



## **Editorial Volume 2, Issue 2 Dr Randolph Bowers**

What an exciting year for counselling in Australia!

cphJournal has grown from zero to three issues in this short space of time. We were honoured by our Canadian colleagues who contributed many innovative and thoughtful articles in Volume 2 Issue 1 Special Issue on Aging and Spirituality, which comprised part of their conference proceedings that went up for peer review.

On the 5 to 8 July 2006 in Brisbane, the International Association of Counselling co-hosted a large conference with the Australian Counselling Association and several other partners 'Connecting, Creating, Celebrating,' which brought practitioners together from across Australia and the world. Much to our regret, the Psychotherapy and Counselling Federation of Australia (PACFA), who are another significant association in Australia, declined the invitation to co-partner with other associations on the conference. Regardless the event was a great success, and cphJournal invited the delegates to submit their conference proceedings for peer review, and this process will likely take the better part of this year to accomplish, with the aim of publishing the special issue of proceedings in the new year of 2007.

cphJournal is receiving a steady stream of papers for future Issues, and visitors to our website have increased to over 3,500 people per month in only that past six months. We are extremely pleased with these outcomes, and we are so proud to have a fantastic team to support an open-to-the-public format that is free and in accessible language. I really wish to encourage creative and multimedia submissions that include jpg format photographs and other visual media that can be printed into a PDF format. As we grow, future possibilities include inclusion of sound files and video streaming, and we welcome submissions that will encourage our team to explore these developments.

Other areas of growth relate to supporting creative approaches to narrative, story, and personal reflective essays that look outside the boxes of traditional 'research.' Please consider the in-depth nature of counselling consultations across the wide spectrum of education, health, and professional studies as a cultural landscape worth exploring, deconstructing, and re-inventing. We are also aware that many of our Board Members, including myself, have a passion for rural based counselling, education, and health issues,

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and we are pleased to have articles coming forward from several countries where rural issues are also at the forefront of social consciousness.

### **cphJournal Indigenous**

Discussions related to supporting Indigenous issues are progressing, and Dr Nadine Pelling is Editing a special issue of cphJournal on Indigenous issues for future publication. To inquire about this exciting project, contact Dr Pelling at <[Nadine.Pelling@unisa.edu.au](mailto:Nadine.Pelling@unisa.edu.au)>.

As part of our Editorial vision for cphJournal we wish to support an Indigenous Board of Editors who can develop an international specialisation in Indigenous issues from a multidisciplinary and wholistic perspective and applicable to the fields of counselling, education, health, social and emotional well being and community development. We admit that it is early days in the development of counