: what was the horrible things

Mum: Just things you didn't need to see darling um (.) (*addressing the therapist*) to both (.) just asleep (.) um (.)

(Family 1/1 Lines 364-369)

This lack of clarity of information given by parents to their children is understood by Shapiro (1994) as the result of the "needs, projections and instructions of adults" (p.86), but it is hugely disruptive to sense making and coherence for children who rely on their parents for much of the information about the death. Later on in this story, Alice describes her own fears about going to sleep at night, suggesting possibly that the use of unclear language by the Mum has had a direct impact on Alice's behaviour. This creates even further incoherence, as Alice now has anxiety and misunderstandings about the nature of sleep. The difficult aspects of the story need to be talked about, otherwise the event cannot be

transformed into a 'neutral narrative' nor synthesised into a wider context and story with a past, present and future (van der Kolk & van der Hart, 1989).

In Family Four, the parents describe reading the coroner's report that gave further details of the events surrounding their eldest son's death. When the therapist asks the 17 year old son about the document, he states: "I've never read the report (.) I've never um well actually I was never offered it really (.) I was never given the chance to (.)" (Family 4/2 Lines 713-714). He goes on to say that he "sort of knows the details" but the parents do not then respond to this with a follow up question or offer any further details to the son in the session. Not giving children full details of events in an age-appropriate way perpetuates mystery for them, and does not allow them to create a coherent account of what happened. Children need accurate information about the death so they can avoid 'magical thinking' or filling in the gaps with misinformation that may lead to self-blame for the loss (Howarth, 2011; Lampton & Cremeans, 2002). Withholding details also results in the creation of a story where a family member professes to have exclusive insight or understanding about events, meaning there cannot be a co-created story as details are not shared. This can also be seen in stories when one member stated they had a sense the person would die or was dead before other family members knew.

In most of the families' stories there are disjunctures between children's and adult's memories; different family members remembering different versions of the events. There are also examples of disagreement between the members of the family as they tell the story, over both factual events and interpretations of the events:

> Dad: Chloe was in the house at the time (.) weren't you darling (.) but you didn't see Mummy c- c-collapse but um
>
> Chloe: neither did you
>
> Dad: No (.) I kind of did darling
>
> (Family 2/2 Lines 466-469)

This is to be expected to some extent within a family group; however it is the resistance to allowing all parts of the story to be told that creates incoherence. In Family Four, a significant factor contributing to incoherence is resistance by the Dad to parts of the son's narrative in the family story. The son, Mike,

speaks openly regarding his brother Tim's financial issues before his death but Dad strongly resists his son's understanding of some of the events:

> Mike: I always find there's one person who always speaks about the time when he actually died and that's Mum's Mum my Grandma…..and she told me he had lots of money troubles and he was pretty sort of stressed out on money problems (.) which did make a lot of sense as to-
>
> Mum: hmm
>
> Dad: he didn't really (.) but anyway (.)
>
> Mike: he-
>
> Dad: he phoned me the week before he came home
>
> Mike: he-
>
> Dad: to say that a package was (.) sorry
>
> Mike: he didn't have any money troubles (.)
>
> Dad: well he was (.) no (.) he was only as much as he had no money like all students I mean
>
> Mike: yeh I know [[but he was really]]
>
> Dad: [[he wasn't massively in debt or anything]]
>
> Mike: he was very stressed about by that apparently
>
> Therapist: yeh it might have caused him anxiety mightn't it
>
> Mum: okay
>
> Dad: [[yeh yeh]]
>
> Mike: [[yeh yeh that's what]]
>
> Dad: yeh yeh it did it did
>
> Mum: yeh
>
> Dad: it did it did (.) but he wasn't massively in debt or anything (.).
>
> (Family 4/2 Lines 169-183)

Dad is extremely dismissive of Mike's view initially and continues telling the story his way. Mike repeatedly interrupts his Dad to have this dismissal addressed. Dad does partially concede; however, this part of Mike's understanding and narrative is not truly included in the family story. Dad minimises the impact of the possible financial stress and does not allow it the causality that Mike attributes to it. Mike's search for meaning and sense making is disrupted by Dad's disallowing of this part of the narrative.

Research shows that seeing eye to eye with family members and having a congruence in the story may be more important for adjustment and wellbeing than the interpretation given to the event, even if this is a positive one (Davis, Harasymchuk, & Wohl, 2012). A family's ability to allow a variety of perspectives in a story is disrupted by trauma and loss (Kiser, Baumgardner, & Dorado, 2010), so by continuing to disallow a 'full' story, even if this includes negative interpretations of the events, the incoherence is perpetuated.

Another feature of this theme of creating incoherence is parents reshaping the story to match their own understanding. In Family Five, the children have been talking about seeing their Mum's body in the open casket, and Steve (age 5) had already described his sister Brenda (age 7) as being scared and not wanting to kiss the body, and Brenda agreed this was right, she had been scared and had been slower to kiss her mum's body than her brother. However, Dad then goes on to tell this part of the story differently:

> Dad: the kids got to go and say their goodbyes and they weren't a bit scared and they were constantly kissing her (Family 5/1 Lines 822-823).

This 'rewriting' of the story denies the children validity in their emotions around a particularly difficult point and creates dissonance between their experience and what is being told as the family story. This can be understood as a display of 'misattunement' (Fonagy, Gergely & Jurist, 2002) from the Dad to his children's story and emotional state.

Dissonance is also created by parents not tolerating distress or being emotionally dismissive towards their children in sessions. One parent (Family Four) uses the phrase 'anyway 'repeatedly to start sentences redirecting away from emotive material such as whether the son had financial difficulties. In Family One, Lucy the youngest daughter (age 3) although not actively engaged in creating the verbal narrative, is still present for the session and impacts on the story telling process. There are some really chaotic passages in the session where Lucy is clearly very distressed, but this is not acknowledged nor brought into the story telling. At one point Lucy asks "where my Daddy" (Family 1/1 Line 64), and this is not answered or addressed by anyone, including the therapist. Lucy continues to disrupt the session as it goes on, and adds to the incoherence of the narrative. Often the dialogue is interspersed with her crying and at one point Alice (age 7) has to shout to make herself heard above Lucy's noise when clarifying with her Mum the actual date that Dad died. Mum's response to Lucy is anger and discipline rather than

comfort or involvement in the story in an appropriate way. This demonstrates Mum's lack of ability to engage emotionally with her children at this time and to empathise with their distress in an appropriate way. Mum has to leave the session with Lucy and this adds to the incoherence as they are no longer present for a part of the story telling. There is a strong sense of emotional disconnection between mother and child and there are no instances of Mum offering comfort to either child, nor offering sense making to them. Although there is evidence of Mum actively encouraging Alice to engage in the process, Mum is emotionally withdrawn and passive in response to both current distress and accounts of distress.

As well as being emotionally dismissive, the mother in this family creates incoherence by having a strong emphasis on the 'good girl' behaviour displayed by her older daughter Alice; particularly at the funeral and in relation to Alice's return to school in the second telling of their story. In contrast to the first telling, the elements of the story that are important to Alice and show personalisation and ownership of the story such as her descriptions of their shared pets or using rich descriptive language are missing. It can be understood that this 'grown up good girl' talk acts in a dismissing manner as it has squashed the sense of creativity and engagement that was present in Alice's story before in the first telling. It also creates an incoherence in the story as the child's individual narrative is subsumed into the mother's narrative of 'everyone doing well'. There is a sense of emotional shutdown and Alice now expresses resistance to talking about her step-dad:

> Therapist: Does it help talking about Daddy or is it difficult?
>
> Alice: Urm (.) I don't like speaking about it because I don't like sharing it
>
> Therapist: I'm sorry you don't like sharing it
>
> Alice: Yeh
>
> Therapist: but is it ok to talk to Mummy and Lucy about it
>
> Alice: No
>
> (Family 1/2 Lines 375-382)

Alice's reluctance to talk about her Step-dad results in a shorter and less complete narrative. This may be a sign of traumatic grief as the details and remembering become triggers and are therefore avoided (Brown, McQuaid, Farina, Ali, & Winnick-Gelles, 2006). In line with this understanding, at the end of the

second retelling, Alice describes avoidant behaviour at home and school to deal with her sadness and distress.

This theme of creating incoherence also describes action taken by adults: the therapists; parents or sometimes parents and therapists together. In some stories, parents use exclusive adult language which leaves the child out of the story, for example, medical terminology that is not understandable by the child, such as specific names of drugs or treatments. Other instances of adult exclusivity are phrases used that create 'in-jokes' between parent and therapist. In Family Two, the Dad is talking about a cruise holiday the family took together before the death of his wife that had been recommended by his father-in-law. He says:

> Dad: Sarah's father was (.) for want of a better phrase (.) a serial cruiser
> Therapist 1: Ha-ha
> (Family 2/1 Lines 273-274)

Although this may be understood as a harmless joke between adults, or even strengthening the therapeutic relationship, it has the possibility of disengaging the child from the process of story-telling as the language used is not understandable by them, nor co-created.

In two of the families' stories, the therapist is involved in the co-creation and maintenance of a disorganised narrative. This is primarily through the use of unclear language when talking about the dead body. In Family One, the level of incoherence in the first story is high, and at points the therapist is party to creating the incoherence. In this extract, Alice and her Mum are talking about what happened to the step-dad's body once he had died:

> Mum: And that was before no that was after Daddy had gone
> Alice: yeh
> Therapist: And where did Daddy go to
> Alice: hospital
> Therapist: ah so the ambulance took him
> Alice: yeh

Therapist: ah ok

Mum: it was (.) it wasn't the ambulance that took him was it

Alice: what was did it

Mum: it was the funeral people wasn't it

(Family 1/1 Lines 144-153)

The language used gives a sense of 'aliveness' to the Dad and we could easily believe they are referring to the step-dad going to hospital because he is unwell until the Mum mentions "funeral people". The therapist is pulled into this incoherence and instead of using a phrase such as 'Daddy's body', which would clearly indicate that he was dead, she continued to use language such as 'him' that perpetuates the incoherence and disbelief he is dead. This resembles Salvatore, Dimaggio & Semerari's (2004) findings regarding the impact of disorganised narratives on therapists: experiencing feelings of confusion and chaos and at worst being pulled into behaviours that become anti-therapeutic.

Another way in which families create incoherence in their story telling is by missing out significant details in the second telling of the story. As part of the analysis, I used a story mapping technique (Braun & Clarke, 2013) to map out the structure of the stories and the main events. By creating story maps of first and second tellings, I could compare and note where the stories significantly differed from each other. The story map for Family One is included in the Appendices (Appendix Eleven). Some stories had a natural degree of variation between the first and second telling resulting from a particular family member not being present for the second telling (Family 1 and 3). This in itself is not seen as evidence of incoherence. However, when significant details are missing this creates distinct differences between the first and second telling potentially leading to incoherence.

In the attachment literature, there is evidence that those with dismissive status tell shorter stories with less emotional content (Steele & Steele, 2008). Examples of significant variations between stories are different starting points, the second telling missing the earlier parts from the first telling, or significant details missing such as the Grandma being in the house when the son died (Family Four), or the emotional richness and expression created by Alice (Family One) in her first telling that is absent from the second telling. When Alice describes the time she 'found out' Daddy was dead, there is an element of fear and distress in the narrative. This emotional richness and description is missing in the second telling.

Also missing from the second story are details of the poem read out at the funeral and the card Alice wrote and placed on the coffin. These are very intimate and descriptive details of the story for Alice, which would hopefully be remembered and recounted confidently, but are missing from the second telling. In the first telling Alice is creative in her descriptions of grief, using descriptions of bubbles and angels. But in the second story there is a profound sense of loss, avoidance and loneliness. These missing details are thus an important part of the theme of creating incoherence.

Theme 3: *Getting the story straight*: Creating Coherence

This theme describes the positive acts carried out by those involved in the story telling that help the family move towards coherence, both in how the story is told and what words are used. Thus it describes what therapists and family members do in the sessions that help to create a coherent and collaborative story of the death. This theme includes interventions that therapists are trained to use in general therapeutic settings, such as reflections, asking clarifying questions, empathic responses, as well as using verbal prompts to elicit further narrative or support the telling of a difficult part of the story (Worden, 2008). These interventions are recorded in the codebook (see Appendix Ten). However, in this part of the analysis I will focus on the more context-specific interventions that were evident in the data and that seem to be particularly helpful in this bereavement-focussed setting. I will then move on to look at what the families themselves do to help create a more coherent story; skills that they use that help them move forwards in their story telling.

Throughout all the sessions, therapists used the technique of 'psycho-education to the model' to help facilitate the story telling process. Therapists described the story telling task the families will be engaging in, and the way in which the story could be told. Therapists tailored the way this was communicated to each individual family, giving an introduction to the task in a way that was easily understood and developmentally appropriate. In a family with young children, the therapist says at the beginning of the first session: "okay (.) so this bit of work is thinking about what happened when your Mummy died" (Family 5/1 Line 3). The task is clearly stated: "we're going to think about it in (.) th- three sections okay (.) we're going to think about what life was like before (.) what you know about what happened at the time (.) and how things are for your now (.) okay?" (Family 5/1 Line 5-8). By giving a clear outline and task for the work, the frame for a coherent story is set up (Kiser et al., 2010). Therapists are clear in their expectations and in the time boundaries set: "usually what we do we might allow 45 minutes an hour for

you guys to talk about what has happened" (Family 3/1 Line 6). Therapists give the family an idea of what they might experience and normalise any strong emotions that might be felt. In Family Three with two teenagers the therapist is sensitive to potential age related concerns: "yeh and we said we take it in your time and your pace (.) and it is okay if people get upset" (Family 3/1 Line 6).

Therapists also give voice to the possibility that there may be difference in people's stories: "so it's really important for us not to assume it's exactly the same for everybody" (Family 4/2 Line 26). They explain that the purpose of the task is to: "talk about what the two of you remember so there's no right or wrong erm you just may remember different things" (Family 1/2 Line 255). In Family Four, the therapist emphasises that each family member will have experienced the events surrounding the death in a different way, and explicitly states that the purpose of the session is to create "a common story" (4/1 Line 3). The use of the technique of 'psychoeducation to the model' by the therapists is vital for creating coherence in the task, and giving structure and containment for the families' stories, whilst acknowledging the process of co-creation that will hopefully take place. Kiser et al. (2010) described this process of family story telling as: "encouraging the family to appreciate that each member of the family is a partial knower… growing in appreciation for their multiple viewpoints" (p. 247).

Another important part of the theme of Creating Coherence is therapists giving factual details to children and using age-appropriate explanations and language. An example of this follows where the therapist is explaining to Alice (age 7) the factual details of what happens when somebody dies: "when um (.) people die their bodies stop working (.) the heart stops beating (.) and you don't breathe anymore (.)" (Family 1/1 Lines 387-391). This level of explanation is particularly found in the families with younger children and those with younger children who weren't present at the death. The therapist also gives clarity around names of drugs and medical tests, as well as names for funeral specific events: "they travel behind in a big black car which we call a hearse" (Family 5/1 Line 95). Giving children factual detail and language to use to describe events helps create a coherent and fuller narrative (Stokes, 2004).

Alongside using clearer language and factual details to help children understand the events of the death, therapists also makes sense of the story and reflect this back to children. This occurs where the story is incomplete or the child has no memories of part of it. With Family Two, the therapist makes sense of the gaps in the story for Chloe (age 7) who was a toddler when her Mum was diagnosed with cancer: "so you

were very very small so you probably don't remember any part of this part of the story at all" (Family 2/2 Line 44-45). As well as offering sense making to the child, the therapists also 'check in' with children and adults to find out about their own process of sense making during the sessions. For example, the therapist asks Alice (age 7) directly: "does it makes sense?" (Family 1/ 2 Line 176) when they are discussing the difference between ambulance personnel and funeral directors. Sense making is also combined with reassurance giving in the first session with Family Four. Both of the therapists present in this session speak and offer reassurance and a 'professional' perspective to the family, which promotes sense making. The therapists explained how mental health professionals assess risk, and that the decisions the family made to encourage their son to sleep were the right ones in the circumstances. This 'reassurance giving' and 'professional perspective' was not evident in other family sessions, and perhaps the uncertainty surrounding the death (the son was reported missing before his body was found in a river) in this family provokes the therapists to take this position. This reassurance and sense making role is not repeated in the second telling; perhaps the family have less need of it from the therapists as their story has become more coherent.

Another intervention used by therapists to help create coherence is giving children an understanding of their own emotional processes and experiences of 'symptoms' of grief; a form a psycho-education. In Family One, Alice (age 7) is talking about worries that her Mum or sister might die that are disrupting her sleep. The therapist explains to her why this might be happening: "we think if it's happened to someone we love (.) it might happen to other people around us" (Family 1/1 Line 574). The therapist also gives an explanation of intrusive images: "and sometimes what happens when we talk about those things memories or images might even come back about that day or about what ha- has happened" (Family 1/1 Line 486). By acknowledging and validating these experiences, the therapist helps the child to makes sense of their experiences and allow these into the story in a coherent way.

An important bridging intervention that therapists use that creates coherence is that of 'tasking the parent to give explanation and details to the child'. Here the therapists are acting as 'scaffold and bolster' (Kiser et al., 2010), activating the families' skills to tell a story by inviting parents to explain parts of the story to their children. The therapist could choose to take on this explanatory role but instead chooses to explicitly place the parent in the role of sense-maker and information giver. This choice of intervention is important as it increases coherence in two ways. Firstly, it allows the parent to

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successfully fulfil this function, giving a sense of empowerment and ability, as well as allowing them to learn this as a skill to use again in the future. Secondly, it leads to the enhancement of connections between family members and strengthening of attachments as the parent meets the needs of the child, giving clarity and reducing confusion and anxiety. An example of this is in Family Two, where the Dad has a tendency to use medical language, which is hard for his young daughter to understand. In this extract, he is talking about the treatment the doctor had planned for his wife:

> Dad: He arranged to fix the breaks but he took what was called a biopsy where he was going to examine what was around there and do some tests to see if there was anything more sinister or bad there
>
> Therapist: just to stop you there Andrew (.) do you know what a biopsy is or an MRI is (.) do you know what a biopsy is
>
> Chloe: no not really
>
> Therapist: no (.) would it help if Dad explained to you what a biopsy means cos sometimes you hear new words and sometimes we forget what they mean (.) yeh
>
> Dad: my understanding of what a biopsy is is that it is an exploratory operation where
>
> Chloe: exploratory
>
> Dad: exploratory sorry another long word (.) is where they have a look at (.) they have a look at
>
> (Family 2/1 Line 20-29)

The therapist intervenes and invites Andrew (the Dad) to explain the medical terminology to his daughter. As we can see from the above extract, the Dad is prompted to explain, but he struggles to use better age appropriate language using the word 'exploratory'. However, this intervention by the therapist gives the child confidence to then ask her Dad for even more detail and explanation, questioning the meaning of the word 'exploratory'. Although not a 'smooth' transition, the Dad has shifted from a position of having exclusive understanding and his daughter being confused, to sharing and explaining it with his daughter (with some help from the therapist), and together creating a clearer and co-created story in which all family members have taken part and engaged. Giving detail when telling the story of the death is vitally important for creating coherence. Sharing details can trigger new information, insights, emotional states, and uncover thoughts and beliefs held but not shared (Figley & Kiser, 2013). Giving detail can act as an invitation, allowing further processing and understanding.

Therapists also create coherence by connecting disconnected family members back into the story. Family members became disconnected for a variety of reasons. This included because the content was overwhelming. In some families disconnection occurred when one family member was very dominant in the story telling and other members had little 'space' to contribute. In Family Four, the therapist's role is one of including the son's voice, connecting him and helping to create room for him to speak by asking him specific questions, which allowed him to have his narrative heard alongside his that of his parents. Research shows that stories which include the voices of all the family members are more collaborative and lead to better outcomes for families (Bohanek, Martin, Fivush & Duke, 2006).

The theme Creating Coherence also applies to family members' activities within the sessions. One way that parents help create a coherent story with their children is by offering the therapists a 'translation' for phrases used or comments that a child may make that may only be understood by the family. An example of this may be unique names for family members like nicknames. By giving the therapist further information, the therapist can continue to be connected to the story without having to ask for further details. Family members also create coherence by giving further information to the therapist about culturally specific events, such as 'memorial cards' in the Catholic tradition (Family Five), or details about the scene of the death that wouldn't be known to those outside of the family, such as a house having two staircases (Family Four). These 'translations' help create a story that can be understood by those outside of the family. This serves to create a story that is coherent and accessible to others; a story that can be told and understood.

Theme 4: *I can see it's been really difficult for her*: Evidence of Coherence

The final theme in this analysis describes evidence from the therapy transcripts reflecting a move towards a collaborative and increasingly coherent story of the death. These signs of progress encompass how the story is told by the family, how therapy is understood by the family and used as a resource, the management of emotion in the session and evidence of reflective functioning in the parents. This theme describes what we would hope for in a well told and coherent story.

Families that told a more coherent story often used the term 'we' when describing events. The language used to form the sentences in these story is profoundly important when understood through an

attachment lens. Research shows that those individuals with a U coding for unresolved loss use distancing language when undergoing the AAI, for example, the use of more frequent second-person pronouns (Borelli et al., 2013). This means the use of 'we' (the first person plural) by families can be understand as a move towards coherence and a resolution of loss.

When the term 'we' was used, it generally when talking about events in the story: "we parked in the car park didn't we" (Family 3/1 Line 117), as well as when describing how they all felt: "cos obviously we were distraught" (Family 4/2 Line 449). One example of a shift from an individual to family story, from an 'I' to a 'we', is in Family Two's second telling. Dad is describing the last holiday the family took before his wife died. Earlier in the session he'd said that he'd known that it was going to be their last holiday together. His daughter Chloe (age 7) then says she also thought it was going to be their last holiday too, and he responds to her by saying, "she knew this was going to be our last holiday (.) we we felt it really" (Family 2/1 line 579). This use of the 'we' to acknowledge and describe them all sharing this sense rather than just the adults knowing, gives a sense of togetherness, shared experience and coherence.

Other signs of coherence include agreements between family members, for example when discussing whether Alice slept in her Mum's bed the night Dad died:

> Therapist: Did you stay with her the whole night?
> Alice: Half the night
> Mum: Half the night
> (Family 1/2) Line 138-139

Particularly in this family, which has difficulty in creating a well ordered and coherent story, moments of agreement bring the family members together, creating a mirroring effect between mother and daughter.

Alongside agreement between family members, recognition and acknowledgement by parents and children of the differing perspectives of the story are signs of coherence. This was seen when family members recognised that the story of the death might start in different places for each of them due to circumstances or knowledge. In Family Two's second story the Dad explicitly states this: "for the majority

I can see (.) Chloe's memories are a lot more recent (.)" (Family 2/1 Line 126). When family members can acknowledge the difference in understanding and perspectives, this shows an ability to hold other's perspectives. This is similar to the skill of 'agility' in family story telling; described as the ability of a story teller to imagine alternatives to their own perspective (Kiser et al., 2010). The Mum in Family Three gives a good example of this when talking about hearing the news that her ex-husband had gone to hospital in an ambulance with chest pains. She was not too concerned, "because it didn't once cross my mind that nothing else but whereas Suzie said she just knew that you know he wasn't coming home" (3/1 Line 186). The Mum can hold both perspectives of that event, hers and her daughters, and offers both of these in the story telling, indicating coherence.

Another sign of coherence in the stories is seeking clarification from other members of the family and checking out of memories. This can be understood as the story being told more collaboratively, with invitations to other members to adjust or amend it as they want to. The story is allowed to be flexible and alterable, acknowledging that other members of the family may remember things differently:

Steve: and then an ambulance came and Daddy came back from the chippy (.) is that right Daddy (Family 5/1 line 52)

Dad: but um (.) he went to bed on the Saturday night (.) to watch a film with you didn't he about eleven 'o' clock (Family 4/2 line 216)

This seeking of clarification may also be understood as reassurance seeking from each other as they tell their traumatic story, connecting the family members together.

Another indicator of a move towards coherence was seen when new details were added to the story the second time it was told. This was greater details about the story that had been remembered, or seen as more important as time had passed and added in the second time the story was told. One example of this is when the daughter in Family 5 recalls when she was asleep at her Gran's house and found out her mum had been in an accident. This detail was not included in the first story. Another example of new details would be talking about the flowers at the funeral (Family 5) or friends that visited soon after the death (Family 4). See below Table Six for a summary of changes in the stories from first to second telling.

Table Six: Summary of changes in families' stories between first and second tellings

	Changes over the tellings
Family 1 *4 months between recordings*	This story shows the least movement towards coherence of all the stories. Life before death totally omitted from story, story shorter and significantly less descriptive. Details of funeral are missing, such as details of the poem and the card daughter wrote and placed on coffin. Mum talks about her 'being a good girl' and being 'grown up' at the funeral. Daughter talks more about days after the death and feeling 'smothered' at school and being distracted from her work. Talk about missing Daddy's cooking, Mum acknowledges daughter finds it hard to talk about her stepdad, and daughter agrees, doesn't like sharing it or talking with mum or sister but will if she needs to, says 'We need to move on'. No reference to after-life or sense of closeness to Dad as before. No reference to work with Winston's Wish.
Family 2 *14 months between recordings*	Daughter more involved in this telling, but unclear where to start the story as 'Mummy had been poorly for a long time'. Dad explains medical language to daughter more easily this telling with help of therapist. Story more focussed on key events, less details of the protracted illness. Daughter remembers funeral clearly and more details about the day and about the internment of the ashes. Reflective of their process, and different emotions – happy and sad, and how helpful the Winston's Weekend was, using techniques at home and celebrating anniversaries both happy (birthdays) and sad (Mother's day), daughter says 'we need to move on'. Story told more easily and clearly, with more involvement from daughter.
Family 3 *9 months between recordings*	Daughter gives more details about the day Dad died, including practical jokes he played on her and a friend, accessing happy memories. Less crying in this session. Same key elements of events, more information about how youngest son responded to seeing body at funeral home and questions he asked. More info about events at the funeral and the wake, like the bouncy castle and seeing their grandad cry. Lots of reflection about how life is now, how they miss their Dad and his role in their life. They can laugh now, but also tears when they visit the cemetery is usual but okay. Importance of Winston's input and support, particularly the Weekend, refer to the techniques as a family and would like further input for the son in the future.
Family 4 *8 months between recordings*	Story details before and about the death similar; however, Grandma staying the night is omitted from second telling. Mum speaks less and Son's voice feels louder and more confident, challenging Dad more in second telling and questioning. Fuller details about after the death and police involvement. Son talks about family friends visiting and showing them where the accident happened, aware he was trying to make sense of things himself – more reflective than first telling, and more engaged in the process. Less crying as telling story and therapists offer less reassurance and clarification as it is not needed as much as before. More information about places ashes scattered, and talk of sense of presence and memory making. Son reflects on his process and aware he tried to avoid telling his friends, but he did in the end. Whole family reflects on changes in relationships, loss of connection with some people,

	strengthening with others. Therapist recognises that family has shared different aspects of the story this time, no unexplained exits from the room.
Family 5 *1 month between recordings*	Story much clearer and ordered, no one left the room nor examples of stark avoidance in the story telling, mainly the children telling the story as before. Less questions from children to Dad in the session as they had been answered in process of first telling. Less detail about before the accident, and no acting out but all able to give much more information about the tests done and treatments doctors tried in the two day 'gap' that was discovered in the first telling. This made the timeline more coherent and children were confident in their telling. Clear information about the funeral and more detail about the wake that didn't feature before. Reflection about life after Mum's death, which was missing from the first telling, about how they miss their Mum and say a special prayer for her every night. Also, reflection on emotions – that they are sometimes happy and sometimes sad.

An important part of creating coherence is evident when families are able to display their ability to notice, feel and express emotional reactions during the session. Parents who are both able to tolerate distress in their children and model feeling and expressing difficult emotions help create a story that is fuller and more coherent. Mum in Family Three illustrates this well: "it's not wrong to talk about things and not wrong to talk about being sad and... and it's okay to be upset as well and it's um (.) and you sort of (.) I feel quite sad today" (Family 3/2 Line 398-400). There are few instances in the study where children are able to name their emotions in their stories, which is in line with previous research findings (Fivush & Sales, 2003). However, when children do name their emotions, it adds a depth and congruence to the story telling. When asked by the therapist: "How is life now", Chloe (Family 2, age 7) answers: "well it's a bit sad and (.) um but we still need to move on so I've had happy times with Isabelle (a school friend)" (Family 2/2 Line 164). Chloe (age 7) is able to recognise both feelings of sadness and happiness and articulate those clearly in context of her story and how life has changed since her Mum has died. Steve (age 5) in Family Five is able to identify and name how he's feeling and the reason for it: "I know why I'm sad (.) because we don't have a Mummy anymore" (Family 5/1 Line 1189). Children's ability to label feelings appropriately after a bereavement is seen as a sign of adjustment (Dunning, 2006) and adds a depth to the narratives, which promotes coherence and integration of emotion into the story.

As well as family members being able to express how they are feeling and why they might be feeling this way, a clear sign of coherence is the parent expressing empathy for their child. This only occurred in two of the families. In Family Three, Mum was able to identify how her children were feeling and express it: "you could see in their eyes they looked so sad" (Family 3/2 Line 352) and this adds detail to the story.

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She later goes on to describe how she misses being able to speak to the children's father: "and then I think (.) god I bet they feel the same" (Family 3/2 Line 32). This mother is able and willing to enter into the emotional world of her children and reflect this back in the story telling with them. This demonstrates a level of resolution and coherence in her story. When talking about the moment his wife died, Andrew (Family 2) recognises that his daughter might be upset as she hears this bit of the story being told. He asks her: "how are you feeling darling" (Family 2/1 Line 1794-795). This ability to recognise the impact of the story on the child and to check in with her shows an ability to hold his daughter's emotional state in mind.

Another example of the move towards coherence is a parent offering comfort to their distressed child during the session. Kiser et al. (2010) state that for stories to be told in a coherent way, family members "must be able to recognise and respond congruently to the affect expressed" (p. 245). The following extract illustrates this occurring in Family Three when the daughter is talking about hearing the news of the death of her Dad:

> Suzie: I didn't wanna hear it (.) that he'd gone (long pause 11 seconds, crying)
> Mum: do you want some tissue
> Suzie: Uh-huh
> Mum: I'll get meself a box while I'm there
> (Family 3/2 Line 65)

The Mum notices her daughters' emotional reaction, responds sensitively and appropriately to it, and normalises and validates her emotional reaction by suggesting she may need some tissues herself. There is emotional connection and support between mother and daughter at this point, comfort is given and received. Kiser et al. (2010) compare a family who is able to co-regulate affect within a coherent storytelling to the responsive, repetitive dyadic interactions used to encourage internalisation of emotional regulation within the infant-caregiver relationship. This ability to co-regulate affect is disrupted by trauma and loss, so the presence of this is a clear sign of a move towards coherence and resolution (Kiser et al., (2010). Fiese and Marjinsky (1999) have found that families who are better able to regulate affect during co-constructed family narratives have children who display fewer behaviour problems, supporting the idea that the way in which emotion is handled within family narratives is

critical and those that can manage it in an empathic and sensitive way are moving towards a coherent story and better outcomes.

Another aspect of coherent stories in this study was acknowledging the value and usefulness of therapy for the family. The family members describe the therapy sessions as: "quite cathartic actually" (Family 4/1 Line 735) and effective: "I could say it works 100%". (Family 3/2 Line 509). Integrating their current experiences of therapy, of the here and now, into their story demonstrates a wider timeline and broadening of the experience of the death of their loved one to include life afterwards. This shows a siting of the story within a broader context and reflection on their difficulties and emotional states, which required additional support. Interestingly, two families describe using therapy techniques at home. Andrew described his experience of a Winston's Wish weekend, saying: "one of the things I took away from that weekend was the idea of compartment boxes" (Family 2/2 Line 184-185). This refers to the idea that memories can be contained and revisited in a positive way, but also that life can move on with new experiences. By including therapy in the story the family acknowledges the role of Winston's Wish in the 'after' section of the death story and engages in an acknowledgment and acceptance of the journey they've been on, and that help and support was sought and received.

A really touching example of a family utilising therapy techniques at home is in Family Three. One of the teenage children (Tom) hasn't wanted to engage in therapy, but because the Mum and daughter Suzie talk about what they've been doing in sessions, he can connect to the process. They speak about the 'Rocky Rocks' technique (Stokes, 2004) for talking about feelings and special things in which the rough-edged rock represents difficult memories, a smooth pebble represents ordinary, everyday memories, and a polished gemstone represents precious, bright-shining memories:

> Mum: and although he jokes about our stones
>
> Therapist: (laugh)
>
> Mum: 'what's your rough stone today then mum'
>
> Daughter: (laugh)
>
> Mum: but then I tell him (.) 'Well what's your smooth then' (.) and he'll joke about it but deep down you know (.) he'll say 'Am I your gem' (.) 'Are you my gem' (.)
>
> (Family 3/2 Line 420-424)

This family are able to use what they've learnt in session to continue to explore how they're feeling, and offer this to other 'disconnected' members of the family. They have internalised the support given and are using it in their everyday lives, demonstrating integration and coherence of the story.

Another aspect of coherence is evidence of memory making within the families. This takes the form of celebrating special days that remind them of the deceased family member, for example birthdays, anniversaries or specific remembering at Christmas time (all of the families were culturally Christian). This is the opposite of avoidance and key in maintaining a healthy continuing bond with the deceased, which is fundamental to Winston's Wish's philosophy (Stokes, 2004). In Family Two, Andrew for example talks about how they remember his wife on their significant days and that they have different ways of celebrating different days:

> Dad: We do have a point of doing things on anniversaries (.) we have the two sad anniversaries are obviously the anniversary of Sarah's death and Mother's day are two tough days for us
> Daughter: and her birthday
> Dad: well her birthday is a tough day but what we try and do with her birthday is happy things isn't it that's why I didn't mention that then (.) we did um (.) we did on her birthday last year we went to the Zoo
> (Family 2/2 Line 201-207)

Other families describe memory boxes or special items such as photos, which they use to remember their loved one. All of these can be understood as evidence of a coherent story with the deceased remembered and their memory integrated into their lives going forwards.

The final aspect of the theme Evidence of Coherence is the ability of parents to think reflectively. There were examples of this firstly in their own thinking and process, secondly with regard to their child's process and needs, and thirdly in awareness of the role changes and difference in life for the family now. As previously noted, this can be described as 'reflective function' and metacognitive monitoring (Main et al., 1995). Reflective function (RF) is defined as an overt manifestation, in narrative, of an individual's mentalising capacity, which is the capacity to reflect on one's own mental experiences (e.g., beliefs,

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emotions, desires, and needs) and those of others (Fonagy et al., 1991; Fonagy et al., 2002). This ability for parents to reflect was not common within these stories, and this is not surprising due to the major disruption within the attachment system for all of those within this study. The death has left family members with a lack of resolution, which means that they are unable to access their metacognitive functioning easily. As can be seen in the data, when parents are able to use their reflective functioning, this can be understood as a sign of coherence and progress towards resolution of the loss. Importantly, not only is this evidence of reflective functioning a sign of coherence, but it also promotes further coherence when acting in a mirroring way towards their children.

In two of the families, parents showed an ability to think about thinking and reflected on their own process in the session. In Family Two the Dad reflects: "I thought I was better than I was and now in hindsight now we're through 2015 I think 2014 was very tough" (Family 2/2 Line 178). This is an example of representational change (Main et al., 1985), the Dad is able to see change through time and process. During the first session with Family Five, Dad talks about the two days his wife was in hospital in a coma before she died. He states that he had never thought or spoken about his experiences of those two days with anyone including his children: "I think I was in a bad place at that time and I never wanted to go back to it (.) and you've made me think about that now" (Family 5/1 Line 1217). In talking about the death and the events surrounding it during the family session, the Dad has recognised how he was feeling at the time and how that influenced his thinking and processing of that part of the story. He acknowledges that talking about that time with the therapist and his children has allowed him to think differently about it, and integrate it into the story. Semerari et al. (2003) describe this as understanding one's own mind with respect to relating variables ie change over time; taking into account how his emotional state at the time influenced his thinking and his behaviour and how this can be different now. Coherence was also demonstrated though the ability of parents to reflect on how they might have done things differently in the past. In Family Four, the Dad speaks about the night his son Tim died: "and you know in hindsight what we should have done is said to you 'if Tim starts acting strangely come and wake us up' (.)" (Family 4/2 Line 221). This is not an unreasonable thought and demonstrates reflective capacity in the parent with hindsight as they tell their story.

There were examples in three of the five families of the parent's ability to be aware of their children's own grief process. In Family Three, the Mum was able to describe her response to finding her son

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Googling 'What happens to your body when you die?' she states: "I was like (.) ugh and I just think ah and you forget don't you that they wanna know they wanna know" (Family 3/2 Line 224). Mum is able to demonstrate thinking about her son's thinking and being aware of his needs whilst he is grieving. This can be understood as an example of 'decentration' (Semerari et al., 2003), where she is able to understand that her son seeking more information about the process of bodily decay, although she may find it distasteful, as demonstrated by the 'ugh', it is important for him and his process of understanding and making sense of what he's seen in the funeral parlour. In Family Four, Dad is able to recognise that his son may need to attend a separate Winston's Wish event for teenagers. In the session he says to his son Mike: "it's entirely up to you" (4/1 Line 916), acknowledging Mike's own autonomy and individual grief process and needs. One mother was able to reflect on how the death has impacted on roles within the family. She talked about how her son cannot speak to his Dad about sport anymore: "that's really sad because I don't understand rugby (laugh) and they wind me up about it (.) (Family 3/2 Line 358).

This final theme, evidence of coherence, reflects the hopeful signs of a move towards a more coherent and resolved family story. Family members are more aware of their emotions and more able to express them, telling a fuller story including the value of therapy and their continuing healthy bond with the deceased. Parents are less preoccupied with the loss and more able to act in a reflective and emotionally present way towards their children, which promotes coherent thinking and behaviour.

DISCUSSION

The aim of this research project was to utilise the framework of Attachment Theory to examine: 1) if there was evidence of narrative incoherence in the stories told by bereaved families; and 2) whether there was evidence of shifts and changes in the stories over time that could be understood as reflecting an increase in coherence, which might indicate a move towards greater attachment security and resolution of the disruption caused by a death in the family. The analysis shows there was some evidence of narrative incoherence in all of the families' narratives in the first telling of the story of the death and that on the whole, there were changes in the stories on the second telling that reflect an increase in coherence. This can be seen in Table 11 in the Appendix. The analysis produced 4 themes: evidence of incoherence, creating incoherence, creating coherence and evidence of coherence. In this discussion I will explore the relevance of the findings for both Attachment Theory and the practice of family therapy

with bereaved families. Implications for counselling psychology practice, training, and counselling psychology as a discipline are also examined. Finally, limitations of the current study and further research recommendations are discussed.

Overview of Key Findings
The Relevance of the Findings for Attachment Theory

Attachment Theory predicts that death of an attachment figure leads to a disruption in the IWM and that this in turn will lead to incoherence in speech about that person, particularly in the more immediate aftermath of the death. One of the key aims of this study was thus to examine if there was evidence – as predicted by Attachment Theory - of narrative incoherence in the stories told by bereaved families. The findings of this study have clearly demonstrated that incoherence and evidence of unresolved loss can be found in the stories of the death told by bereaved families who were providing their narratives on average 9.4 months following the loss. This finding was generated through the use of 'U' codes from the AAI which have been transferred out of their original context (AAI interviews) and used on family therapy data. The project thus also demonstrates that these codes can provide a meaningful framework for making sense of therapy data. Some researchers have suggested that attachment patterns explored by the AAI do not influence discourse outside of an AAI interview, proposing that there is something 'intrinsic within the interview itself which is a necessary part of the process of classification' (Hughes, Hardy, & Kendrick, 2000, p.282). However, the findings of this study suggest otherwise. In these stories, the families' narratives demonstrated examples of all of the different types of incoherence included in the AAI codebook: lapses in the monitoring of reasoning and discourse as well as behavioural reactions. Previous research has also shown that unresolved loss codes can be identified in transcripts of an individual's clinical treatment sessions (Thomson, 2010). Therefore the findings from this study add to the body of evidence demonstrating the value of AAI coding outside of the AAI interviewing process. The presence of these linguistic markers additionally demonstrate that an 'unresolved' narrative is created not only in the AAI interview setting or individual therapeutic settings but also in a family therapy setting as well.

As well as supporting the theoretical premise of Attachment Theory, along with its assumption of the existence of IWM underpinning the creation of a coherent narrative, these findings add to the theoretical understanding of the (attachment) incoherence that follows loss, and how it can be

promoted and maintained. Not only is incoherence demonstrated through individual narratives in this study, but also, as can be seen from the analysis, incoherence is manifested in behaviour and seen interactionally between and within family members, providing evidence of the co-creation of attachment in families. These findings illustrate how incoherence is evident both in the 'talk' and behaviour of family members when talking about the death of their loved one. Baradon and Steele (2008) identify behaviours (as well as narrative) in infant-parent psychotherapy that they understand as demonstrating representational knowledge (i.e. IWM) through "action and enactment" (p.209) in therapy sessions. These include FR behaviours/parental anomalous behaviours (as discussed in the introduction) such as moving away from the infant without cause and dissociative 'blind moments'. The findings of the current study show examples of incoherence enacted between family members such as adults resisting giving further information or resistance to hearing or discussing certain parts of the story, and adults reshaping the story or being emotionally dismissive. The behaviours that are demonstrated in these sessions can be likened to the FR behaviours (or parental anomalous behaviours) identified by Abrams et al. (2006) that are proposed to 'transmit' unresolved loss from parent to child. Some of the interactive patterns found in the families' narratives are also subtle, brief and unmonitored by the parents, such as the prolonged silences or unfinished sentences (parallels with the FR dissociative 'blind' moments). However, some are more overt, such as disagreement about the facts or leaving the room during the session (parallels with FR backing away from a child). Whether subtle or overt, these actions all create further incoherence.

These are aspects of incoherence that could not be present in an individual narrative as they are interpersonal manifestations of incoherence. Using an attachment-informed analysis has thus allowed these broader aspects of incoherence to be recognised and understood within the context of a family's bereavement narrative. The findings have implications for Attachment Theory as they suggest ways that those in attachment systems can collaboratively create incoherence and perpetuate lack of resolution by resisting the process of resolution. As well as broadening our understanding of what how incoherence manifests in family stories, the findings demonstrate how coherence can be increased or decreased in the telling of the stories. These findings show the impact of other people's interactions on the coherence of a story as it is told, and demonstrate the idea of co-construction of coherence. As Neimeyer et al. (2006) argue, the self-narrative is "always extensively co-authored by relevant others" (p.130), and the findings of the current study show that the families' narratives can be impacted by interactions with others, which lead to a more or less coherent story. This is an important idea for Attachment Theory that

historically has tended to focus on assessing attachment status in individuals (babies, young children, adults); the focus in this study on the attachment system at a time of crisis (following family bereavement) allows a systemic understanding of attachment to emerge. As discussed below, this systemic understanding also has significant implications for family therapists seeking to intervene effectively with families experiencing attachment disruptions.

The findings of this study show that following a period of therapeutic input, most of these families were able to tell an increasingly coherent story over time. See Table Six on page 109 for summary table of changes between first and second tellings. In this study, evidence of coherence was demonstrated through how the family told the story, therapy being seen as a resource, the management of emotion in session and evidence of reflective functioning in the parents. These elements of coherence have been identified in both a family context and in a therapeutic context, adding a wider understanding to the original individual interview based understanding of coherence proposed by the AAI. The original AAI is not designed to be used as a clinical tool with an individual, and it focusses on the narrative created by an individual, with coherence measured by the discourse created in that research interview setting. In this study with families, evidence of coherence has additionally included the interpersonal dimension of the story-telling process as well as the discourse itself. These findings echo those of Davis et al. (2012), who show that the co-constructive and interpersonal aspects of storytelling (such as shared meaning and agreement) are important in promoting a resolution of loss and increase in coherence in family stories.

The findings also demonstrate that reflective functioning (the capacity to reflect on one's own mental experiences and those of others) in parents is an important feature of telling a coherent family story. Research shows the importance of an adult's reflective functioning in outcomes for children (Fonagy, Target, Steele & Steele, 1997). In particular, recent research shows that mothers who can demonstrate reflective functioning specifically when talking about their own traumatic childhood experiences have infants with more secure attachments (Berthelot et al., 2015). Although families in this study were talking about current experiences, the significance of reflective functioning for children's outcomes can be seen in the findings. For example, reflective functioning enabled parents to reflect on their own process in session and also to be aware of their children's grief process. Not all families demonstrated reflective functioning, but when they did, it added to the coherence of the story. Reflective functioning has been shown to develop through psychotherapy (Hörz-Sagstetter, Mertens, Isphording, Buchheim &

Taubner, 2015; Gullestad & Wilberg, 2011) and the evidence and development of reflective functioning can be understood as an important indicator of coherence in a bereaved family's story telling. Recently there have been developments in using treatments that work to develop reflective function and focus on improving mentalisation skills. For example, a mentalisation-based treatment with families has been developed (Asen & Fonagy, 2012); to date, however, there is little research regarding reflective functioning and mentalisation specifically in bereaved families. This study thus usefully gives some examples of what reflective functioning looks like in family grief work; including parent's reasonable reflections on events, parent's reflecting on their own process, parental awareness of their child's need and their awareness of role changes.

Another important aspect of the findings in terms of Attachment Theory is the presence of continuing bonds and memory making as evidence of coherence. Continuing bonds describes the restructuring of the relationship with the deceased rather than relinquishing the bond. Attachment Theory (Bowlby, 1980) historically included the proposition that once an attachment figure was deceased, the bond must be severed to promote an adaptive grieving process and updated IWM. However, researchers have proposed that Bowlby was not so clear that this severing was possible or advisable, and have argued that ultimately he acknowledged that change in the nature of the attachment bond, rather than its severance, was the critical goal of grief (Stroebe & Schut, 2005). In this context, the aim is that the relationship or 'bond' with the lost loved one should be internalised, maintaining psychological rather than physical proximity to the attachment figure. Other ways of maintaining a continuing bond may be to take the deceased as a role model, remembering and appreciating their unique legacy, or cultivating a sense of the figure's comforting presence at times of stress (Field, Gao, & Paderna, 2005). Previous research on bereavement outcomes state that fostering a constructive and continuing bond with the deceased is important for both children and adults (Dallos & Vetere, 2009; Klass et al., 1996), and that a major feature of an adaptive continuing bond is that it occurs in the context of healthy communication among family members (Field, 2006). The findings of this study echo this research, showing that families who have more coherent stories talk about their continuing bond with the deceased, and remember and mark special dates such as birthdays and mother's or father's day. The importance of fostering continuing bonds is a fundamental theoretical premise of Winston Wishes' work with families (Stokes, 2004) and there are opportunities throughout the therapeutic family work to develop and express this

internalised relationship with the deceased. This in turn, has an impact on the narratives created by families in therapy, increasing coherence.

Relevance of the Findings for Therapy with Bereaved Families

The findings of this study give support for the utility of the intervention studied – the bereaved family telling the story of the death of their family member. Other forms of therapy such as Cognitive Behavioural Therapy (CBT) ask clients to engage with difficult stories. For example, Foa's rape protocol places a large emphasis on retelling the story of the rape in great detail (Foa & Rothbaum, 1998). Narrative Exposure Therapy (Schauer, Schauer, Neuner & Elbert, 2011) also bases treatment on retelling the story of the trauma, focussing on particularly emotive parts, and placing these in an ordered timeline. The theoretical understanding is that clarifying details and engaging with strong emotional reactions helps to bring resolution of traumatic memories and experiences. In the same way, by having a fuller story of the death, families create greater narrative coherence and, it is theorised, foster better resolution of the family death by being aided to collectively enhance attachment security following disruption of the attachment systems in the family through family bereavement.

It is common for bereavement therapy to focus on telling the story of the death. This intervention has been shown to be a significant moderator in the outcomes of grief-therapy (Goenjian et al., 1997; Neimeyer & Currier, 2009; Rosner et al.,2010). The findings of this study thus add to the body of research that demonstrates that it is important and helpful that families tell the story of the death in bereavement work. Additionally, the findings of this study give more detail and understanding of *how* this intervention creates coherence and helps families become resolved in their stories, and also of the role of the therapist in this process.

I shall now go on to discuss in greater detail the implications the findings have for therapeutic practice.

Implications for Therapeutic Practice with Bereaved Families

Attachment Theory has long been proposed as a useful framework for therapists and researchers (Bateman & Fonagy 2005; Fonagy, 2001; Holmes, 2009; Main & Goldwyn, 1984) and John Bowlby himself was a psychoanalyst and psychotherapist (Slade, 2008). Eagle and Wolitzky (2009) state that the ideal relationship between Attachment Theory and therapy is to: "sensitise therapists to certain issues and

phenomena and to provide a new perspective" (p.373). Researchers have suggested that listening with attachment organisation 'in mind' can be helpful for therapists (Levy et al., 2006; Slade, 2008). Slade (2008) calls for clinicians to be exposed to the methods and measures of attachment research so that they can use these methods to inform clinical listening and formulation. The specific recommendation of "tracking attachment processes in language" (Slade, 2008, p.773) has been used as a broader term to encourage therapists to pay attention to the words used by clients and their patterns of thoughts and feelings, with this awareness of attachment processes helping the therapist to: "understand the dynamic patterns that evolved in early childhood" (Slade, 2008, p.773) and which may influence the therapeutic work. Thus there is a history of using Attachment Theory and methods and even (informally) attachment codes as a way to understand clients presenting for psychotherapy in terms of how past relational experiences may impact on the present therapeutic relationship. The findings of this study sit within this tradition of using Attachment Theory and methods to inform clinical work (Slade, 2008). I will now discuss how the findings of this study can directly inform therapists' work with bereaved families.

This study has used data from the therapy intervention 'Telling the Story', which is used by Winston's Wish in their work with bereaved families. The results suggest that, for these families at least, this was a beneficial intervention. The second telling of the story as a family group is however not normal procedure at Winston's Wish; typically family members tells their stories again in same-age peer groups (with children and adults separate) within the context of a Winston's Weekend. However, the study suggests that the practice of telling the story of the death and then re-telling it again *as a family* within a therapeutic setting is a potentially useful and valid one. This gives evidence of the value of this intervention with bereaved families. Additionally, the study suggests that bereavement work with families may benefit from including more than one opportunity to tell the story as a family group, alongside existing individual/peer group opportunities.

The findings of this study also provide practically useful information that can be valuable for therapists in formulating their work and guiding their approach to interventions with this client group. I shall now present three specific ways in which the findings could directly influence practice. First, the findings show the importance of the speech and behaviours within the therapy session itself that are indicators of a lack of resolution. The markers of incoherence found in the narratives can be 'red flags' to therapists. This could 'cue' them that there is lack of resolution and incoherence in the story. These

markers can suggest the things to listen for, and where they are clustered, understanding these as areas that might need focussed work in terms of clarifying, adding detail, reflecting or sense making. This is similar to the idea of 'hot spots' in trauma work (Ehlers & Clark, 2000). These markers are listed in Table 6 below.

Table 6: Markers of incoherence and unresolved loss (Red Flags) *

	Marker of incoherence and example	Notes/examples from data
Monitoring of reasoning	Slip of the tongue to present tense	'He is' not 'He was'
	Deceased and speaker living parallel lives in the present	'Daddy is watching' This is to be understood within context of continuing bonds
	Being dead is an activity	Wanting to keep the body warm after death
	Change of pronouns/attributing deceased actions to self	I wrote/He wrote I died/He died
	Timeline confusion – dates/events leading up to death/own age/when death occurred	
	Paradoxical/impossible statements showing confusion Intentional, unwriting or undoing of history or aspects of it	'I knew something was wrong, but I didn't know'
Monitoring of discourse	Unusual attention to detail – acting out scene of death, reliving the past in details so as to bring the person to life again or poetic phrasing Speech more appropriate for written text, eulogistic feel, sense of it being 'rehearsed'	For example, acting out scene of death or using words that seem age inappropriate (e.g. 'everyone smothered me')
	Prolonged silences either at end or mid-sentence	Six seconds or more in a family context
	Unfinished sentences/trail-offs	

Behaviours	Giggles/laughter/incongruous emotion when talking about the death/difficult event	
	Family member physically leaves the room or goes significantly off topic during distressing content	
Therapist Counter-transference	Therapist co-constructing disorganised narrative	'And where did Daddy go to' instead of using the term 'Daddy's body'

*The lighter boxes contain codes taken directly from the AAI Loss Codes. The darker boxes contain codes that were from the inductive-deductive coding and are derived (bottom-up) from the data.

The second way in which the findings may directly influence practice is through therapists using the markers to guide the choice of intervention. This study highlights the importance of the interactions between family members, both helpful and unhelpful, thus such an awareness can directly inform practice. For example, if one family member's perspective is regularly dismissed this will add to the formulation and understanding of the family's unhelpful dynamics and resistance to creating a more coherent family story. The findings additionally suggest useful interventions that help promote connection between family members and which (in turn) allow for a more coherent story to be told. Thus, therapists may choose to intervene at more incoherent points in the story and model the use of clear language (e.g. avoidance of euphemisms for death or explanations about processes that follow a death such as arrival of undertakers). Alternatively, therapists may promote connecting behaviour with the intention of helping the family to retell the story in a more coherent way, such as the therapist asking the parent to explain a part of the story or a specific word to the child.

Table 7 lists the processes that occurred in sessions that created further incoherence, and suggests interventions the therapist may use to promote coherence.

Table 7: Processes that create further incoherence and suggested interventions

Sub-categories	Creating incoherence (Theme 2)	Suggested intervention (Creating coherence, Theme 3)
Missing info	• Children left vague about details or with gaps in timeline • Details lost from the narrative during second telling • Non-specific language e.g. about death • Therapist and adult exclusive adult language or narrative – child left out	• Therapist tasking parent to give explanation and details to child • Therapist asking for details/clarification • Therapist reflection - summary and reflection back to family • Therapist giving factual details to clarify and using age-appropriate explanations/language • Therapist facilitating story telling process – psycho-education to the model • Therapist giving verbal prompts/cues to elicit further narrative or support the telling of a difficult part of the story • Therapist checking re child's own sense making
Difficulty telling a 'family story'	• Parental reshaping of story to match own understanding • Disjuncture between child and adult memory • Disagreement about the facts • Child telling their story their way • One member of the family's narrative not included in family story	• Therapist facilitating co-construction of narrative – engaging all members • Therapist making members connect to each other • Therapist connecting disconnected/overwhelmed member • Therapist facilitating story telling process – psycho-education to the model • Therapist sense making

Sub-category	Evidence of coherence	Therapist interventions – example questions/reflections
Parental insensitivity	• Adults resistance to giving child details and lack of understanding of child's perspective • Parent not tolerating distress or emotionally dismissive	• Therapist facilitating story telling process – psycho-education to the model • Empathic response • Therapist facilitating child's understanding of their emotional processes/psycho-education

The third way that findings may influence practice is that they add to the understanding of what a coherent story in family bereavement work can look like. These findings acknowledge the intersubjective narrative process of therapy and story making. The following table (Table 8) outlines the findings that therapists may use as a therapeutic goal, or a way of assessing the coherence of a family's story as they progress through therapy.

Table 8: Evidence of coherence and therapist interventions to promote further coherence

Sub-category of evidence of coherence	Evidence of coherence	Therapist interventions – example questions/reflections
Collaborative approach	• Creating narrative of 'we' as the bereaved family • Agreement between child and parent about the task • Child engaging with process and asking questions about what happened • Child recognising differing stories, perspectives and	• 'Could you retell that part of the story by using 'we' instead of 'I'? • I can hear that both of you are describing that part of the story in a similar way • 'You both/all remember that' • Would it be helpful to ask Mum more about that? • Are there any new details that you can remember now you're telling the story

	knowledge about the death	again?
	• Parent recognising different stories, perspectives and knowledge about the death	• So you can see that you are remembering things differently from Dad
	• Adding new material and details to the second telling to create richer, more elaborated story	
	• Seeking clarification from other family members – checking out own memories	
Emotionally responsive	• Parent offering comfort to child	• Therapist inviting parent to comfort child and encouraging this process
	• Empathy between family members	• Therapist asking adult/child how they felt at certain points in the story
	• Parent able to tolerate distress of child/self	• Offering child emotional language by modelling use of words: happy/sad/confused/angry/excited/nervous etc.
	• Child naming emotions	• Therapist encouraging parent when child distressed
		• 'I can see that you are really able to feel your son/daughter's sadness too'
Memory Making	Talk about Memory Making – planning and remembering celebrations, remembering anniversaries, evidence of the presence of healthy continuing bonds	• So how are marking important dates together as a family?
		• How are you remembering Dad….?

Reflective process	• Reflecting on events – taking new perspectives, having reasonable thoughts about how they might act or do things differently • Parent showing ability to think about thinking (metacognition or reflective function) – able to reflect on own process • Parent aware of child's process and needs and able to reflect on child processing • Parent aware of role changes/ differences since the bereavement, way the family has shifted	• I'm wondering how you feel about that part of the story 6 months on? Is that different from how you felt at the time? • How do you think things have changed for your son/daughter since the death? • How have things been different for you in your role at home/in the family • How do you think your child is feeling about coming today/talking about the death/going to school etc. etc. • What does your child miss the most about Daddy?
Therapy as resource	• Using therapy techniques at home e.g. facilitating continuing bonds, using visualisations, 'Rocky Rocks' technique • Valuing therapy – evidence of family valuing of the therapeutic process and as finding it useful in their grief journey	• Asking how therapy has helped • Are there techniques you are using at home? • What has it been like telling your story here today? • Further support offered

The findings of this research show the importance of both individual words and sentences, and how grammar and dysfluencies have meaning when telling the story of the death. The findings also show the

importance of the collaborative process through which the story is told as a family and the narrative is created. It may be useful for this perspective and understanding to be shared by therapists with families they are working with. This could be added to the psycho-education element of the intervention shared at the beginning of the sessions, and explained in simple and accessible language. It is commonplace in some therapeutic models to share the theory and rationale of an intervention with clients, for example in CBT before a behavioural experiment (Simos & Hofmann, 2013). With this intervention, a short introduction from the therapist along the following lines would explain the reasoning behind 'Telling the Story':

"As we've worked with families like yours we have found out some things that can really help. One of those things is helping families together tell a clear story about what happened when their family member died. It may sound odd but helping families do this can make it easier for the family to cope with the death. So if you agree, we can help you together tell this story. In doing so we will look at the way that you as a family tell the story of the death and the words that you use. Although it can be really difficult in the beginning, if you're able to tell a story that is clear in the order of events, with as much detail as you're able to say, and that tells us how you were feeling at the time, we know that this will help you. It helps to 'get the story straight' and clears up any confusions that a family member might have. As we're listening, we may ask questions to clarify things, or perhaps to include somebody that seems a bit left out of the story as it's important that everybody's story is heard. We may ask you how you were feeling at a certain time or perhaps how you think other people in your family were feeling. Is that okay?"

The first value of educating the family about the 'telling the story of the death' intervention is that it may bring families' attention more closely to the way they speak and the words they use. This may then help them be more reflective in their discourse and therefore increase coherence in the narrative. Second, by sharing the importance of the structure and way the story is told collaboratively, this may then enable therapists to more explicitly intervene and address, for example, timeline confusion or disjuncture between memories, with less resistance from family members. They may also be able to ask more questions that will help develop reflective function or empathy in the story. As Asen and Fonagy (2012) note, focussing on developing reflective functioning or mentalisation does not need to "radically alter the priorities of a systemic therapist but it focuses on essential phenomena that might otherwise be

marginalised" (p.368). The extent of this needs to be guided by the families, and therapists need to take a gentle approach, working at a level that the parent can manage (Dallos & Vetere, 2009; Slade 2008).

As well as these very specific bereavement family therapy focussed implications, there are broader application of these findings to general therapeutic work. These findings have implications for therapeutic work with individuals and couples as well as for families, and for those who do not directly present with a bereavement. The markers of unresolved loss discussed in this study may be seen in therapeutic settings with clients who have had other disruptions in their attachment systems. For example, the client(s) may have experienced a loss that may not be typically understood as a direct bereavement or loss, for example, a miscarriage (Bakermans-Kranenburg, Schuengel, & Van Ijzendoorn, 1999), stillbirth (Hughes, Turton, Hopper, McGauley, & Fonagy, 2004), or a romantic relationship that has ended (Feeney & Monin, 2008). Therapists working with these clients could be informed by these findings to recognise unresolved loss through the speech patterns and discourse used by clients in session, and may then use this understanding to inform their work. As the AAI also demonstrates that as individuals can be 'unresolved' due to trauma experienced in childhood such as physical, sexual or emotional abuse or neglect (George et al, 1985) we may expect that the loss codes and evidence of incoherence could also present in the narratives of clients who have this kind of history. Thus, elements of the findings of this study could additionally be transferable to practitioners working with such clients.

Implications for Therapeutic Training

The findings of this study are relevant to how therapists 'do' therapy and therefore have implications for therapeutic training. Although Attachment Theory is widely taught in counselling psychology courses and other counselling training, it is rare for counselling psychologists to utilise the AAI in their practice. The full coding handbook of the AAI is typically only accessible to those who undertake the AAI training, which is time-consuming and rarely undertaken by those whose predominant employment is therapy. Various ways of working therapeutically in an attachment-informed way have developed (e.g. Attachment Narrative Therapy, Dallos & Vetere 2009); Parent-infant Psychotherapy (Stern, 1995), Circle of Security (Marvin, Cooper, Hoffman, & Powell, 2002), and Emotionally Focussed Therapy (Johnson & Greenberg, 1988). These models come with explicit guidance as to how therapists work, for example in Parent-infant Psychotherapy, the therapists would model reflective functioning to the parent, through

verbalising affects, intentions and anxieties that they see or assume in the baby (Baradon & Steele, 2008).

In contrast to these full therapeutic models listed above, the findings from this study could be utilised with a broader group of therapists that could include a variety of ways of working (e.g. CBT, Person-Centred, Psychodynamic, Systemic, Narrative). Therapists from different backgrounds that place value on the words a client uses to tell their story, and accept the principles of Attachment Theory, could utilise the findings of this study. Slade (1999) expressed the hope that there may be ways of reducing the complexity of the AAI and the coding so that clinicians may be able to incorporate the insights into their work more easily. This study provides an example of one way of doing this, with a small part of the AAI coding book being used in a simpler form to deepen understanding of how families construct bereavement narratives.

There are two more specific training suggestions that arise from this study. First, that therapists can be trained to listen for incoherence markers. There have been calls for including study of the "fine-grained moment-by-moment interactional processes" (Gross, 2014, p.512) in therapeutic training courses (Gross, 2014; Rey, 1994). Training therapists to focus on the subtleties of talk when training and practicing would lead to increased awareness of the importance of the way a story is told and micro-moments of session. My suggestion is that therapists can be trained to 'hear' the markers of incoherence in stories told by clients. This would involve students studying the table of markers (see Table 5 above) and familiarising themselves with these both through listening to therapy sessions where they are in evidence, and also through working with a session transcript and coding it. Trainees could be asked to audio-record one of their own sessions in which a family or individual client talks about loss and analyse the transcript for markers of incoherence. This would also include a reflective aspect as they classify their own responses as helpful or not. This focussed piece of training would enable therapists to have familiarity with the discourse markers of incoherence and an increased awareness of their presence and importance in client's material.

A second training recommendation is that therapists learn to think actively about how to promote coherence with clients, be they individuals, couples or family groups. The training could focus on the findings of this study, and the five ways in which coherence is demonstrated in these stories:

collaborative approach, emotional responsiveness, memory making, reflective process and recognition of therapy as a resource. Training would focus on teaching therapists how to actively develop these aspects of the story telling with their clients. This may be in the form of using specific questions, reflections, interventions or information giving among other techniques. Some examples are given above in Table 3; however the specific elements of this active promotion of coherence may look different with differing styles of therapy and therapists can mould this to fit their own practice. Using the findings of this study in training would lead to more research-informed practice and therapists who are not only aware of their clients' ability to create coherence, but also more aware of their own role in the therapeutic process.

The counselling psychology values of inter-subjectivity and the relational stance (Milton, 2010) provide an additional framework for understanding these findings of this study. As reflective-practitioners (Woolfe, 2006) counselling psychologists are required to have, "a high level of self-awareness and competence in relating the skills and knowledge of personal and interpersonal dynamics in the therapeutic context" (Sims, 2016, p.461). The findings of this study give examples of the impact a therapist has on therapy, for example co-constructing disorganisation in the narrative. This shows the need for this skill of self-awareness and awareness of interpersonal dynamics in the therapy room to be developed through training as well as through supervision and reflective practice.

Implications for Research Practice: Methodological reflections

In addition to having implications for Attachment Theory and research, bereavement theory, research and practice and therapeutic training, there are some potential implications of this study in terms of research practice as a result of the innovative method used in this research. As an example of theory-informed thematic analysis following an adaptation and development of the Braun and Clarke (2006) process, this study offers itself as a possible method of analysis for further research in counselling psychology and other fields. The development of the method in this study and using it to analyse therapy transcripts additionally has several implications for research.

First, the methodology of this study offers a new way of conducting research on therapy data. It has been noted in the literature that there is little research based on directly analysing what happens in therapy sessions (Finlay, 2014) and there have been calls for further process research based on therapy

data (Henton, 2012; Mallinckrodt, 2011, Scheel et al., 2011) with the recognition that, "There is probably no area of research that poses more practical problems than studies of actual client interactions with actual counsellors" (Mallinckrodt, 2011, p.711). Most research in counselling psychology has been: "small-scale explorations of trainee or therapist experiences, or discussions of professional or theoretical topics… and relatively little practice-based research" (Henton, 2012, p.16). However, this study offers an example of a different possibility for counselling psychology research, that of using 'live' data and engaging in process research.

One of the perceived difficulties of engaging in qualitative research with 'therapy talk' may be the complicated methods of analysis on offer that require large amounts of training (such as Conversational and Discourse Analysis, Sacks, Schegloff, & Jefferson, 1974; Foucault, 1984). However, theory informed thematic analysis (TA) allows a simpler and more accessible way of working with therapy data. TA is widely used in counselling and psychotherapy research and described by McLeod (2011) as "flexible, straightforward and accessible" (p. 146), and it has been specifically recognised as a suitable method for psychotherapy process research, due to its nature as a reflexive and flexible approach (Mörtl & Gelo, 2015). The relative accessibility of TA is important because while various approaches to psychotherapy change process research have developed, those focussed on transcript analysis have typically involved often rather complex approaches to therapy transcript analysis that are quantitative at their core, including Theme-Analysis (Meier, Boivin, & Meier, 2008) and the Core-Conflictual Relationship Theme (CCRT) method (Luborsky, 1977). However, theory informed TA following the Braun and Clarke (2006) process offers the 'accessible' method McLeod (2011) recognised it to be. This approach allows trainee practitioners and other early career researchers (like me!) to do interesting research that is based on the 'in the room' work, which is the main focus of our training.

Counselling psychologists occupy the role of 'scientist-practitioners' and have a professional value of creating practiced-based evidence. As Corrie (2010) noted, "the relationship between research and practice must be bi-directional: clinical practice has a vital role to play in informing research as much as the other way round" (p.51). This theory-informed method, when used with live therapy data, offers a way forward with this challenge, promoting practiced-based evidence. Additionally, the method has allowed for use of longitudinal data, which although beginning to increase within qualitative research, is rare, particularly within counselling psychology qualitative research, which usually focusses on one-off

interviews (Thomson & McLeod, 2015). As therapists, we are engaged in the work of change with our clients and this method allows the reflection on this process over time.

Secondly, this methodology permits a unique combination of theory and analysis. TA is often (particularly outside of the US) associated with inductive non-theory informed research, so this project is unusual in that it is explicitly informed by Attachment Theory. This analytic process promotes both an exploration of the data and the practical application of the theory to the data – in other words both deductive and inductive, theory-driven, top-down and data-driven, bottom-up analysis of the data. As such, it clearly seeks to link theories (of change, that is, increasing coherence) to actual practice in the room. This research is informed by theory in both an explicit and exploratory way, whilst following a systematic six phased process of analysis that helps ensure quality and rigour. This methodology thus opens up opportunities for researchers to use this method with other theoretical stances: possibilities include a person-centred (Rogers, 1959) theory-informed TA focusing on congruence, or perhaps a psychodynamic theory- (Freud, 1912) informed TA focusing on defences as they are demonstrated within session. Or as part of a reflective piece, counselling psychologists could explore how their own integration of theories and values is reflected in their own in-session work. In my opinion, the possibilities are endless; this methodology offers exciting and accessible opportunities to both new and experienced counselling psychologists and psychotherapy researchers to link their chosen theoretical framework to the process of therapy.

Implications and Relevance for Counselling Psychology

As a counselling psychologist, I adhere to the scientist-practitioner model of professional practice (Corrie & Callahan, 2000; HCPC, 2015; Sauer & Vespia, 2006), which emphasises the role of the practitioner as producer as well as user of theoretical and research knowledge. This research offers the discipline an example of theory informed, practice-based research with three key facets.

First, this study offers the discipline a new and innovative methodology. Counselling psychology views itself as having a maverick and novel way of approaching therapy and research (Moore & Rae, 2009). As a counselling psychologist, professional artistry (BPS, 2005) is core to my identity as a researcher and those in the discipline are encouraged to have a curious and question-lead attitude to research methodology (Kasket, 2012). These values towards research have encouraged me to take an innovative

approach to analysis and the use of theory to inform TA allowed me to create a direct link between theory and research. This methodology offers new options to counselling psychologists to creatively explore how theory can explicitly inform research methodology.

Second, this study offers an important focus on process-based research – specifically how attachment 'works' in session. There have been calls for more process-based research in the field (Henton, 2012; Mallinckrodt, 2011, Scheel et al., 2011) and this study offers an example of how theory can be applied to process to deepen understanding of what is happening 'in-session'. By analysing therapy transcripts, I have been able to study in closer depth the 'real work' of therapy and explore how attachment works in session. The relational stance of counselling psychology and its stress on the value of inter-subjectivity (Milton, 2010) lends itself well to looking at the interpersonal processes that are engaged in the therapy and the impact of the therapist in these. Counselling psychologists take the position of 'reflexive practitioners' (Woolfe, 2006) requiring, "high levels of competence to work both with structure/content and with process/interpersonal dynamics as they unfold during the therapeutic encounter." (BPS, 2014, p.4) These skills have been transferred to the research context and informed the analysis; this study highlights the role of the therapist in the creation of the story – both leading families towards, and (at times) away, from a coherent narrative.

Third, I have studied a client group that is traditionally unrepresented in counselling psychology research, which usually focusses on adults rather than children or families (Davy & Hutchinson, 2010). Therefore, this study adds to the sparse literature in counselling psychology about children and family work. It demonstrates that despite the main emphasis being adult one-to-one work and the discipline not requiring children and family work in the clinical hours (Davy & Hutchinson, 2010), there is still scope for counselling psychologists to carry out meaningful research amongst families and children.

Limitations and Suggestions for Further Research

There were several limitations to this research study. Firstly, the families that took part were of a similar ethnic background – they were all white British and all had 'Christian' rituals around the funeral. Death and mourning, according to Dallos and Vetere (2009), are "circumscribed by rituals, beliefs, religious principles, family traditions and these may shape what people think is appropriate and also what they

feel they can expect in terms of support" (p.147). It would be valuable to see how different death practices may have an impact on the way the story is told, or whether different cultural or spiritual practices more generally impact the experience of the family death as well as the intervention. For example, cultures that utilise semi-scripted family/religious events at proscribed times following a family death (e.g. at points during the first year, or annually thereafter such as the Orthodox Jewish or Hindi [Shradda Ceremony] religions) may tell different or more organised stories. Repeating the study with a wider and more diverse sample would develop our understanding of the relevance of the intervention for other cultural groups. It may be possible to explore the other centres that Winston's Wish has in the north of England that may have a more diverse client group, or connecting with other family bereavement organisations in the UK or abroad. This study only involved five families, so further research could also use a larger group of families and would allow findings to be developed based on a wider and more diverse sample.

The AAI suggests that 'U' coding is evident in those who have experienced trauma or abuse perpetuated by an attachment figure in childhood. To broaden the understanding of what coherence/incoherence looks like in family stories, it would be useful to explore the narratives of families who have experienced trauma, abuse or domestic violence. This could be with a new client group through a different organisation, such as NHS Child and Adolescent Mental Health Service (CAMHS) or domestic violence refuges. Another option would be within Winston's Wish. As well as the Accident and Illness branch of support, Winston's Wish also offers support to families nationally who have been affected by murder, manslaughter and suicide. While recognising that there might be significant ethical hurdles to such research given the traumatic nature of the deaths, repeating this study with those families would develop the findings, as these deaths are likely to have more traumatic elements. Using an attachment informed analysis would allow exploration of how their story demonstrates coherence and how this changes through time.

Families often remain connected to Winston's Wish for years after their initial therapeutic input, attending celebrations, parties and memory making events. Further research could involve following up families over a longer period of time, perhaps repeating the story of the death every couple of years, which would allow an even longer term study of how stories change over time and allow the exploration of how coherence is demonstrated years after the death.

Another limitation, and one discussed with practitioners at Winston's Wish in the preliminary stages of the research, is that storytelling is a natural and everyday activity (Brockmeier, 2012). It cannot be known how often the families that took part in this study were telling the story of the death outside of the therapeutic setting, and how this may have impacted on the way the story was told in session. There was no way of accounting for this, nor would it be ethical to do so. This means that it is not possible to ascribe changes in the narratives of death only to the therapeutic intervention; it is important to exercise caution in drawing conclusions about the value of the Winston's Wish intervention. In addition, it is assumed that there is a normative process of adjustment to loss such that positive change is expected, particularly after the first year. In order to provide clarity that any positive changes towards more coherent stories were in fact due to the therapeutic interventions, it would be important to have a comparison (e.g. control) group. In this type of (positive paradigm) research it would also be necessary to find a way to quantitatively assess narrative coherence. To test the hypothesis that using the 'Telling the Story' intervention leads to better outcomes for families (due to a more coherent story), a quantitative study could be used. Families could be assigned to two groups – one control (wait list or accessing other parts of the support services) and one group who engage with the intervention (telling the story twice). The families would complete questionnaires measuring complex grief, depression, anxiety and the two groups compared. This could provide a quantitative assessment of the 'efficacy' of the intervention. An alternate design could involve quantitatively assessing level of coherence in post-therapy stories in the two research groups to assess if the therapy group showed more indices of narrative coherence.

There also limitations related to the methodology used in this study. Audio recordings of the therapy sessions were used for this project, rather than video recordings, which limited the amount of information and data available for transcription and coding. There were elements of behaviour that could be picked up on the recordings, such as family members leaving the room, but the remainder of the behavioural aspect of sessions was not accessible by using only audio recordings of the sessions. Although the AAI coding is based solely on verbal narrative, other methods of measuring attachment status (e.g. the Strange Situation procedure, Ainsworth & Wittig, 1969) place importance on physical proximity and positioning (proximity seeking), as well as touch and giving of comfort between parent and child. Using only audio recording, this study only captured a limited part of this data, which perhaps could be partly overcome with a contemporaneous note-taking of such interactions during the session or

(if ethically appropriate) by video recording the session. To address these limitations, further research could include using video recording of therapy sessions, which would allow for a wider analysis of the behavioural aspects that are important in Attachment Theory. Analysis could draw on the Child Attachment Interview (2003) developed by Target, Fonagy and Shmueli-Goetz, which incorporates behaviour as well as linguistic markers of incoherence.

Another limitation of this study is that the creative work (drawings, writing) that is produced by children and therapists in session could not be included in the analysis due to the ethical framework agreed with Winston's Wish and families (although in this study only one family used drawings in session). Using the creative work of children could add further insights particularly to temporal coherence, for example examining where children place events along a timeline when drawing their story. Research has also examined associations between family drawings and attachment relationships (e.g., Fury, Carlson, & Sroufe, 1997; Pianta & Longmaid, 1999). Further research could examine how children represent their family before and after the death, and this could add to the understanding of continuing bonds and coherence. Analysis of drawings could be informed by projective attachment measures (e.g. Family Drawing Measure, Kaplan & Main, 1986).

As the findings from this study demonstrate the therapist plays a role in creating in/coherence, further research could explore the experiences of therapists working with bereaved families, and how they experience incoherence and disorganisation within the sessions. This could be used to further inform work with bereaved families and the training of therapists working in this setting. The therapists themselves were different for each family and although this is typical of Winston's Wish and therefore a realistic reflection of the organisations' work, this may have led to 'natural' variations in the way the intervention was carried out. All therapists are trained to use the intervention in a similar way, but as a client-led service, the therapists are encouraged to fit the therapy to the needs of the clients. Therapists may use this intervention alongside other interventions in the same session, for example, using stones to explore feelings as an introduction to the session, or using drawing with younger children whilst telling the story of the death. This may mean that families have a slightly different context within their session for the intervention. Nonetheless, the premise underpinning the use of the telling the story intervention is the same across all families. Families' tellings of the story were recorded at different times along their therapy journey with Winston's Wish and therefore there are additional factors of time since the death

and also variation in which family members attended sessions. However, this research was not undertaken in a 'trial' setting but intentionally based within a real life therapeutic setting; as such the research is an example of practice-based research with all the strengths and potential limitations of this approach (Corrie, 2010).

CONCLUSIONS

The aims of this study were to examine if, as predicted by Attachment Theory, there was evidence of markers of unresolved loss in the stories told by bereaved families, and to explore if, following a therapeutic intervention focussed on the family story of the death, there was any evidence of shifts and changes in these stories and the way they were told that could be understood as potentially evidencing greater coherence. The role of the therapist in the creation of coherence was also an area of focus. The findings demonstrate that there are markers of unresolved loss evident as predicted by Attachment Theory. The use of an innovative methodology, theory informed thematic analysis, has enabled identification of these markers and also exploration of the changes through time and the processes involved in creating or thwarting more coherent stories. Four key themes were created: evidence of incoherence, creating incoherence, creating coherence and evidence of coherence. The themes show how unresolved loss is manifest in the stories told and how stories move towards and away from coherence and the role of therapists in this process.

The study demonstrates the value of using Attachment Theory as a paradigm for understanding bereavement narratives and the therapeutic encounter. The study highlights processes which occur in family bereavement work and contributes to the discipline new knowledge about bereavement narrative processes and coherence. This new understanding has direct application for practitioners and trainers and can guide further research and practice.

This study contributes to the development of empirical knowledge within the discipline of counselling psychology, and demonstrates methodological creativity and innovation that hopefully will be built on by future researchers. The study offers the discipline an example of theory-informed thematic analysis, contributing to the development of methodological knowledge and specifically expanding the methodological toolkit available to counselling psychologists for process research. The study shows theory-informed thematic analysis to be a novel and accessible methodology that allows theory to be

directly integrated into research. The method demonstrates the possibilities of using Attachment Theory-informed thematic analysis in process research utilising family therapy transcripts, but also potentially for other theories and topics of interest to counselling psychologists. As one of a handful of studies that have used theory-informed thematic analysis this study also offers an example of how this may be carried out within a limited time frame and by an early career researcher. By using therapy transcripts and analysing 'therapy talk', this study has added to our understanding of what helps bereaved families move towards a more coherent story of their loss. I hope the results of this study are a response to the call for more "carefully crafted therapies" (Niemeyer & Currier, 2009 p. 355), and lead to more skilful and informed therapists and better outcomes for bereaved families in the future.

References

Abrams, K. Y., Rifkin, A., & Hesse, E. (2006). Examining the role of parental frightened/frightening subtypes in predicting disorganized attachment within a brief observational procedure. *Development and Psychopathology*, *18*(2), 345-361.

Adam, K. S., Sheldon-Keller, A. E., & West, M. (1996). Attachment organization and history of suicidal behavior in clinical adolescents. *Journal of Consulting and Clinical Psychology*, *64*(2), 264.

Ahn, H. N., & Wampold, B. E. (2001). Where oh where are the specific ingredients? A meta-analysis of component studies in counseling and psychotherapy. *Journal of Counseling Psychology*, *48*(3), 251.

Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation*. Hillsdale, NJ: Erlbaum.

Ainsworth, M. D. S., & Eichberg, C. (1991). Effects on infant-mother attachment of mother's unresolved loss of an attachment figure, or other traumatic experience. *Attachment Across the Life Cycle*, *3*, 160-183.

Ainsworth, M. D. S. & Wittig, B. A. (1969). Attachment and exploratory behavior of 1-year-olds in a strange situation. In B. M. Foss (ed.), *Determinants of Infant Behavior, IV* (pp. 111–136). London: Methuen.

Akerman, R., & Statham, J. (2011). Childhood bereavement: A rapid literature review. London: Child Wellbeing Research Centre.

Allen, J. P., Hauser, S. T., & Borman-Spurrell, E. (1996). Attachment theory as a framework for understanding sequelae of severe adolescent psychopathology: an 11-year follow-up study. *Journal of consulting and clinical psychology*, *64*(2), 254.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (DSM-5®)*. American Psychiatric Pub.

Ammaniti M., Dazzi N., & Muscetta S. (2008). The AAI in a clinical context: Some experiences and illustrations. In H. Steele, M. Steele (Eds.), *Clinical applications of the Adult Attachment Interview*. (pp.236-269). New York: Guilford Press

Asen, E., & Fonagy, P. (2012). Mentalization-based therapeutic interventions for families. *Journal of Family Therapy*, *34*(4), 347-370.

Bakermans-Kranenburg, M. J., Schuengel, C., & Van Ijzendoorn, M. H. (1999). Unresolved loss due to

miscarriage: An addition to the Adult Attachment Interview. *Attachment & Human Development*, *1*(2), 157-170.

Baradon, T., & Steele, M. (2008). Integrating the AAI in the clinical process of psychoanalytic parent-infant psychotherapy in a case of relational trauma. In Steele, H., & Steele, M. (Eds.). (2008). *Clinical applications of the adult attachment interview*. (p. 195-212). New York: Guilford Press.

Bateman, A., & Fonagy, P. (2005). *Psychotherapy for borderline personality disorder*. Oxford: Oxford University Press.

Beck, A. T. (1979). *Cognitive therapy and the emotional disorders*. New York: Penguin Books Ltd.

Belitsky, R., & Jacobs, S. (1986). Bereavement, attachment theory, and mental disorders. *Psychiatric Annals*, *16*(5), 276-280.

Benoit, D., & Parker, K. C. (1994). Stability and transmission of attachment across three generations. *Child Development*, *65*(5), 1444-1456.

Berger, I. (2011). Support and evidence for considering local contingencies in studying and transcribing silence in conversation. *Pragmatics*, *21*(3), 291-306.

Berthelot, N., Ensink, K., Bernazzani, O., Normandin, L., Luyten, P., & Fonagy, P. (2015). Intergenerational transmission of attachment in abused and neglected mothers: The role of trauma-specific reflective functioning. *Infant Mental Health Journal*, *36*(2), 200-212.

Bishop, S., Stedmon, J., & Dallos, R. (2015). Mothers' narratives about having a child with cancer: A view through the attachment lens. *Clinical Child Psychology and Psychiatry*, *20*(4), 611-625.

Boelen, P. A., de Keijser, J., van den Hout, M. A., & van den Bout, J. (2007). Treatment of complicated grief: a comparison between cognitive-behavioral therapy and supportive counseling. *Journal of Consulting and Clinical Psychology*, *75*(2), 277.

Bohanek, J. G., Marin, K. A., Fivush, R., & Duke, M. P. (2006). Family narrative interaction and children's sense of self. *Family Process*, *45*(1), 39-54.

Bonanno, G. A., & Kaltman, S. (2001). The varieties of grief experience. *Clinical psychology review*, *21*(5), 705-734.

Borelli, J. L., David, D. H., Rifkin-Graboi, A., Sbarra, D. A., Mehl, M. R., & Mayes, L. C. (2013). Language use in the Adult Attachment Interview: Evidence for attachment-specific emotion regulation. *Personal relationships*, *20*(1), 23-37.

Bosmans, G., & Kerns, K. A. (2015). Attachment in middle childhood: Progress and prospects. *New*

directions for child and adolescent development, *2015*(148), 1-14.

Bosticco, C., & Thompson, T. L. (2005). Narratives and story telling in coping with grief and bereavement. *OMEGA-Journal of Death and Dying*, *51*(1), 1-16.

Bowlby, J. (1969/1982). Attachment and loss, volume 1: Attachment. *New York: Basic*.

Bowlby, J. (1973). Attachment and loss: Volume 2. Separation. *Anxiety and Anger*. *New York: Basic*

Bowlby, J. (1979). The making and breaking of affectional bonds. *London: Tavistock.*

Bowlby, J. (1980). Attachment and loss: Volume 3. Loss. *New York: Basic*.

Bowlby‐West, L. (1983). The impact of death on the family system. *Journal of Family Therapy*, *5*(3), 279-294.

Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. Thousand Oaks, CA: Sage.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101.

Braun, V., & Clarke, V. (2013) *Successful qualitative research: A practical guide for beginners.* London: Sage.

British Psychological Society, D. o. C. P. (2005*). Guidelines for Professional Practice in Counselling Psychology*. Retrieved from: http://www.bps.org.uk/sites/default/files/documents/professional_practice_guidelines_-division_of_counselling_psychology.pdf

British Psychological Society (2009) *Code of Ethics and Conduct* Retrieved from: http://www.bps.org.uk/system/files/Public%20files/aa%20Standard%20Docs/inf94_code_web_ethics_conduct.pdf

British Psychological Society (2010) *Code of Human Research Ethics* Retrieved from: http://www.bps.org.uk/sites/default/files/documents/code_of_human_research_ethics.pdf

British Psychological Society, D.o.C.P (2014) *Standards for Doctoral programmes in Counselling Psychology.* Retrieved from: http://www.bps.org.uk/system/files/Public%20files/PaCT/dcounspsy_standards_approved_may_2014.pdf

Brennan, K. A., Clark, C. L., & Shaver, P. R. (1998). S*elf-report measurement of adult attachment: An integrative overview.* In J. A. Simpson & W.S. Rholes (Eds.), *Attachment theory and close relationships* (pp. 46–76). New York: Guilford.

Bretherton, I., Prentiss, C., & Ridgeway, D. (1990). Family relationships as represented in a story-completion task at thirty-seven and fifty-four months of age. *New Directions for Child and Adolescent Development*, *1990*(48), 85-105.

Brockmeier, J. (2012). Narrative Scenarios: Toward Culturally Thick Notion of Narrative in Valsiner, J. (Ed.). (2012). *The Oxford handbook of culture and psychology*. (439-465) Oxford University Press.

Brown, E. J., McQuaid, J., Farina, L., Ali, R., & Winnick-Gelles, A. (2006). Matching interventions to children's mental health needs: Feasibility and acceptability of a pilot school-based trauma intervention program. *Education and Treatment of Children*, 257-286.

Brown, E. J., Amaya-Jackson, L., Cohen, J., Handel, S., Bocanegra, H. T. D., Zatta, E., & Mannarino, A. (2008). Childhood traumatic grief: A multi-site empirical examination of the construct and its correlates. *Death Studies*, *32*(10), 899-923.

Burke, L.A., & Neimeyer, R. (2012). Prospective risk factors for complicated grief. In M. Stroebe, H. Schut, & J. van den Bout (Eds.), *Complicated grief: Scientific foundations for health care professionals* (pp. 145–161). Hove: Routledge.

Busch, A. L., Cowan, P. A., & Cowan, C. P. (2008). Unresolved loss in the Adult Attachment Interview: Implications for marital and parenting relationships. *Development and psychopathology*, *20*(02), 717-735.

Caplan, G. (1964). *Principles of preventive psychiatry.* New York: Basic Books.

Cassidy, J. (1988). Child-mother attachment and the self in six-year-olds. *Child development*, 121-134.

Cassidy, J., & Marvin, R. S. (1992). Attachment organization in preschool children: Coding guidelines. *Unpublished manuscript, University of Virginia*.

Charles, D. R., & Charles, M. (2006). Sibling loss and attachment style: An exploratory study. *Psychoanalytic psychology*, *23*(1), 72.

Coffino, B. (2009). The role of childhood parent figure loss in the etiology of adult depression: findings from a prospective longitudinal study. *Attachment & human development*, *11*(5), 445-470.

Collins, N.L., & Read, S. J. (1994) Cognitive representations of adult attachment: The structure and function of working models. In K. Bartholomew & D. Perlman (Eds.) *Advances in personal relationships, Vol. T: Attachment Processes in adulthood (pp.534-90).* London: Jessica Kingsley, Inc

Corrie, S. (2010). What is evidence? In Strawbridge, S., & Woolfe, R. (2010). *Handbook of counselling Psychology (3rd Ed.)*. (p.44-61) London: SAGE Publications.

Corrie, S. & Callahan, M. (2000). A review of the scientist-practitioner model: Reflections on its potential contribution to counselling psychology within the context of current healthcare trends. *British Journal of Medical Psychology*. 159 *73*, 413-427.

Currier, J. M., Holland, J. M., & Neimeyer, R. A. (2007). The effectiveness of bereavement interventions with children: A meta-analytic review of controlled outcome research. *Journal of Clinical Child and Adolescent Psychology, 36*, 253–259.

Currier, J. M., Neimeyer, R. A., & Berman, J. S. (2008). The effectiveness of psychotherapeutic interventions for bereaved persons: a comprehensive quantitative review. *Psychological Bulletin*, *134*(5), 648.

Dallos, R. (2006). *Attachment narrative therapy*. McGraw-Hill Education (UK).

Dallos, R., & Vetere, A. (2009). *Systemic therapy and attachment narratives: Applications in a range of clinical settings*. London, England: Routledge.

Dalton, T. A., & Krout, R. E. (2006). The grief song-writing process with bereaved adolescents: An integrated grief model and music therapy protocol. *Music Therapy Perspectives*, *24*(2), 94-107.

Daniel, S. I. (2006). Adult attachment patterns and individual psychotherapy: A review. *Clinical Psychology Review*, *26*(8), 968-984.

Daniel, S. I. (2009). The developmental roots of narrative expression in therapy: Contributions from attachment theory and research. *Psychotherapy: Theory, Research, Practice, Training*, *46*(3), 301.

Daniel, S. I. (2011). Adult attachment insecurity and narrative processes in psychotherapy: An exploratory study. *Clinical psychology & psychotherapy*, *18*(6), 498-511.

Davis, C. G., Harasymchuk, C., & Wohl, M. J. (2012). Finding meaning in a traumatic loss: A families approach. *Journal of traumatic stress*, *25*(2), 142-149.

Davy, J., & Hutchinson, J. (2010). Special Edition: Working with children and their families. *Counsellling Psychology Review*, *25*(1), 1-5.

Diener, M. J., & Monroe, J. M. (2011). The relationship between adult attachment style and therapeutic alliance in individual psychotherapy: a meta-analytic review. *Psychotherapy*, *48*(3), 237.

Dimaggio, G., & Semerari, A. (2004). Disorganized narratives: The psychological condition and its

treatment. In Angus, L. E., & McLeod, J. (2004). *The handbook of narrative and psychotherapy: Practice, theory and research*. (p.263-282) Thousand Oaks. CA: Sage.

Dowdney, L. (2000). Annotation: Childhood bereavement following parental death. *Journal of Child Psychology and Psychiatry*, *41*(07), 819-830.

Doughty, E. A., & Hoskins, W. J. (2011). Death education: An internationally relevant approach to grief counseling. *Journal for International Counselor Education*, *3*, 25-38.

Dozier, M., Chase Stovall-McClough, K., & Albus, K.E. (2008). Attachment and psychopathology in adulthood. In J. Cassidy & P.R. Shaver (Eds*.), Handbook of attachment: theory, research, and clinical applications* (2nd ed., pp. 718–744). New York: Guilford.

Draper, R., & Dallos, R. (2010). *An Introduction to Family Therapy: Systemic Theory and Practice*.(3rd ed.) Maidenhead, UK: McGraw-Hill Open University Press.

Dunning, S. (2006). As a young child's parent dies: Conceptualizing and constructing preventive interventions. *Clinical Social Work Journal*, *34*(4), 499-514.

Dyregrov, A., & Dyregrov, K. (2013). Complicated grief in children. In M. Stroebe, H. Schut, J. van den Bout, & P. Boelen (Eds.). *Complicated grief: Scientific foundations for health care professionals*. (pp. 68-81). London, UK: Routledge.

Dyregrov, K., & Dyregrov, A. (2005). Siblings after suicide "The forgotten bereaved". *Suicide and Life-Threatening Behavior*, *35*(6), 714-724.

Eagle, M., & Wolitzky, D. L. (2009). Adult psychotherapy from the perspectives of attachment theory and psychoanalysis. In Obegi, J. H., & Berant, E. (Eds.). (2010). *Attachment theory and research in clinical work with adults*. (p. 351-378) New York: Guilford Press.

Ehlers, A., & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour research and therapy*, *38*(4), 319-345.

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, *38*(3), 215-229.

Fauth, B., Thompson, M. & Penny, A. (2009) *Associations between childhood bereavement and children's background, experiences and outcomes. Secondary analysis of the 2004 Mental Health of Children and Young People in Great Britain data.* London: NCB

Feeney, B., & Monin, (2008) *An Attachment theoretical perspective on Divorce* in J. Cassidy & P.R. Shaver (Eds*.), Handbook of attachment: theory, research, and clinical applications* (2nd ed., pp.934-958). New York: Guilford.

Field, N. P., Gao, B., & Paderna, L. (2005). Continuing bonds in bereavement: An attachment theory based perspective. *Death studies*, *29*(4), 277-299.

Field, N. P. (2006). Continuing bonds in adaptation to bereavement: Introduction. *Death Studies*, *30*(8), 709-714.

Fiese, B. H., & Marjinsky, K. A. (1999). III. Dinnertime stories: Connecting family practices with relationship beliefs and child adjustment. *Monographs of the Society for Research in Child Development*, *64*(2), 52-68.

Figley, C. R., & Kiser, L. J. (2013). *Helping traumatized families*. New York: Routledge.

Finlay, L (2014) Qualitative Methodologies in Vossler, A., & Moller, N. (Eds.). (2014). *The Counselling and Psychotherapy Research Handbook*. (p. 164-183) London: SAGE.

First, M. B. (2011). DSM-5 proposals for mood disorders: A cost-benefit analysis. *Current Opinion in Psychiatry*, 24, 1–9.

Fivush, R., & Sales, J. M. (2003). Children's memories of emotional events. *Memory and emotion*, 242-271.

Fletcher, P. N. (2002). Experiences in family bereavement. *Family & community health*, *25*(1), 57-70.

Foa, E. B., & Rothbaum, B. O. (1998). *Treating the trauma of rape: Cognitive behavioral therapy for PTSD.* New York: Guilford Press.

Folke, S., Daniel, S. I., Poulsen, S., & Lunn, S. (2016). Client attachment security predicts alliance in a randomized controlled trial of two psychotherapies for bulimia nervosa. *Psychotherapy Research*, *26*(4), 459-471.

Fonagy, P. (2001). *Attachment and psychoanalysis*. New York: Other Press

Fonagy, P., Gergely, G., & Jurist, E. L. (Eds.). (2002). *Affect regulation, mentalization and the development of the self*. New York, US: Karnac Books

Fonagy, P., Leigh, T., Steele, M., Steele, H., Kennedy, R., Mattoon, G., Target, M., & Gerber, A. (1996). The relation of attachment status, psychiatric classification, and response to psychotherapy. *Journal of consulting and clinical psychology*, *64*(1), 22.

Fonagy, P., Steele, M., Steele, H., Moran, G. S., & Higgitt, A. C. (1991). The capacity for understanding mental states: The reflective self in parent and child and its significance for security of attachment. *Infant mental health journal*, *12*(3), 201-218

Fonagy, P., Steele, M., Moran, G., Steele, H., & Higgitt, A. (1993). Measuring the ghost in the nursery: An empirical study of the relation between parents' mental representations of childhood experiences and their infants' security of attachment. *Journal of the American Psychoanalytic Association*, *41*(4), 957-989.

Fonagy, P., Target, M., Steele, H., & Steele, M. (1997). Reflective-functioning manual, version 5.0, for application to adult attachment interviews. *London: University College London*.

Foucault, M. (1984). *The Foucault reader*. Rabinow, P. (Ed.) London: Pantheon.

Freud, S., (1912). *The dynamics of transference*. In: Strachey, J., (Ed. & Trans). The Standard Edition of the Complete Psychological Works of Sigmund Freud. Vol. 12 1917. Reprint, London: Hogarth Press; 1957

Freud, S., (1917). *Mourning and Melancholia*. In: Strachey, J., (Ed. & Trans). The Standard Edition of the Complete Psychological Works of Sigmund Freud. Vol. 14 1917. Reprint, London: Hogarth Press; 1957

Fury, G., Carlson, E. A., & Sroufe, L. A. (1997). Children's representations of attachment relationships in family drawings. *Child development*, 1154-1164.

Georgaca, E., & Avdi, E. (2009). Evaluating the talking cure: The contribution of narrative, discourse, and conversation analysis to psychotherapy assessment. *Qualitative research in Psychology*, *6*(3), 233-247.

George, C., Kaplan, N., & Main, M. (1985). The Berkley Adult Attachment interview. *Unpublished manuscript, University of California, Berkeley*.

George, C., Kaplan, N., & Main, M. (1985). Adult Attachment interview protocol (2nd ed.) *Unpublished manuscript, University of California, Berkeley*.

George, C., Kaplan, N., & Main, M. (1996). Adult Attachment interview protocol (3rd ed.) *Unpublished manuscript, University of California, Berkeley*.

Gilbert, K. R. (2002). Taking a narrative approach to grief research: Finding meaning in stories. *Death studies*, *26*(3), 223-239.

Gillibrand, R., Lam, V., & O'Donnell, V. (2011) *Developmental Psychology*. Harlow: Pearson Prentice Hall

Goenjian, A. K., Karayan, I., Pynoos, R. S., Minassian, D., Najarian, L. M., Steinberg, A. M., & Fairbanks, L. A. (1997). Outcome of psychotherapy among early adolescents after trauma. *American Journal of Psychiatry*, *154*(4), 536-542.

Granot, D., & Mayseless, O. (2001). Attachment security and adjustment to school in middle childhood. *International Journal of Behavioral Development*, *25*(6), 530-541.

Grice, Paul (1975). Logic and conversation. In Cole, P., & Morgan, J.,. *Syntax and semantics*. 3: Speech acts. (p. 41–58.) New York: Academic Press.

Gross, C. (2014). Couple narratives and adult attachment using conversation analysis in assessment. *British Journal of Psychotherapy,* 30 (4), 499- 516.

Gullestad, F. S., & Wilberg, T. (2011). Change in reflective functioning during psychotherapy—A single-case study. *Psychotherapy Research*, *21*(1), 97-111.

Haine, R. A., Ayers, T. S., Sandler, I. N., & Wolchik, S. A. (2008). Evidence-based practices for parentally bereaved children and their families. *Professional Psychology: Research and Practice*, *39*(2), 113.

Hautamäki, A., Hautamäki, L., Neuvonen, L., & Maliniemi-Piispanen, S. (2010). Transmission of attachment across three generations. *European Journal of Developmental Psychology*, *7*(5), 618-634.

Harper, M., O'Connor, R. C., & O'Carroll, R. E. (2014). Factors associated with grief and depression following the loss of a child: A multivariate analysis. *Psychology, health & medicine*, *19*(3), 247-252.

Hazan, C., & Shaver, P. (1987). Romantic love conceptualized as an attachment process. *Journal of personality and social psychology*, *52*(3), 511.

HCPC. (2015). Health and care professions council standards of proficiency practitioner psychologists. Retrieved from: http://www.hpc-uk.org/assets/documents/10002963sop_practitioner_psychologists.pdf

Henton, I. (2012). Practice-based research and counselling psychology: A critical review and proposal. *Counselling Psychology Review*, *27*(3), 11-28.

Herbert, M. (1991). *Clinical child psychology*. Chichester: Wiley.

Hesse, E., & Main, M. (1999). Second-generation effects of unresolved trauma in nonmaltreating parents: Dissociated, frightened, and threatening parental behavior. *Psychoanalytic Inquiry*, *19*(4), 481-540.

Hesse, E., & Main, M. (2000). Disorganized infant, child, and adult attachment: Collapse in behavioral and attentional strategies. *Journal of the American Psychoanalytic Association*, *48*(4), 1097-1127.

Hesse, E., & Main, M. (2006). Frightened, threatening, and dissociative parental behavior in low-risk samples: Description, discussion, and interpretations. *Development and psychopathology*, *18*(02), 309-343.

Higham, J. E., Friedlander, M. L., Escudero, V., & Diamond, G. (2012). Engaging reluctant adolescents in family therapy: an exploratory study of in‐session processes of change. *Journal of Family Therapy*, *34*(1), 24-52.

Hilliard, R. E. (2007). The effects of Orff-based music therapy and social work groups on childhood grief symptoms and behaviors. *Journal of Music Therapy*, *44*(2), 123-138.

Holmes, J., (1993). *John Bowlby and Attachment Theory*. London: Routledge

Holmes, J., (2009). *Exploring in security: Towards an attachment-informed psychoanalytic psychotherapy*. London: Routledge.

Holland, J. M., Neimeyer, R. A., Boelen, P. A., & Prigerson, H. G. (2009). The underlying structure of grief: A taxometric investigation of prolonged and normal reactions to loss. *Journal of Psychopathology and Behavioral Assessment*, *31*(3), 190-201.

Hooghe, A., De Mol, J., Baetens, I., & Zech, E. (2013). The measurement of couple and family interactions and relationship quality in bereavement research. *Family Science*, *4*(1), 66-78.

Hope, R. M., & Hodge, D. M. (2006). Factors affecting children's adjustment to the death of a parent: The social work professional's viewpoint. *Child and Adolescent Social Work Journal, 23,* 107-126

Horowitz, M. J., Bonanno, G. A., & Holen, A. (1993). Pathological grief: Diagnosis and explanation. *Psychosomatic Medicine*, *55*(3), 260-273.

Hörz-Sagstetter, S., Mertens, W., Isphording, S., Buchheim, A., & Taubner, S. (2015). Changes in reflective functioning during psychoanalytic psychotherapies. *Journal of the American Psychoanalytic Association*, *63*(3), 481-509.

Howarth, R. A. (2011). Promoting the adjustment of parentally bereaved children. *Journal of Mental Health Counseling*, *33*(1), 21-32.

Hughes, J., Hardy, G., & Kendrick, D. (2000). Assessing adult attachment status with clinically-orientated interviews: A brief report. *British Journal of Medical Psychology*, *73*(2), 279-283.

Hughes, P., Turton, P., Hopper, E., McGauley, G. A., & Fonagy, P. (2004). Factors associated with the unresolved classification of the Adult Attachment Interview in women who have suffered stillbirth. *Development and psychopathology*, *16*(01), 215-230.

Hughes, P., Turton, P., McGauley, G. A., & Fonagy, P. (2006). Factors that predict infant disorganization in mothers classified as U in pregnancy. *Attachment & human development*, *8*(2), 113-122.

Humphrey, G. M., & Zimpfer, D. G. (2007). *Counselling for grief and bereavement*. London: Sage.

Hynson, J. L., Aroni, R., Bauld, C., & Sawyer, S. M. (2006). Research with bereaved parents: a question of how not why. *Palliative Medicine*, *20*(8), 805-811.

Jacobs, S. (1999). *Traumatic grief: Diagnosis, treatment, and prevention*. London: Taylor and Francis

Jacobvitz, D., Curran, M., & Moller, N. (2002). Measurement of adult attachment: The place of self-report and interview methodologies. *Attachment & Human Development*, *4*(2), 207-215.

Jefferson, G. (1988) Notes on a possible metric which provides for a 'standard maximum' silence of approximately one second in conversation. In D. Roger and P. Bull (eds.), *Conversation: An interdisciplinary perspective.* (p. 167-196.) Clevedon, UK: Multilingual Matters

Johnson, S. M., & Greenberg, L. S. (1988). Relating process to outcome in marital therapy. *Journal of Marital and Family Therapy*, *14*(2), 175-183.

Kalantari, M., Yule, W., Dyregrov, A., Neshatdoost, H., & Ahmadi, S. J. (2012). Efficacy of writing for recovery on traumatic grief symptoms of Afghani refugee bereaved adolescents: A randomized control trial. *OMEGA-Journal of death and dying*, *65*(2), 139-150.

Kalter, N., Lohnes, K. L., Chasin, J., Cain, A. C, Dunning, S., & Rowan, J. (2002). The adjustment of parentally bereaved children: Factors associated with short-term adjustment. *Omega, 46,* 15-34.

Kaplan, N., & Main, M. (1986). *Instructions for the classification of children's family drawings in terms of representation of attachment*. Berkeley: University of California.

Kasket, E. (2012). The counselling psychologist researcher. *Counselling Psychology Review*, *27*(2), 64-73.

Kerns, K. A., Klepac, L., & Cole, A. (1996). Peer relationships and preadolescents' perceptions of security in the child-mother relationship. *Developmental psychology*, *32*(3), 457.

Kidder, L. H., & Fine, M. (1987). Qualitative and quantitative methods: When stories converge. *New directions for program evaluation*, *1987*(35), 57-75.

Kiser, L. J., Baumgardner, B., & Dorado, J. (2010). Who are we, but for the stories we tell: Family stories and healing. *Psychological Trauma: Theory, Research, Practice, and Policy*, *2*(3), 243.

Kissane, D., & Lichtenthal, W. (2008). Family-focused grief therapy: From palliative care into

bereavement. In M.S. Stroebe, R.O. Hansson, H. Schut, & W. Stroebe (Eds.), *Handbook of bereavement research and practice: Advances in theory and intervention* (pp. 485–510). Washington, DC: American Psychological Association.

Klass, D., Silverman, P. R., & Nickman, S. L. (1996). *Continuing bonds*. Abingdon: Taylor and Francis

Koenig Kellas, J., & Trees, A. R. (2006). Finding meaning in difficult family experiences: Sense-making and interaction processes during joint family storytelling. *The Journal of Family Communication*, *6*(1), 49-76.

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

Lampton, C. C., & Cremeans, K. J. (2002). Recent advances in the understanding of childhood grief and mourning*. Marriage and Family, (5)* 467-476.

Larson, D. G., & Hoyt, W. T. (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.

Leveridge, M., Stoltenberg, C., & Beesley, D. (2005) Relationship of attachment style to personality factors and family interaction patterns. *Contemporary Family Therapy, 27 (*4), *577-597*

Levy, K. N., Meehan, K. B., Kelly, K. M., Reynoso, J. S., Weber, M., Clarkin, J. F., & Kernberg, O. F. (2006). Change in attachment patterns and reflective function in a randomized control trial of transference-focused psychotherapy for borderline personality disorder. *Journal of consulting and clinical psychology*, *74*(6), 1027.

Levy, K. N., Ellison, W. D., Scott, L. N., & Bernecker, S. L. (2011). Attachment style. *Journal of clinical psychology*, *67*(2), 193-203.

Leick, N., & Davidsen-Nielsen, M. (1991). *Healing pain: Attachment, loss, and grief therapy*. London: Tavistock/Routledge.

Lichtenthal, W. G., Cruess, D. G., & Prigerson, H. G. (2004). A case for establishing complicated grief as a distinct mental disorder in DSM-V. *Clinical psychology review*, *24*(6), 637-662.

Lichter, I., Mooney, J., & Boyd, M. (1993). Biography as therapy. *Palliative medicine*, *7*(2), 133-137.

Lin, K. K., Sandler, I. N., Ayers, T. S., Wolchik, S. A., & Luecken, L. J. (2004). Resilience in parentally bereaved children and adolescents seeking preventive services. *Journal of Clinical Child and Adolescent Psychology*, *33*(4), 673-683.

Lindemann, E. (1944). Symptomatology and management of acute grief. *American Journal of Psychiatry, 1944; 101,*:141-–148.

Luborsky, L. (1977). Measuring a pervasive psychic structure in psychotherapy: The core conflictual relationship theme. In Freedman, N. (Ed.) *Communicative structures and psychic structures* (p. 367-395). USA: Springer

Luecken, L. (2008) Long-term consequences of parental death in childhood: Psychological and physiological manifestations. In Stroebe, Margaret S. (Ed); Hansson, Robert O. (Ed); Schut, Henk (Ed); Stroebe, Wolfgang (Ed). (2008)*. Handbook of bereavement research and practice: Advances in theory and intervention ,* (pp. 397-416). Washington, DC, US: American Psychological Association

Lyons-Ruth, K., Yellin, C., Melnick, S., & Atwood, G. (2005). Expanding the concept of unresolved mental states: Hostile/helpless states of mind on the Adult Attachment Interview are associated with disrupted mother–infant communication and infant disorganization. *Development and psychopathology*, *17*(01), 1-23.

Lysaker, P. H., Carcione, A., Dimaggio, G., Johannesen, J. K., Nicolò, G., Procacci, M., & Semerari, A. (2005). Metacognition amidst narratives of self and illness in schizophrenia: associations with neurocognition, symptoms, insight and quality of life. *Acta Psychiatrica Scandinavica*, *112*(1), 64-71.

Madill, A., Jordan, A., & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British journal of psychology*, *91*(1), 1-20.

Main, M., & Cassidy, J. (1988). Categories of response to reunion with the parent at age 6: predictable from infant attachment classifications and stable over a 1-month period. *Developmental psychology*, *24*(3), 415.

Main, M., & Goldwyn, R. (1984a) *Adult attachment scoring and classification system.* Unpublished manuscript, University of California at Berkeley.

Main, M., & Goldwyn, R. (1984b). Predicting rejection of her infant from mother's representation of her own experience: Implications for the abused-abusing intergenerational cycle. *Child Abuse & Neglect*, *8*(2), 203-217.

Main, M., Goldwyn, R., & Hesse, E. (2003). The adult attachment interview: Scoring and classification system, version 7.2. *Unpublished manuscript, University of California at Berkeley*.

Main, M. and Hesse, E. D. (1990). Parents' unresolved traumatic experiences are related to infant Disorganized attachment status: Is frightened and/or frightening parental behavior the linking mechanism? In M. Greenberg, D. Cichetti, and M. Cummings, (Eds), *Attachment in the Preschool Years*.(p161-182) Chicago: Chicago University Press.

Main, M., Kaplan, N., & Cassidy, J. (1985). Security in infancy, childhood, and adulthood: A move to the level of representation. In I. Bretherton & E.Waters (Eds.), Growing points of attachment theory and research. *Monographs of the Society for Research in Child Development* (p. 66-107) 50 (1-2, Serial No. 203).

Main, M. & Solomon, J. (1990). Procedures for identifying infants as disorganized/disoriented during the Ainsworth strange situation. In M. T. Greenberg, D. Cicchetti, & E. M. Cummings (Eds.), Attachment in the preschool years (pp. 121–160). Chicago: University of Chicago Press.

Mallinckrodt, B. (2011). Addressing the decline in counseling and supervision process and outcome research in the Journal of Counseling Psychology. *The Counseling Psychologist*, *39*(5), 701-714.

Mallon, B. (2008). *Dying, death and grief: working with adult bereavement*. Sage.

Marvin, R. S., & Pianta, R. C. (1996). Mothers' reactions to their child's diagnosis: Relations with security of attachment. *Journal of Clinical Child Psychology*, *25*(4), 436-445.

Marvin, R., Cooper, G., Hoffman, K., & Powell, B. (2002). The circle of security project: Attachment-based intervention with caregiver-pre-school child dyads. *Attachment & Human Development*, *4*(1), 107-124.

McIntyre, B., & Hogwood, J. (2006). Play, stop and eject: Creating film strip stories with bereaved young people. *Bereavement Care*, *25*(3), 47-49.

McLeod, J. (2011). *Qualitative research in counselling and psychotherapy*. London: Sage.

McLeod, J. (2013). Process and outcome in pluralistic Transactional Analysis counselling for long-term health conditions: A case series. *Counselling and Psychotherapy Research*, *13*(1), 32-43.

McClatchey, I. S., Vonk, M. E., Lee, J., & Bride, B. (2014). Traumatic and complicated grief among children: One or two constructs?. *Death studies*, *38*(2), 69-78.

McFarland-Piazza, L., Hazen, N., Jacobvitz, D., & Boyd-Soisson, E. (2012). The development of father–child attachment: associations between adult attachment representations, recollections of childhood experiences and caregiving. *Early Child Development and Care*, *182*(6), 701-721.

Meert, K. L., Shear, K., Newth, C. J., Harrison, R., Berger, J., Zimmerman, J., & Willson, D. F. (2011). Follow-up study of complicated grief among parents eighteen months after a child's death in the pediatric intensive care unit. *Journal of palliative medicine*, *14*(2), 207-214.

Meier, A., Boivin, M., & Meier, M. (2008). Theme-analysis: Procedures and application for psychotherapy research. *Qualitative Research in Psychology*, *5*(4), 289-310.

Melhem, N., Brent, D., Ziegler, M., Iyengar, S., Kolko, D., Oquendo, M., & Mann, J. (2007). Familial pathways to early-onset suicidal behavior: familial and individual antecedents of suicidal behavior. *American Journal of Psychiatry*, *164*(9), 1364-1370.

Midgley, N. (2004). Sailing between Scylla and Charybdis 1: Incorporating qualitative approaches into child psychotherapy research. *Journal of Child Psychotherapy*, *30*(1), 89-111.

Milton, M. (Ed.). (2010). *Therapy and Beyond: Counselling psychology contributions to therapeutic and social issues*. London: John Wiley & Sons.

Moore, T., & Rae, J. (2009). "Outsiders": How some counselling psychologists construct themselves. *Counselling Psychology Quarterly*, *22*(4), 381-392.

Moreira, P., Beutler, L. E., & Gonçalves, Ó. F. (2008). Narrative change in psychotherapy: differences between good and bad outcome cases in cognitive, narrative, and prescriptive therapies. *Journal of clinical psychology*, *64*(10), 1181-1194.

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of counseling psychology*, *52*(2), 250.

Mörtl, K., & Gelo, O. C. G. (2015). Qualitative methods in psychotherapy process research. In *Psychotherapy research* (pp. 381-428). Springer Vienna.

Moss, E., Cyr, C., & Dubois-Comtois, K. (2004). Attachment at early school age and developmental risk: examining family contexts and behavior problems of controlling-caregiving, controlling-punitive, and behaviorally disorganized children. *Developmental Psychology*, *40*(4), 519.

Muscetta, S., Dazzi, N., Decoro, A., Ortu, F., & Speranza, A. M. (1999). "States of mind with respect to attachment" and change in a psychotherapeutic relationship: A study of the coherence of transcript in a short-term psychotherapy with an adolescent. *Psychoanalytic Inquiry*, *19*(5), 885-921.

Neimeyer, R. A. (2000). Searching for the meaning of meaning: Grief therapy and the process of reconstruction. *Death studies*, *24*(6), 541-558.

Neimeyer, R. A., Herrero, O., & Botella, L. (2006). Chaos to coherence: Psychotherapeutic integration of traumatic loss. *Journal of constructivist psychology*, *19*(2), 127-145.

Neimeyer, R. A., Holland, J. M., & Currier, J. M. (2008). *Meaning reconstruction in later life: Toward a cognitive-constructivist approach to grief therapy.* In D. Gallagher-Thompson, A. Steffan, & L. Thompson (Eds.), Handbook of behavioral and cognitive therapies with older adults (pp. 264–277). New York: Springer and Verlag.

Neimeyer, R. A., & Currier, J. M. (2009). Grief therapy evidence of efficacy and emerging directions. *Current Directions in Psychological Science*, *18*(6), 352-356.

Neimeyer, R. A., Burke, L. A., Mackay, M. M., & van Dyke Stringer, J. G. (2010). Grief therapy and the reconstruction of meaning: From principles to practice. *Journal of Contemporary Psychotherapy*, *40*(2), 73-83.

Nickman, S. L., Silverman, P. R., & Normand, C. (1998). Children's construction of a deceased parent: The surviving parent's contribution. *American journal of orthopsychiatry*, *68*(1), 126-134.

Obegi, J. H., & Berant, E. (Eds.). (2010). *Attachment theory and research in clinical work with adults*. New York: Guilford Press.

Office of National Statistics Death Registrations by Single Year of Age - United Kingdom, 2011 http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-240174

Oliver, L. E. (1999). Effects of a child's death on the marital relationship: A review. *Omega-Journal Of Death And Dying*, *39*(3), 197-227.

Parkes, C. M. (1965). Bereavement and mental illness. *British Journal of Medical Psychology*, *38*(1), 13-26.

Parkinson, B., & Totterdell, P. (1999). Classifying affect-regulation strategies. *Cognition & Emotion*, *13*(3), 277-303.

Parliament, British. (1998). *Data protection act of 1998*. Retrieved from: http://www.legislation.gov.uk/ukpga/1998/29/pdfs/ukpga_19980029_en.pdf

Penman, E. L., Breen, L. J., Hewitt, L. Y., & Prigerson, H. G. (2014). Public Attitudes About Normal and Pathological Grief. *Death studies*, 38, (8) 510-7

Peräkylä, A., Antaki, C., Vehviläinen, S., & Leudar, I. (Eds.). (2008). *Conversation analysis and psychotherapy*. Cambridge, UK: Cambridge University Press.

Pianta, R. C., & Longmaid, K. (1999). Attachment-based classifications of children's family drawings: Psychometric properties and relations with children's adjustment in kindergarten. *Journal of Clinical Child Psychology*, *28*(2), 244-255.

Ponzetti Jr, J. J., & James, C. M. (1997). Loneliness and sibling relationships. *Journal of Social Behavior & Personality*.

Prigerson, H. G., Horowitz, M. J., Jacobs, S. C., Parkes, C. M., Aslan, M., Goodkin, K., & Maciejewski, P. K.

(2009). Prolonged grief disorder: Psychometric validation of criteria proposed for DSM-V and ICD-11. *PLoS medicine*, *6*(8)

Prigerson, H. G., Maciejewski, P. K., Reynolds, C. F., Bierhals, A. J., Newsom, J. T., Fasiczka, A., et al. (1995). Inventory of Complicated Grief: A scale to measure maladaptive symptoms of loss. *Psychiatry Research*, 59, 65–79

Rando, T. A. (1984). *Grief, dying, and death: Clinical interventions for caregivers* Champaign, Ill: Research Press Co

Raval, V., Goldberg, S., Atkinson, L., Benoit, D., Myhal, N., Poulton, L., & Zwiers, M. (2001). Maternal attachment, maternal responsiveness and infant attachment. *Infant Behavior and Development*, *24*(3), 281-304.

Rey, H. (1994) *Universals of Psychoanalysis in the Treatment of Psychotic and Borderline States*. London: Free Association Books.

Ribbens Mccarthy, J. (2007). 'They all look as if they're coping, but I'm not': The Relational Power/lessness of 'Youth' in Responding to Experiences of Bereavement. *Journal of Youth Studies*, *10*(3), 285-303.

Rogers, C. R. (1959). A theory of therapy, personality, and interpersonal relationships, as developed in the client-centered framework. In S. Koch (Ed.), *Psychology: A Study of a Science: Vol. 3* (pp. 184-256). New York, NY: McGraw-Hill.

Rogers, C. H., Floyd, F. J., Seltzer, M. M., Greenberg, J., & Hong, J. (2008). Long-term effects of the death of a child on parents' adjustment in midlife. *Journal of family psychology*, *22*(2), 203.

Rolls, L., & Payne, S. (2004). Childhood bereavement services: issues in UK service provision. *Mortality*, *9*(4), 300-328.

Rosenblatt, P. C. (1995). Ethics of qualitative interviewing with grieving families. *Death studies*, *19*(2), 139-155.

Rosenblatt, P. C. (2000). *Parent grief: Narratives of loss and relationship*. Brunner/Mazel.

Rosner, R., Kruse, J., & Hagl, M. (2010). A meta-analysis of interventions for bereaved children and adolescents. *Death Studies*, *34*(2), 99-136.

Sacks, H., Schegloff, E. A., & Jefferson, G. (1974). A simplest systematics for the organization of turn-taking for conversation. *Language*, 696-735.

Saldaña, J. (2003). *Longitudinal qualitative research: Analyzing change through time*. Walnut Creek, CA:

AltaMira Press

Salvatore, G., Conti, L., Fiore, D., Carcione, A., Dimaggio, G., & Semerari, A. (2006). Disorganized narratives: Problems in treatment and therapist intervention hierarchy. *Journal of Constructivist Psychology*, *19*(2), 191-207.

Salvatore, G., Dimaggio, G., & Semerari, A. (2004). A model of narrative development: Implications for understanding psychopathology and guiding therapy. *Psychology and Psychotherapy: Theory, Research and Practice*, *77*(2), 231-254.

Sanders, C. M. (1989). *Grief: The mourning after: Dealing with adult bereavement*. New York: John Wiley & Sons

Sandler, I. N., Ma, Y., Tein, J. Y., Ayers, T. S., Wolchik, S., Kennedy, C., & Millsap, R. (2010). Long-term effects of the family bereavement program on multiple indicators of grief in parentally bereaved children and adolescents. *Journal of consulting and clinical psychology*, *78*(2), 131.

Sandler, I. N., Wolchik, S. A., Ayers, T. S., Tein, J. Y., & Luecken, L. (2013). Family Bereavement Program (FBP) approach to promoting resilience following the death of a parent. *Family science*, *4*(1), 87-94.

Sauer, E. M., & Vespia, K. M. (2006). Defining characteristic or unrealistic ideal: Historical and contemporary perspectives on scientist-practitioner training in counselling psychology. *Counselling Psychology Quarterly, 19*(3), 229-251.

Scheel, M. J., Berman, M., Friedlander, M. L., Conoley, C. W., Duan, C., & Whiston, S. C. (2011). Counseling-related research in counseling psychology: Creating bricks, not edifices. *The Counseling Psychologist*, *39*(5), 719-734.

Schauer, M., Schauer, M., Neuner, F., & Elbert, T. (2011). *Narrative exposure therapy: A short-term treatment for traumatic stress disorders*. Cambridge, MA: Hogrefe Publishing

Semerari, A., Carcione, A., Dimaggio, G., Falcone, M., Nicolo, G., Procacci, M., & Alleva, G. (2003). How to evaluate metacognitive functioning in psychotherapy? The metacognition assessment scale and its applications. *Clinical Psychology & Psychotherapy*, *10*(4), 238-261.

Shapiro, E. R. (1994). *Grief as a family process: A developmental approach to clinical practice*. New York: Guilford Press.

Shaver, P. R., & Mikulincer, M. (2009). An overview of adult attachment theory. In Obegi, J. H., & Berant, E. (Eds.), *Attachment theory and research in clinical work with adults*, (17-45). New York: Guildford Press

Shear, K., Frank, E., Houck, P. R., & Reynolds, C. F. (2005). Treatment of complicated grief: a randomized controlled trial. *Jama*, *293*(21), 2601-2608.

Shear, K., Monk, T., Houck, P., Melhem, N., Frank, E., Reynolds, C., & Sillowash, R. (2007). An attachment-based model of complicated grief including the role of avoidance. *European archives of psychiatry and clinical neuroscience*, *257*(8), 453-461.

Shear, M. K. (2010). Complicated grief treatment: The theory, practice and outcomes. *Bereavement Care*, *29*(3), 10-14.

Shear, M. K. (2011). Bereavement and the DSM5. *OMEGA--Journal of Death and Dying*, *64*(2), 101-118.

Shirani, F., & Henwood, K. (2011). Continuity and change in a qualitative longitudinal study of fatherhood: relevance without responsibility. *International Journal of Social Research Methodology*, *14*(1), 17-29.

Silverman, P. R., & Worden, J. W. (1992). Children's reactions in the early months after the death of a parent. *American journal of Orthopsychiatry*, *62*(1), 93.

Simos, G., & Hofmann, S. G. (2013). *CBT for anxiety disorders: a practitioner book*. Oxford: John Wiley & Sons.

Sims, C. (2016). Counselling psychology in forensic settings. In Douglas, B., Woolfe, R., Strawbridge, S., Kasket, E., & Galbraith, V. (Eds.). (2016). *The Handbook of Counselling Psychology*. (p. 454-483) Los Angeles: SAGE.

Singer, J. A., & Rexhaj, B. (2006). Narrative coherence and psychotherapy: A commentary. *Journal of Constructivist Psychology*, *19*(2), 209-217.

Slade, A. (1999). Attachment theory and research: Implications for the theory and practice of individual psychotherapy with adults. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications (p.575-595)* New York: Guilford Press.

Slade, A. (2008). The implications of attachment theory and research for adult psychotherapy: Research and clinical perspectives. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (2nd ed.).(p 762-783) New York: Guilford Press.

Slough, N. M., & Greenberg, M. T. (1990). Five-year-olds' representations of separation from parents: Responses from the perspective of self and other. *New Directions for Child and Adolescent Development*, *1990*(48), 67-84.

Spuij, M., Reitz, E., Prinzie, P., Stikkelbroek, Y., de Roos, C., & Boelen, P. A. (2012). Distinctiveness of symptoms of prolonged grief, depression, and post-traumatic stress in bereaved children and

adolescents. *European child & adolescent psychiatry*, *21*(12), 673-679.

Spuij, M., Dekovic, M., & Boelen, P. A. (2015). An Open Trial of 'Grief-Help': A Cognitive–Behavioural Treatment for Prolonged Grief in Children and Adolescents. *Clinical psychology & psychotherapy*, *22*(2), 185-192.

Stanton, M., & Welsh, R. (2012). Systemic thinking in couple and family psychology research and practice. *Couple and Family Psychology: Research and Practice*, *1*(1), 14.

Steele, H., Steele, M., & Fonagy, P. (1996). Associations among attachment classifications of mothers, fathers, and their infants. *Child Development*, *67*(2), 541-555.

Steele, H., & Steele, M. (Eds.). (2008). *Clinical applications of the adult attachment interview*. New York: Guilford Press.

Stern, D. N. (1995). *The motherhood constellation: A unified view of parent-infant psychotherapy*. London: Karnac books.

Stokes, J. A. (2004). *Then, now and always: supporting children as they journey through grief: A guide for practitioners*. Winston's Wish.

Stokes, J. (2009). Resilience and bereaved children: Helping a child to develop a resilient mind-set following the death of a parent. *Bereavement Care*, *28*(1), 9-17.

Stroebe, M. (1997). From mourning and melancholia to bereavement and biography: An assessment of Walter's new model of grief. *Mortality*, *2*(3), 255-262.

Stroebe, M. S. (2002). Paving the way: From early attachment theory to contemporary bereavement research. *Mortality*, *7*(2), 127-138.

Stroebe, M. S. (2010). Bereavement in family context: Coping with the loss of a loved one 1. *Family Science*, *1*(3-4), 144-151.

Stroebe, W., & Stroebe, M. S. (1987). *Bereavement and health: The psychological and physical consequences of partner loss*. Cambridge, UK: Cambridge University Press.

Stroebe, M., & Schut, M. (1999). The dual process model of coping with bereavement: Rationale and description. *Death studies*, *23*(3), 197-224.

Stroebe, M., & Schut, H. (2005). To continue or relinquish bonds: A review of consequences for the bereaved. *Death studies*, *29*(6), 477-494.

Stroebe, M. S., Folkman, S., Hansson, R. O., & Schut, H. (2006). The prediction of bereavement outcome:

Development of an integrative risk factor framework. *Social science & medicine*, *63*(9), 2440-2451.

Stroebe, M., Schut, H., & Van den Bout, J. (Eds.). (2013). *Complicated grief: Scientific foundations for health care professionals*. New York: Routledge.

Sutherland, O. A., Sametband, I., Silva, J. G., Couture, S. J., & Strong, T. (2013). Conversational perspective of therapeutic outcomes: The importance of preference in the development of discourse. *Counselling and Psychotherapy Research*, *13*(3), 220-226

Talia, A., Daniel, S. I., Miller-Bottome, M., Brambilla, D., Miccoli, D., Safran, J. D., & Lingiardi, V. (2014). AAI predicts patients' in-session interpersonal behavior and discourse: A "move to the level of the relation" for attachment-informed psychotherapy research. *Attachment & human development*, *16*(2), 192-209.

Target, M., Fonagy, P., & Shmueli-Goetz, Y. (2003). Attachment representations in school-age children: the development of the child attachment interview (CAI). *Journal of child psychotherapy*, *29*(2), 171-186.

Thomson, P. (2010). Loss and disorganization from an attachment perspective. *Death studies*, *34*(10), 893-914.

Thomson, R., & McLeod, J. (2015). New frontiers in qualitative longitudinal research: an agenda for research. *International Journal of Social Research Methodology*, *18*(3), 243-250.

Tonkin, L. (1996). Growing around grief—another way of looking at grief and recovery. *Bereavement Care*, *15*(1), 10-10.

Tremblay, G. C., & Israel, A. C. (1998). Children's adjustment to parental death. *Clinical Psychology: Science and Practice*, *5*(4), 424-438.

Tuval-Mashiach, R., Freedman, S., Bargai, N., Boker, R., Hadar, H., & Shalev, A.Y. (2004). Coping with trauma: narrative and cognitive perspectives. *Psychiatry*, 67(3), 280-293.

Valentine, C. (2008). *Bereavement narratives: Continuing bonds in the twenty-first century*. Abingdon: Routledge.

Van der Kolk, B. A., & Van der Hart, O. (1989). Pierre Janet and the Breakdown of Adaptation. *American Journal of Psychiatry*, *146*(12), 1S30-1S40.

Van IJzendoorn, M. (1995). Adult attachment representations, parental responsiveness, and infant attachment: a meta-analysis on the predictive validity of the Adult Attachment Interview. *Psychological bulletin*, *117*(3), 387.

Wagner, B., Knaevelsrud, C., & Maercker, A. (2006). Internet-based cognitive-behavioral therapy for complicated grief: a randomized controlled trial. *Death studies*, *30*(5), 429-453.

Walter, T. (1994). *The revival of death*. London: Routledge

Walter, T. (1996). A new model of grief: Bereavement and biography. *Mortality 1(1), 7-25*.

Warmuth, K. A., & Cummings, E. M. (2015). Examining developmental fit of the Adult Attachment Interview in adolescence. *Developmental Review*, *36*, 200-218.

Weller, R. A., Weller, E. B., Fristad, M. A., & Bowes, J. M. (1991). Depression in recently bereaved prepubertal children. *American Journal of Psychiatry*, *148*(11), 1536-1540.

Westen, D., Nakash, O., Thomas, C., & Bradley, R. (2006). Clinical Assessment of Attachment Patterns and Personality Disorder in Adolescents and Adults. *Journal of Consulting and Clinical Psychology, 74, 1065-1085.*

Wilkinson, S. (1988, January). The role of reflexivity in feminist psychology. In *Women's Studies International Forum* (Vol. 11, No. 5, pp. 493-502).

Willig, C. (2013). *Introducing qualitative research in psychology*. Maidenhead: Open University Press.

Winnicott, D. W. (1953) Transitional Objects and Transitional Phenomena -A Study of the First Not-Me Possession. *International Journal of Psycho-Analysis*, *34*, 89-97.

Winston's Wish (2010), *A Child's Grief.* Winston's Wish Publication.

Winston's Wish (2014)   http://www.winstonswish.org.uk Retrieved 1/3/2014

Woolfe, R. (2006) 'Counselling psychology in Britain: past, present and future', *Counselling Psychology Review*, 11(4), pp. 7-18.

Worden, J. W. (1991). *Grief counseling and grief therapy: A handbook for the mental health practitioner*. (1st Edition) New York: Springer

Worden, J. W. (1996). *Children and grief: When a parent dies*. London: Guilford Press.

Worden, J. W. (1999). Comparing parent loss with sibling loss. *Death studies*, *23*(1), 1-15.

Worden, J. W. (2008). *Grief counseling and grief therapy: A handbook for the mental health practitioner*. (4th Edition) New York: Springer

Appendices Contents

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Appendix 1: Journal Article Information

The paper is intended for submission in The Family Journal, the official journal of the International Association of Marriage and Family Counsellors. The journal publishes articles concerned with theory, research, and practice in counselling with couples and families. This journal was chosen because it aims to provide ground breaking, innovative scholarship for counselling researchers, educators and practitioners. The journal welcomes qualitative research and it has features focussing on interventions from a systemic perspective. It was also targeted because they would like to receive manuscripts from professionals working in countries outside the USA.

The journal states that they prefer manuscripts that are 20 pages or less in length, double-spaced, using guidelines from the *Publication Manual of the American Psychological Association* (6th or latest edition), and saved in Microsoft Word (97 or later version). The guidelines say there should be separate pages for the title page, abstract, references, and any tables or figures. These guidelines have been followed for the paper.

www.winstonswish.org.uk

To Whom it May Confirm

I can confirm that Winston's Wish has agreed to work with Rachel Willcox to support the data collection needed for her doctoral thesis:

A study of bereaved families' narratives at the beginning and end of therapy

Any questions about Winston's Wish's involvement in this study can be directed to myself or the Clinical Lead, Gianna Daly.

We look forward to working with Rachel during this study.

Yours faithfully

Suzannah

Suzannah Phillips
Clinical Services Development Lead

Winston's Wish ● 3rd Floor ● Cheltenham House ● Clarence Street ● Cheltenham ● Gloucestershire ● GL50 3JR
helpline 08452 03 04 05 ● tel 01242 515157 ● fax 01242 546187 ● email info@winstonswish.org.uk
Winston's Wish is a registered charity (England and Wales) 1061359 (Scotland) SC041140

**A study of bereaved families' narratives at the
beginning and end of their family work**

Adult Participant information sheet

You are invited to take part in a research study exploring how bereaved families tell the story of their bereavement in their family sessions.

The study involves audio recording two of your family sessions with your key worker; one at the beginning of your sessions, and one towards the end of your family sessions. Before deciding if you would like to take part, it is important you understand why the research is being done and what it will involve. Please talk to others about the project if you'd like to. Feel free to ask me for more information about the project if this would be helpful. Take time to decide whether or not you wish to take part.

Who is carrying out this research?
My name is Rachel Willcox and I am a trainee Counselling Psychologist at the University of the West of England, Bristol. This research project is supervised by Dr Naomi Moller and Dr Victoria Clarke.

What is the research about?
The study is looking at how families tell the story of their bereavement in their family sessions. I'm interested in hearing the words you use and how you tell the story together. I'm also interested in how the story might be different at the beginning and end of your family work, which is why I'll be recording 2 sessions at different times.

Why is it important?
By taking part in this study you will be providing important information about the experiences of families who have been bereaved, how they understand their experience and how they tell the story together as a family. This will hopefully be useful in improving services for families who are bereaved.

Who is being asked to take part?
You are being asked to take part if:
- You and your children have experienced a bereavement of a close family member
- You are accessing family support through Winston's Wish Accident and Illness Team

Do I have to take part?
No. Taking part is voluntary and entirely up to *you*. You can decide not to take part without providing any reason. If you do take part you will be free to withdraw without providing a reason. If you decide during

your family session that you do not wish to take part, you can ask the therapist to stop the recording at any point.

What does the study involve?
If you are interested in taking part, two of your family sessions will be audio recorded on a digital recorder. The final session will be an extra session that will be added on to the usual number of sessions offered by Winston's Wish. This is for the purpose of this research project. The digital recorder will be placed on the table in the room while you have your session. I will then type up these recordings and use them for my research. It is not intended that the recording will make any difference to the content of your session, or how the key worker will work with you.

What are the possible risks and benefits of taking part?
Previous studies have found that people like to be offered the opportunity to be involved in studies and it may give you satisfaction that you have contributed to research, to help increase understanding of how families come to terms with their bereavement and the impact on their family.

This study does not involve any direct risks. Sources of further support are listed below. If you would like the opportunity to talk to me about your research experience please contact me on rachel2.willcox@live.uwe.ac.uk

Sources of further support:
If you experienced distress during or after your engagement in this research project it might be helpful to seek some support. You can speak to your Key Worker at Winston's Wish. Also, your GP is available for support. Further sources of support are listed below

- *Family Lives*: a national family support charity providing help and support in all aspects of family life. 24 hour helpline 0808 800 2222 and online support at www.familylives.org.uk

- *Young Minds* a charity committed to improving the emotional wellbeing and mental health of children and young people. Parents Helpline: 0808 802 5544   www.youngminds.org.uk

What if there is a problem?
Any complaint about the way you have been dealt with during the research project will be promptly addressed.   If you are unhappy with any aspect of the project, in the first instance you should discuss the matter with the Key Researcher or Supervisor, Dr Naomi Moller, whose details are at the bottom of this page. Alternatively you could speak to Suzie Phillips, Clinical Services Development Lead, the Winston's Wish Contact for the project sphillips@winstonswish.org.uk

If you decide to withdraw your data from the study please contact rachel2.willcox@live.uwe.ac.uk
If you do decide to withdraw data, I would strongly encourage you to do this within 3 months of the recording.

Will my taking part in this study be kept confidential?
Yes. We will follow accepted ethical and legal practice concerning confidentiality.   The recordings of the family sessions will be typed up, and all data will be stored securely on password-protected computers

and will be coded with a number, so you will not be identifiable. Transcripts will be seen only by myself and my research supervisors. The signed consent form will be stored separately from your responses in a locked filing cabinet and will be shredded following completion of the study. All recordings and transcripts will be deleted or shredded following completion of the study.

In terms of your responses to the research questions, any personally identifying information will be removed from transcripts (e.g. place names, person names). You will be given the opportunity to choose pseudonyms with your family members and key worker.   Any published results (either at a conference or in a journal) from the study may include quotations from your interview answers but they will not include any participant identifiable information.

As in any piece of research, if information is disclosed which clearly shows that you or a child is currently at risk, confidentiality could not be maintained. In these cases I would be obliged to discuss this with the appropriate services. I would try to discuss this with you first.

What will happen to the results of this study?
The results may be published in my thesis, academic journals, publications, and presented at conferences. Participants will not be identifiable in any reports. If you wish, you will be provided with a short summary of the research findings once the study is completed.

Who has reviewed the study?
The study has been reviewed and approved by University of West of England Department of Psychology Ethics Committee.

Contacts for further information

Key Researcher:
Rachel Willcox
Trainee Counselling Psychologist rachel2.willcox@live.uwe.ac.uk

1st Supervisor:
Dr. Naomi Moller, C. Psychologist
Naomi.Moller@uwe.ac.uk
Associate Head of Department of Health and Social Sciences, Psychology Cluster Leader
University of the West of England
Frenchay Campus, Coldharbour Lane
Bristol, BS16 1QY

2nd Supervisor
Dr Victoria Clarke
Victoria.Clarke@uwe.ac.uk
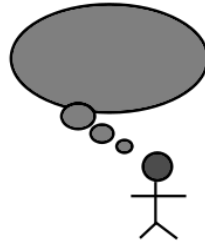Associate Professor in Sexuality Studies
Health and Applied Social Sciences
University of the West of England
Frenchay Campus, Coldharbour Lane
Bristol , BS16 1QY

Understanding families stories about their bereavement

By Rachel Willcox

You are being asked to take part in a piece of work that Rachel is doing. Before you decide if you want to do it, please read this form to find out what it's all about.

If there is anything that is hard to understand, please ask your key worker and they will help explain. You can also ask an adult to email me to answer your questions on rachel2.willcox@live.uwe.ac.uk

What is the work about?
I want to find out how families talk about the story of the death of their family member. I hope that this will help me to find different ways to work with families to make their problems better.

What do I have to do?
Nothing!

If you want to take part then your key worker will record 2 of the sessions you have together. One of these will be an extra session for this project. This means that I can listen to the recordings and write down important information that you talk about. I won't use your real name so nobody else will know what you have said. If you don't like having the recorder on then your key worker can turn it off at any time.

What happens if I say no?
It's ok to say no. You will still work with your key worker but they won't record the sessions.
Even if you've already said yes, you can change your mind and say no at any time and the recorder will be switched off.

A Study of Bereaved Families' Narratives at the Beginning and End of Therapy

Family (Adult) Consent Form

Please write an 'X' in the boxes to show your consent to the following statements.

(1) I confirm that I have read and understand the information sheet for the above research project. I have been given the opportunity to consider the information and to ask questions and my questions have been answered satisfactorily.

(2) I understand that my participation in the research project is entirely voluntary, and that I am free to withdraw at any time without giving any reason, and without my care or legal rights being affected.

(3) I understand that direct anonymised quotations from my therapy session may be used in the write up of the research project.

(4) I agree to participate in the above research project.

(5) I agree for my children to participate in the above research project.

_____   _____   _____

Participant Name   Date   Signature

If you would like to receive information about the results of the study please note down your email here:

Family Consent form

We agree to take part in Rachel's study – we're happy for our key worker to record two of our family sessions.

Family members:

Key worker:

Signed:………………………………………………………………… Date:……………………………………...

Researcher's Name:……………………………………………………………………………………….

Researcher:…………………………………………………… Date:………………………………….

A study of bereaved families' narratives at the beginning and end of therapy

Therapist Information Sheet

You are invited to take part in a research study exploring how bereaved families tell the story of their bereavement in their therapy sessions.

The study involves recording two of your therapy sessions with the family you are working with; one towards the beginning of your sessions, and one towards the end of your therapy sessions. The final session will be an extra session that will be added on to the usual number of sessions offered by Winston's Wish. This is for the purpose of this research project. Before deciding if you would like to take part, it is important you understand why the research is being done and what it will involve. Please talk to others about the project if you want to. Feel free to ask me for more information about the project if this would be helpful. Take time to decide whether or not you wish to take part.

Who is carrying out this research?
My name is Rachel Willcox and I am a trainee Counselling Psychologist at the University of the West of England, Bristol. This research project is supervised by Dr Naomi Moller and Dr Victoria Clarke.

What is the research about?
The study is looking at how families tell the story of their bereavement. . I'm interested in hearing the words they use and how they tell the story together. I'm also interested in how the story might be different at the beginning and end of therapy, which is why I'll be recording 2 sessions at different times.

Why is it important?
By taking part in this study you will be providing important information about the experiences of families who have been bereaved, how they understand their experience and how they tell the story together as a family.

Who is being asked to take part?

You are being asked to take part if:

* You will be providing therapy to a family who have agreed to take part in this research project.

Do I have to take part?

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No. Taking part is voluntary and entirely up to *you*. You can decide not to take part without providing any reason. If you do take part you will be free to withdraw without providing a reason.

What does the study involve?
If you are interested in taking part, two of your therapy sessions will be recorded on a digital recorder. The digital recorder will be placed on the table in the room while you have your session. I will then transcribe these recording and use them for my research. The recording is not intended to make any difference to the content of your session.

What are the possible risks and benefits of taking part?
Previous studies have found that people like to be offered the opportunity to be involved in studies and it may give you satisfaction that you have contributed to research, to help increase understanding of how families come to terms with their bereavement and the impact on their family. This study does not involve any direct risks. Sources of support are listed below.

Further support:
If you experienced distress during or after your engagement in this research project it might be helpful to seek some support. You can speak to your Supervisor or Line Manager at Winston's Wish. Also, your GP is available for support.

What if there is a problem?
Any complaint about the way you have been dealt with during the research project will be promptly addressed. If you are unhappy with any aspect of the project, in the first instance you should discuss the matter with the researcher or supervisor, Dr Naomi Moller, whose details are at the bottom of this page. Alternatively you could speak to Suzie Phillips, Clinical Services Development Lead is the Winston's Wish Contact for the project sphillips@winstonswish.org.uk

If you decide to withdraw your data from the study, please contact rachel2.willcox@live.uwe.ac.uk . I would strongly encourage you to do this within 3 months of the recording.

Will my taking part in this study be kept confidential?
Yes. We will follow accepted ethical and legal practice concerning confidentiality. The recordings of the therapy sessions will be transcribed, and all data will be stored securely on password-protected computers and will be coded with a number, so you will not be identifiable. Entire transcripts of sessions will be seen only by myself and my research supervisors. The signed consent form will be stored separately from your responses in a locked filing cabinet and will be shredded following completion of the study. All recordings and transcripts will be deleted or shredded following completion of the study.

In terms of your responses to the research questions, any personally identifying information will be removed from transcripts (e.g. place names, person names). You will be given the opportunity, along with the family you are working with, to choose a pseudonym. Any published results (either at a conference or in a journal) from the study may include quotations from your interview answers but they will not include any participant identifiable information.

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As in any piece of research, if information is disclosed which clearly shows that any of your clients are currently at risk, confidentiality could not be maintained. Similarly, if the research team is concerned about material in terms of clinical risk, the key researcher will talk to the Project Liaison at Winston's Wish, Suzie Phillips, (Clinical Service Development Lead). I would try to discuss this with you first.

What will happen to the results of this study?
The results may be published in my thesis, academic journals, publications and presented at conferences. Participants will not be identifiable in any reports. If you wish, you will be provided with a short summary of the research findings once the study is completed.

Who has reviewed the study?
The study has been reviewed and approved by University of West of England Department of Psychology Ethics Committee.

Contacts for further information

Key Researcher:
Rachel Willcox
Trainee Counselling Psychologist
rachel2.willcox@live.uwe.ac.uk

1st Supervisor:
Dr. Naomi Moller, C. Psychologist
Naomi.Moller@uwe.ac.uk
Associate Head of Department of Health and Social Sciences, Psychology Cluster Leader
University of the West of England

Frenchay Campus, Coldharbour Lane
Bristol, BS16 1QY

2nd Supervisor
Dr Victoria Clarke
Victoria.Clarke@uwe.ac.uk
Associate Professor in Sexuality Studies
Health and Applied Social Sciences
University of the West of England
Frenchay Campus, Coldharbour Lane
Bristol , BS16 1QY

A Study of Bereaved Families' Narratives at the Beginning and End of Therapy

Therapist Consent Form

Please write an 'X' in the boxes to show your consent to the following statements.

(1) I confirm that I have read and understand the information sheet
for the above research project. I have been given the opportunity to
consider the information and to ask questions and my questions have
been answered satisfactorily.

(2) I understand that my participation in the research project is entirely
voluntary, and that I am free to withdraw at any time without giving any
reason.

(3) I understand that direct anonymised quotations from my therapy
session may be used in the write up of the research project.

(4) I agree to participate in the above research project.

_____   _____   _____

Therapist Name   Date   Signature

If you would like to receive information about the results of the study please note down your email
here:

Appendix 9: Braun & Clarke (2013) Transcription notation system for orthographic transcription (adapted from Jefferson, 2004)

Feature	Notation and explanation of use
The identity of the speaker; turn-taking in talk	The speaker's name, followed by a colon (e.g., Anna:) signals the identity of a speaker (use Moderator/Mod: or Interviewer/Int: for when the moderator/interviewer is speaking; or the moderator/interviewer's first name); start a new line every time a new speaker enters the conversation, and start the first word of each new turn of talk with a capital letter
Laughing, coughing etc.	((laughs)) and ((coughs)) signals a speaker laughing or coughing during a turn of talk; ((General laughter)) signals multiple speakers laughing at once and should be appear on a separate line (to signal that no one speaker 'owns' the laughter)
Pausing	((pause)) signals a significant pause (i.e., a few seconds or more; precise timings of pauses is not necessary); can also use (.) to signal a short pause (a second or less) or ((long pause)) to signal a much longer pause
Spoken abbreviations	If someone speaks an abbreviation, then use that abbreviation (e.g., TV for television; WHO for World Health Organisation), but do not abbreviate unless a speaker does so
Overlapping speech	Type ((in overlap)) before the start of the overlapping speech
Inaudible speech	Use ((inaudible)) for speech and sounds that are completely inaudible; when you can hear something but you're not sure if it's correct, use single parentheses to signal your best guess or guesses as to what was said – for example (ways of life) or (ways of life/married wife)
Uncertainty about who is speaking	Use ? to signal uncertainty about the speaker – just ? for total uncertainty, F? or M? if you can identify sex of the speaker, or or a name followed by a question mark (e.g., Judy?) if you think you might know who it is
Non-verbal utterances	Render phonetically and consistently (common non-verbal sounds uttered by your participants. For English-as-a-first-language speakers, these include 'erm', 'er', 'mm', 'mm-hm', but note that how these are written is context-dependent. In Aotearoa/New Zealand, the first two would be written 'um' and 'ah'
Spoken numbers	Spell out all numbers (and be mindful of the difference between 'a hundred' and 'one hundred')

Use of punctuation	It is common to use punctuation to signal some features of spoken language (such as using a question mark to signal the rising intonation of a question or a comma to signal a slight pause but with the intonation of continuing speech). However, adding punctuation to a transcript is not straightforward and it is important to be mindful of the ways in which adding punctuation can change the meaning of an extract of data. Equally, punctuation enhances the readability of spoken data, especially extracts quoted in written reports (see Box 11.5 in Chapter 11)
Cut off speech and speech-sounds	This level of detail is not necessary for most experiential forms of analysis, although it can be useful to signal moments when participants are struggling to articulate their thoughts, feelings etc.; to signal cut off speech, type out the sounds you can hear, then add a dash (e.g., wa-, wor-, worl-); try to capture this at the level of phonetic sound
Emphasis on particular words	Again, this level of detail is not necessary for most experiential forms of analysis, although it can be useful as an indicator of words or sounds that are particularly emphasised by underlining (e.g., <u>word</u>)
Reported speech	Reported speech is when a person provides an apparent verbatim account of the speech (or thoughts) of another person (or reports their own speech in the past). Signal this with the use of inverted commas around the reported speech (e.g., … and she said 'I think your bum does look big in that dress' and I said 'thanks a bunch'…)
Accents and abbreviations/vernacular usage/mispronunciation	It's important not to transform participants' speech into 'standard' English; however, fully representing a strong regional accent can be a complex and time consuming process. A good compromise is to signal only the very obvious or common (and easy to translate into written text) abbreviations and vernacular usage, such as 'cos' instead of 'because' or a Welsh speaker saying 'me Mam' (instead of the English 'my Mum'), unless it is absolutely critical for your analysis to fully represent exactly how a speaker pronounces words and sounds. Don't 'correct' mispronunciation or misspeaking of works, such as "compostle" instead of "compostable"
Names of media (e.g., television programmes, books, magazines etc.)	Should be presented in italics (e.g., *The Wire, Men's Health*)

Identifying information	You can change identifying information such as people's names and occupations, places, events, etc. in one of two ways (see also Box 7.3): By changing details and providing unmarked, appropriate alternatives (e.g., 'Bristol' to 'Manchester'; 'my sister is fourteen' to 'my sister is twelve'; 'I'm a really keen knitter' to 'I'm a really keen sewer'.) By replacing specific information with marked generic descriptions (indicated by in square brackets, so 'London' might be replaced with [large city]; 'Michael' with [oldest brother]; 'running' with [form of exercise])

This codebook is in two parts. The first part is the compilation of AAI Unresolved Loss codes found in the data, forming the deductive codes. The second part of the codebook are the codes created using the inductive-deductive coding process, codes found in the data but informed by Attachment Theory.

Part 1: Deductive Codes from AAI Unresolved Loss codes	

Title of Code	Example from study data (Family number/recording number)
Slip of the tongue to present tense	*Family 2/1 line 832* Dad: The first pain (.) her worst pain's always in the morning *Family 1/1 Line 64* Lucy: where my daddy
Deceased and speaker living parallel lives in the present	Eg: child talking about who's part of their family *Family 1/1 Line 508-513* Alice: and I've got somebody else Therapist: who else Alice: I've got Dad kind of around cos he's (.) still like in the air and things(.) so he's kind of still around Therapist: it feels like he's still around Alice: yeh
Being dead is an activity	e.g: Describing the Dad's body in the hospital *Family 1/ 2 Line 78:* Mum: He was quite cold and different wasn't he so we put him in the blanket to keep him warm
Confusion between dead person and self/ change of pronouns or Attributing deceased actions to self	e.g: Talking about a poem Dad had written that a friend read at the funeral: *Family 1/1 Line 392-396* Alice: Um (.) this is a poem that he writ(.) Therapist: Ooh Alice: this is a poem that I writ about I knew my days would come at last that I would and he said the person that was reading the poem said that "our Darren was a brave man because he knew he was going to die someday really early" and he was only eighty thirty eight. Confusion over his/my: *Family 1/1 Line 63*: Alice: When I went into the lounge cos he wasn't (.) because when I gave him a hug he'd normally put my hands round and he didn't
Confusion about timeline of death itself - for example	*Family 1/1 204-206* Therapist: and what has happened then Alice (.) So you all moved up here (.) Daddy Darren and you and Lucy and mummy

Title of Code	Example from study data (Family number/recording number)
confusion around own age or when death occurred	Alice: Um (.) Darren died *Family 2/1 Line 851* Child: Was I only 5 when she died

Confusion with respect to timeline of events leading up	*Family 5/2 Line 65-67*
	  Steve: she was at the party
	  Brenda: we weren't at the party (.) we weren't
	  at the party when mummy died
	  Steve: oh I forgot a bit

Disorientation with respect to time and space Marked spatial disorientation for example suddenly placing themselves at the scene of an event	*Family 1/2 Line 245-247* Mum: yeh we did yeh but Friday we just went home and blur Alice: Friday we had Muriel and Dan over Mum: I can't remember
Psychological confusion: Paradoxical or impossible statements Intentional, unwriting or undoing of history or aspects of it	*Family 4/1 Line 217-218* Mum: I said 'it will be alright and you're going to see this neurologist you'll be fine don't worry' and I knew he was- I knew something was wrong but I didn't know

Unusual attention to detail – acting out scene of death
 	
Speaker no longer conscious of context. Speaker reliving the past in details so as to bring the person to life again.
	Family 5/1 Line 381
	  Brenda: and mummy was lying on the ground like this
	  Dad: mummy was lying hurt
	  Brenda: was she like this
	  Dad: on her back love
	  Brenda: like that

Poetic phrasing Speech more appropriate for written text, eulogistic feel, sense of it being 'rehearsed'.	*Family 1/ 2 Line 10:* Alice: and then we went home and we found out *Family 1/2 Line 199:* Alice: And lots of people smothered me
Prolonged silences Finish a sentence and then lapse into a long silence, Speaker trailing off mid sentence	*Family 1/1 Line 281-282* Mum: They were just in hospital (.).umm ((long pause 6 seconds)) just checking on his body (.) making sure everything is working as it should have been(.) *Family 1/2 Line 73 - 77* Alice: so I said 'is Daddy dead' and Mummy ((long pause 6 seconds)) Therapist: Hum Alice: And Mummy nodded (.)

Title of Code	Example from study data (Family number/recording number)
Unfinished sentences Overwhelmed by thought of death so aren't able to monitor or repair speech	E.g: Describing children visiting Dad's body *Family 3/2 Line 314* Mum: and then they went to see- I think he'd- I was at work when he- when he came back (.) and I E.g: Talking about Dad's cause of death: *Family 1/1 Line 218-221* Alice: um I this what Darren happened (.) is it where he had his lungs and they stopped (.) and his kidneys Mum: yeh his body jus- Alice: yeh Mum: yeh

Part 2: Inductive-deductive Codes (grounded in data and informed by AT)

Title of Code	Example from study data (Family number/recording number)
Giggles or laughter when talking about the death	e.g: Describing who came to the house as soon as the Dad's body was found *Family 1/1 Line 374-375* Mum: um (.) yeh(.) Jane came (.) aunty Steph came (.) (laugh) then luckily everyone went home. It was quite a (.) I mean cos everything was fine e.g: Talking about the funeral: *Family 1/1 Line 448* Mum: (Laugh) I've never seen so many people in one place (laughs) haha
Incongruous emotion – laughter when talking about something difficult	e.g: Talking about Dad's body in the hospital: *Family 3/1 Line 254* Mum: and you all said didn't you he's it's like he's sleeping and he's abo to snore and they all said we're like waiting for him to (.) start snoring Suzie: laugh Mum: um yeh mm ((3 second pause)) it was quite hard really
Family member physically leaves the room or goes significantly off topic during distressing content	e.g: Immediately after talking about the funeral: *Family 5/1 Line 935-938* Brenda: why is there poo on the window Therapist: because there are some birds that fly by that window that's there's poo on that window Brenda: is that Saint Greg's church Therapist: ah I'm not sure (.) I think it's Saint Martins (.) so after mummy died you went to (.) she was at e.g: The father's immediate response to the younger son talking about may have contributed to his brother's death *Family 4/1 Line 818* Dad: oh (sounds like he's left the group and gone off to the kitchen and banged something)
Children left vague about details or with gaps in timeline	e.g: Parent doesn't explain clearly about what happened when the Dad was receiving medical treatment *Family 1/1 Line 364-369* Mum: I mean it was weird for me because I couldn't panic (.) i just had to make sure didn't see what I call the horrible things Daughter: what was the horrible things? Mum: Just things you didn't need to see darling um (.) to both (.) just asleep (.)

Title of Code	Example from study data (Family number/recording number)
Adults resistance to giving child details and lack of understanding of child's perspective	E.g: Talking about the funeral date *Family 1/1 Line 265 – 267* Daughter: Wednesday 16th Therapist: Oh yeh do you remember it was a Wednesday Mum: (laughter) I can't remember
Parental reshaping of story to match own understanding	e.g: Dad discussing children seeing mum's body in an open casket. Son had alrea[d] described his sister as being scared and not wanting to kiss the body. *Family 5/1 Line 822-823* Dad: so that kids got to go and say their goodbyes and they weren't a bit scared and they were constantly kissing her
Disjuncture between child and adult memory	*Family 1/1 Line 252-254* Mum: Yeh that was Friday but we did go to Nanas on Saturday Alice: We didn't Mum: Yes we did darling *Family 2/1 Line 466* Dad: Chloe was in the house at the time (.) weren't you darling (.) but y[ou] didn't see mummy c- c- collaspse but um Child: Neither did you Dad: No (.) I kind of did darling Child: Did you
Child telling their story their way	Disjunction between Alice's subjective experiences in family 1, resisting melding together 2 narratives (see story map)
One member of the family's narrative not included in family story	Telling story with 2 conflicting facts *Family 1/1 320-324* Alice: like that and his eyes were like that and mummy thought mummy thought he was asleep like that (.) just his eyes a bit open she thought he was asleep but he was actually dead and I thought when I straight away I came in and looked at him I thought he was actually dead and my heart was beating and when I saw mummy calling the ambulance I straight away knew he was dead so I was the one who knew he was dead first
Non-specific language	Eg "stuff"- avoiding detail to 'protect' child but counter-collaborative. *Family 1/1 Line 364* Mum: I just had to make sure didn't see what I call the horrible things *Family 1/1 Line 342* Mum: but they didn't see what I call the 'nasty' stuff (.)
Significant details lost from the narrative during second telling	Missing details both factual and emotional content (see story map)
Disagreement about the facts	*Family 1/1 Line 275-279* Alice: yes (.) cos he had to have a liver transplant

Title of Code	Example from study data (Family number/recording number)
	Mum: say that again darling Alice: liver transpant Mum: no he didn't darling Alice: what was it then? *Family 1/1 Line 84-87* Mum: uh (laugh) We were neighbours Therapist: ah ok(.) so you lived next to each other Alice: not next to each other we had a path Mum: well near enough
One family member has exclusive and unshared understanding/insight	*E.g: talking about Dad going into ambulance feeling unwell* *Family 3/1. Line 174* Daughter: and he didn't come back out (.) that like me and Louise watched it go away and I knew then that he wasn't coming back
Children left vague about details or with gaps in timeline	Eg: Son not given coroner's report to read *Family 4/2 Line 713* Mike: ((in overlap)) I've never read the report (.) I've never um well actually I was never offered it really *Family 5/1 Line 504-505* Dad: see them two days were (.) when Suzie was in hospital (.) I've never sat with them and talked to them two we just talk about the (.) the accident
Adults resistance to giving child details and lack of understanding of child's perspective	e.g: Child is speaking about remembering Mum's perfume, therapist asks if there's some still around as smell is important and Dad replies with resistance and not taking the opportunity to help child's process *Family 5/1 Line 810* Dad: Suzie used all different ones
Parent not tolerating distress or emotionally dismissive	The phrase 'anyway' used by one Dad to start new sentences after difficult content in Family 4/1, Lines 359, 367, 390) In Family 1, Mum is cross with toddler for crying during session – no comfort given
Therapist co-constructing disorganised narrative	Talking about Dad's body: *Family 1/ 2 Line 144-151* Mum: And that was before no that was after Daddy had gone Alice: Yeh Therapist: And where did Daddy go to? Alice: hospital Therapist: Ah so the ambulance took him Alice: Yeh Therapist: Ah ok Mum: It was (.) it wasn't the ambulance that took him was it
Therapist and adult exclusive adult language or	*Family 2/1 Line 273-274* Dad: Sarah's father was (.) for want of a better

Title of Code	Example from study data (Family number/recording number)
narrative – child left out	phrase (.) a serial cruiser Therapist 1 : Hah-ha Use of medical terminology – drug names etc in an exclusive way
Therapist or child asking for details/clarification	*Family 1/1 Line 81* Therapist: So daddy lived somewhere else *Family 5/2 Line 361* Therapist: and did you go and see the coffin
Therapist facilitating story telling process – psycho-education to the model	*Family 3/1 Line 564* Therapist: do you feel (.) do you feel that is where your story ends or- I don't know (.) do you want to talk a little about how life is or what you feel you're left with at the moment (.) it's different for different families so that's why I'm asking *Family 5/1 Line 3* Therapist: ok (.) so this bit of work is thinking about what happened when your mummy died
Therapist facilitating co-construction of narrative – engaging all members	*Family 3/1 Line 166:* Therapist: Suzie is there anything you want to add or what you feel was a bit different for you Therapist speaking to child: *Family 1/1 Line 22-23* Therapist: again(.) we might need to d- we could maybe to double check with mum er mummy what her memories are in a minute
Therapist making members connect to each other	Therapist encouraging child to sit and listen to Dad's part of the story *Family 2/1 Line 149-151* Therapist: Chloe is it ok for you to come and sit and just listen (.) there might be parts of the story that are new to you that you've never heard before" Therapist encouraging family to be aware of how each other are feeling after the session *Family 3/2 Line 471* Therapist: so you can check in with each other how you feeling
Empathic response	Therapist empathically identifying with family member *Family 2/1 Line 115* Therapist: Um, yeh (.) I would feel angry at the cancer yeh Therapist empathising with the difficult feelings of wanting the funeral to be over but not wanting to say goodbye *Family 3/1 Line 478*

Title of Code	Example from study data (Family number/recording number)
	Therapist: a very difficult place to be
Therapist reflection Summary and reflection back to family	*Family 1/1 Line 126*-129 Therapist: so it sounds like when you lived all in Bristol close to each other daddy wasn't ill then (.) and mummy just said how they had met and you said he had 2 dogs and in the beginning you didn't like the dogs but then um (.) and (.) you got used to them and then you guys moved up here
Therapist giving verbal prompts/cues to elicit further narrative or support the telling of a difficult part of the story	*Family 1/2 Line 53 - 60* Alice: When I was taking my bowl in the kitchen Therapist: Yeh Alice: I asked Mummy what she was doing Therapist: Uh-huh Alice: and she said Therapist: Yep what- Mummy: 'Be quiet' and she started to cry Therapist: Yeh (.)That's what you remember
Therapist sense making	Therapist explain to child why they can't remember events *Family 2/2 Line 44-45* T: so you were very very small so you probably don't remember any part of this part of the story at all *Family 1/1 Line 387-391* Therapist: and you were absolutely right Alice that what did happen to Daddy was his body stopped working as you said (.) when um (.) people die their bodies stop working (.) the heart stops beating (.) and you don't breathe anymore (.) it's a little bit like what you said didn't you (.)
Therapist checking re child's own sense making	Family 1/1 583-590 is helping you to make a bit of a link (.) even if daddy has died and Darren can't come back (.) that you still remember him (.) Alice: yeh Theapist: that you still remember him Alice Alice: yeh Therapist: and that you can still feel close to him if that makes sense (.) Alice: yeh *Family 1/ 2 Line 176* Therapist: does it makes sense
Therapist connecting disconnected/overwhelmed member	e.g Therapist engages verbally with child after they express interest to do another activity (disconnect). This follows adult's long discussion of medical detail which may have been overwhelming for the child *Family 2/1 Line 149* Therapist: Chloe (.) is that ok for you to come to sit and just listen to the rest of the story if that's ok

Title of Code	Example from study data (Family number/recording number)
Therapist giving factual details to clarify and using age-appropriate explanations/language Eg about how people's bodies stop working, about funeral cars being black	*Family 1/1 Line 387-391* Therapist: and you were absolutely right Alice that what did happen to daddy was his body stopped working as you said (.)You put it even down there didn't you(.) because that happens to people (.) when um (.) people die their bodies stop working (.) the heart stops beating (.) and you don't breathe anymore (.) e.g Explaining to child about black vehicles at the funeral *Family 5/1 Line 953* Therapist: they travel behind in a big black car which we call a Hearse
Therapist facilitating child's understanding of their emotional processes/psycho-education	E.g: Therapist explaining about intrusive images *Family 1/1 Line 486-489* Therapist: and sometimes what happens when we talk about those things memories or images might even come back about that day or about what ha- has happened about daddy and that is ok(.) so it might well be that there's lots of stuff going on right now in your little head and that is ok (.)
Therapist tasking parent to give explanation and details to child	e.g: Therapist speaking to child *Family 2/2 Line 25* Therapist: (.) would it help if Dad explained to you what a biopsy means E.g: Therapist asking Dad to tell children more about the accident *Family 5/1 Line 512* Therapist: it's really important for children to know what caused the person to die
Crying as telling the story	*Family 3/1 Line 170* Suzie: (CRYING) He went away in an ambulance
Parent offering comfort to child	*Family 3/2 Line 65:* Daughter: I didn't wanna hear it (.) that he'd gone (long pause 11 seconds) Mum: do you want some tissue Daughter: Uh-huh Mum: I'll get meself a box while I'm there
Parent showing ability to think about thinking – able to reflect on own process	*Family 2/2 Line 178* Dad: I thought I was better than I was and now in hindsight now we're through 2015 I think 2014 was very tough e.g Dad explaining to therapist about the 2 days his wife was in hospital in a coma before she died. He had never thought or spoken about his experiences with anyone including his children: *Family 5/1 Line 1217*

Title of Code	Example from study data (Family number/recording number)
	Dad: I think I was in a bad place at that time and I never wanted to go back to it (.) and you've made me think about that now
Parent aware of child's process and needs	Mum's response to finding son googling 'what happens to your body when you die' *Family 3/2 Line 224* Mum: I was like (.) uh and I just think ah and you forget don't you that they wanna know they wanna know Dad speaking to son about his choice whether to go on Winston's Outward Bound weekend *Family 4/1 Line 916* Dad: it's entirely up to you
Parent aware of role changes/ difference	Mum reflecting on how her son can't speak to his Dad about sport anymore Family 3/2 Line 358 Mum: that's really sad because I don't understand rugby (Laugh) and they wind me up about it (.)
Empathy	*Family 3/2 Line 352* Mum: see it you could see in their eyes they looked so sad Mum explaining how she misses being able to speak to the kids' Dad: *Family 3/2 Line 327* and then I think (.) god I bet they feel the same (.)
Able to tolerate distress	*Family 3/2 Line 398* Mum: and it's ok to be upset as well and it's um (.) and you sort of (.) I feel quite sad today it's our-
Using therapy techniques at home	Mum talking about using the 'stones' technique for talking about feelings and special things *Family 3/2 Line 420-424* Mum: and although he jokes about our stones Therapist: laugh Mum: what's your rough stone today then mum Suzie: laugh Mum: but then I tell him (.) well what's your smooth then (.) and he'll joke about it but deep down you know (.) he'll say am I your gem (.) are you my gem (.) Dad talking about the therapy ideas used on the Winston's weekend *Family 2/2 Line 184-185* Dad: one of the things I took away from that weekend was the idea of compartment boxes
Valuing therapy	*Family 3/2 Line 509*

Title of Code	Example from study data (Family number/recording number)
	Mum: yeh (.) I could say it works 100% the whole sessions that I've (.) *Family 4/1 Line 735* Dad: it's quite cathartic actually
Child naming emotions	*Family 2/2 Line 164* Daughter answering the question 'how is life now'? Chloe: well it's a bit sad and (.) um but we still need to move on so I've had happy times with Verity *Family 5/1 Line 1189* Steve: I know why I'm sad (.) because we don't have a mummy anymore
Parent offering therapist explanation/"translating" for child/offering context	For example culturally different burial practices, or explaining 'nicknames' used or details such as having two staircases in the house which is important to the story.
Creating narrative of 'we'	Talking about events in the story *Family 3/1 Line 117* Brad; we parked in the car park didn't we Describing how they all felt *Family 4/2 Line 449* Dad: cos obviously we were distraught
Parent trying to engage child in process of story telling	Speaking to child when therapist has asked a question: *Family 1/1 Line 463* Mum: Go on Dad encouraging child to answer therapist question: *Family 5/2 Line 98* Dad: you know how many days did the nurses try to fix mummy
Agreement between child and parent	Mum and child agreeing on the answer: *Family 1/2 Line 138-139* Therapist: Did you stay with her the whole night? Alice: Half the night Mum: Half the night
Child engaging with process and asking question about what happened	Child offering to bring in her mum's old headscarf to show therapist *Family 2/1 Line 232* Child: and I have one at home (.) and if I come and see you again I can bring it in I can bring one in Child asking how the body got out of the hospital and into the coffin *Family 5/2 Line 331*

Title of Code	Example from study data (Family number/recording number)
	Steve: how did mummy get out the hospital
Child recognising differing stories and knowledge	*Family 4/2 Line 151-153* Mike: I didn't know anything about him having a seizure actually until after he died that's the- Dad: we didn't tell you Mike: you didn't tell me (.) you didn't wanna tell- worry me
Parent recognising different stories and knowledge	*Family 3/1 Line 372-373* Mum: I think I rang the undertakers didn't I and then Son: yeh Mum: I think you already knew cos you said you'd made an appointment
Seeking clarification from other family members – checking out own memories	*Family 5/1 Line 52* Steve: and then an ambulance came and daddy came back from the chippy (.) is that right Daddy
Reflecting on events – would do things differently – reasonable thoughts	*Family 4/2 Line 221* Dad: and you know in hindsight what we should have done is said to yo starts acting strangely come and wake us up' (.)
Adding new material and details to the second telling	*Family 3/2 Line 169* Details about the hospital that aren't in the first story Mum: and she came in and said (.) I remember the nurse been in saying (.) no need to be a post-mortem
Memory Making – celebrations, remembering	*Family 2/2 Line 201-207* Dad: We do have a point of doing things on anniversaries (.) we have the two sad anniversaries are obviously the anniversary of Sarah's death and Mother's day are two tough days for us Chloe: and her birthday Dad: well her birthday is a tough day but what we try and do with her birthday is happy things isn't it that's why I didn't mention that then (.) we did um (.) we did on her birthday last year we went to the Zoo

Appendix 11: Story Maps for Families 1, 2, 3 & 5

Family One introduction:
Alice and Lucy's Stepdad Darren died unexpectedly at home due to chronic illness. Sarah is an Aunt who came to help look after Alice (age 7) and Lucy (age 3) after their Stepdad died. Katie (Mum) and Alice are present in both recordings, Lucy was only present in the first

Family Two introduction:
Chloe's Mum Sarah died after a long fight with cancer. Chloe (age 7) and her Dad are together in both sessions

Family 3 Introduction:
Bradley (age 24), Suzie (age 16) and Zac's (age 13) Dad Ed died from a heart attack. Ed and their Mum (Rosie) were divorced and shared custody. Bradley, Suzie and their Mum were present in session 1. Bradley was not present in session 2.

Family 5 – Introduction:
Brenda (age 7) and Steve's (age 5) Mum Suzie died after an accident at home. They are with their Dad Kevin in both recordings.

Family 1:

First telling of the story by Alice from Family 1 (italics = additions by Mum) 7 months since death	Second telling of the story by Alice Family 1 (italics = additions by Mum) 4 months since first recording, 11 months since death
Before: Daddy was always ill. He lived next door with his dogs. We all moved in together in a new house, had to go to a new school. I don't know how he died.	**Before**: No details given – omitted from story telling.
The death: His lungs and kidneys stopped, he went into hospital before. It was after school, he was sat in the chair with his eyes open. Mummy thought he was asleep but I knew he was dead, my heart was beating fast. Mummy called an ambulance, I went to the social club and friends came to look after us and I played with her son. *The ambulance came, the 'nasty stuff'*. Why couldn't we have taken him to hospital earlier? *He wouldn't have known he was going to die*.	**The day of the death:** Picked up from school, went to Tesco's, went home and found out. We thought he was asleep, we had tea. He said nothing, He was sat on his special chair. Mummy was on the phone, I knew he was dead when I first saw him. *Wrapped him in a blanket*. The man came to help, we went to the social club and the ambulance came. Went for a walk with sister and dog, Big ambulance arrived. Sarah came and played in the playroom. *Aunt arrived and put kids to bed, Dad's body taken by undertakers*. Came down to spend time with mum, then went back to bed.
Funeral: A poem that Daddy had written was read out. Daddy knew he was going to die early, and be an angel. *Mum gave her choice as to whether she wanted to be there.* The wake – lots of people there. So many people not enough chairs at the funeral. Put a card on top of the coffin, *had all talked about how best to do this.*	**Funeral**: *Given a choice as to whether to be there or not.* So many people they couldn't all sit down. *Wake, had a good time and talked about stuff.* Only played with Zeus the dog, not friends. Had to stand outside and let people see us. *You were 'good' and 'grown up'.*
After the death: Mummy and Lucy around, Daddy kind of around still in the air and things. A star in the sky with Grandma and Grandad. Now it's a girly house. Bubble burst and lots of flakes when Daddy died. We've found all the flakes, happy family but one missing piece that will never come back to us. There's a piece of my heart missing. I'm afraid at night mummy or Lucy might die.	**The days after the death:** Went to school for the whole day, *Mum gave her 'choice'.* People 'smothered' her she didn't like it as they were distracting her from work. Friday – family friends over; weekend – went to grandparents 'like normal'.
	Now: It's great but I sometimes miss daddy. *We miss his cooking and him being cheeky.* If I miss him I try and take my mind off it by doing school work. *You find it hard to talk about,* but I come when I need to and talk to you. I don't like speaking about Daddy because I don't like sharing it, I don't like speaking about it with Mummy or Lucy. We've moved house which is better now and we need to move on.

Family 2:

Recording 1 (italics = additions by Dad) 6 months since death	Recording 2 (Italics = additions by Dad) 14 months since recording 1, 18 months since death
Before: Chloe wants to start story at funeral, Dad takes lead. *Mum had a fall, lots of pain, scans. Extensive information about medication and hospital treatments. Confusion over Chloe's age before diagnosis,* Chloe has few memories of early illness. Mummy lost all her hair with the chemotherapy, was bald and had a wig, had bandanas, was very thin. *They all went on a cruise holiday. Another fall, Chloe went to stay with friends when mummy very poorly.* Mummy moved to hospice for a few weeks. Special holiday in Dorset. *Back to visiting once a week in the hospice on Monday, spellings homework night.* Changed care homes and mummy died 3 weeks later	**Before:** Chloe doesn't know where to start story Mummy had a poorly back, Chloe can't really remember *Lots of scans, biopsies and MRI, explains medical language to daughter* Mummy fought the cancer for a really long time, and that was happy but then sad when she died.
The death: Went to visit mummy one evening and had a lovely time, reading and stickering, she looked really well. *Dad went in the following day, and stayed with her the whole day, and she died in the afternoon, lots of tears. Came back and told Chloe, had a cuddle then both went back to the Hospice to see the body. She looked peaceful, Chloe went back into the room again to check her eyeball to see if she was awake or asleep. Process of telling the news.*	**The death**: Chloe remembers being at Nanny's house when Daddy told her Mummy had died.
Funeral: In the church after Christmas, Vicar let Chloe keep the tree lights switched on. Funeral went well, but Daddy cried*. Exit song very special.* Went to the pub, everyone asking me if I'm ok. Holly off from school too*. Body cremated, ashes with funeral director. Chloe keeps asking Dad 'is mummy in the churchyard yet?' as they walk past on their way to school*.	**Funeral**: Chloe missed a day of school, went to the pub afterwards and her friend came too. Filled up the whole church, music and songs and a special exit song *Cremated then buried, Chloe put a note in with the ashes and they're interned in with her mother*, they're 'riding horses together on the clouds'.
	Life now: A bit sad but we need to move on, happy and sad, had a falling out with some school friends this week. *Lonely but feeling like moving on this year. Winstons's weekend helpful, using compartment boxes technique to help access happy memories. Celebrating anniversaries* – both happy (birthday) and sad (mother's day and day of death).

Family 3:

Recording 1 (italics is Mum) 6 months since death	Recording 2 (italics is mum) 9 months since first recording, 15 months since death
Before: *Dad was feeling unwell so didn't pick son up from rugby as per usual to stay the Friday night*, had been asleep on the sofa and eating soup. Kids went out Saturday morning shopping. Ambulance called in the night, Dad laughing but had pain in his shoulder. Lots of calls to A&E, drove to the hospital. Confusion between 2 sites. *Put in the waiting room, Mum called out and told 'I'm really sorry but he didn't quite make it'*. Mum returned to the waiting room and everyone guessed by the look on her face, 'no no no'. Story jumps back: Daughter saw Dad go away in an ambulance without the light on and knew that he wasn't coming back. *On the drive to the hospital, talking about kids having to be less argumentative in front of Dad – reduce stress* Back to the waiting room, *how to tell the group,* sense of grandma's presence, the windows blow open, 'I think that was Dave going'. *Drove to the other hospital where the body was, all went in together with step Mum, and then with Mum 'it's just like he's sleeping' asked for a blanket cos he's getting cold,* concern he'd be left on his own. Went to Morrisons for breakfast. Friends texting the kids, taking time off work. 'nightmare' of having to organise a funeral instead of a holiday, lots of tears and hugs at home.	**Before:** *Dad feeling unwell, Mum picked son up from rugby and dropped him at Dad's.* Daughter been shopping in town with a friend, came back on the bus and Dad played a practical joke on them. Happy afternoon at home, then went to bed as usual. Ambulance called in the night, Dad had pain in his shoulder 'he'll be alright'. Lots of calls to A&E, drove to the hospital. Sister sensed 'grandma's presence' in the waiting room. *Mum called in to see the nurse, 'Unfortunately he didn't come through' – can't remember exact words, 'Oh no don't tell me their Dad's died'*. Children then called in to see nurse too, didn't want to go in as didn't want to hear he'd gone. Everyone crying hysterically in the corridors. *Had to drive to the other hospital, went in to see the body, it was like he was sleeping, wanted to say 'boo' and it all be a big joke. Son wanted to put a blanket on Dad as he was cold.* The window flew open in the family room, and there was a book about ballerinas. Said goodbye's, *but 'it wasn't goodbye it was goodnight'.* And then went to Morrisons to have breakfast, *quiet drive home on the motorway* Daughter's friends came round, sat on the sofa eating chocolates. Had to tell young cousins, that was hard.
Funeral: Planned the funeral with step mum, Tuesday spent talking about it and planning it. *10 days for 'your dad' to come back .* Went to visit the body, picked out an outfit for him to wear, old rugby team shirt, jogging bottoms and slippers. Regularly visit the funeral home to see 'Dad' over the week. Windiest wettest day for the funeral. Details about flowers and	**Funeral**: It was hard 'waiting for their dad to come back' and be taken to the undertakers. Mum at work when body came back, everyone relieved when 'Dad was back home'. Regular visits up to see him, questions from son about his body, cremation and what happens to the soul and the body. *Lots of crying and then planning the funeral.*

how personal all the choices were, songs, speeches and lots of involvement by the kids. Small gifts given to guests - candles and a poem Lots of people there. Son had to wear a suit – and he's still wearing the jacket with all his outfits. Funeral was a celebration of life (No mention of wake)	*Coldest wettest day, but 'it was lovely'* a really good send off, really personal. Son sharing that he misses talking about rugby with Dad, *Mum recognising the gap there will be.* Everyone involved in the funeral, except for one child who now regrets it. Daughter helped pick the songs, lots of flowers. 'It was the best wake', bouncy castle, sat talking with Dad's best friend, saw Grandad cry. Still got the poem and picture given out at the funeral.
Life now: Ashes interned, it was horrible and it rained. Scattering some ashes in favourite seaside places. Putting a plaque in the cemetery, visit it often. Went back to Morrisons the other day to the café.	**Life now:** *You wonder how they'll ever get through it, but we are smiling and laughing now a year later.* Sometimes. *Mum is missing being able to call up the kids Dad and have help if they're playing up.* Kids feeling closer now. Visit the cemetery regularly, *and now don't cry so much.* Still sad, but can also laugh and joke now. *It's not wrong to laugh.* Winston's support has been so important, helped daughter speak openly about feelings and normalise the sadness. *The weekend was really important and daughter got a lot from it, good to meet others, do creative activities. Son may need support in the future, jokes about the stones.* Off to Zumba and having a nice tea later.

Family 5:

First telling (Italics is Dad) 10 months after death.	Second telling (Italics is Dad) One month after 1st recording.
Before: Mummy had the accident, Aunty called the ambulance *and they'd been to a party.* Mummy used to work shifts and they'd had babysitters, problems with friends. Lots of details about the party itself, clothes and events. (All leave to go to the toilet during session). Discussion about the accident, kids act out position mum was found in. No details about 2 days mum spent in hospital: *'Mummy was sleeping'*. Granny told them Mum had had an accident. *Kids 'picked up' that Mum wasn't going to get better. L*ots of talk about spirit, body, heaven and the grave.	**Before**: *Been to a party, kids were staying with Granny the following evening* Mum had an accident and an ambulance came, Dad came back from the restaurant. Daughter found out about Mum's accident by overhearing a phone call at granny's house where she was sleeping Mum had 2 days in hospital, lots of detail given by kids about tests and treatment doctors tried.
Funeral: Mum's body smelt minty and was very cold Dad went in alone with the coffin and played a song she liked Didn't recognise the clothes Mum's body was dressed in the coffin, scared of giving her a kiss. *Made a card* and put flowers on the coffin. Coffin carried high and everyone crying. Daughter worried about her mum going down into the ground. They sang songs and threw flowers onto the coffin. A man put a sign so they knew where her grave was. How does the priest know they're dead – hospital chaplain gave a final blessing in hospital.	**Funeral**: *Body was in the coffin at rest at Granny's house.* They prayed for her by the open casket, saw her face and her clothes and bracelets, gave her a kiss. Lots of flowers by the church – more detail: daises and roses. Lots of people crying and carrying the coffin up high. The coffin was in a side chapel with a statue and a candle before being put on the priest's table for the service. Singing and prayers. Put flowers on the coffin when it was put in the ground.
(No mention of wake)	After the burial, kids went shopping for sweets and a drink then went back to Granny's house for a family gathering.
Life now: Sometimes sad, sometimes happy. Further talk about hospital – did she have a tube in mouth and a sore head, therapist helps Dad answer some of these, Dad recognises not ever thought about those 2 days or told children.	**Life now:** Don't see mummy anymore, they say a special prayer for her every night. Granny has a new kitten and they have moved house, school and have new friends. Sometimes happy and sometimes sad.

S.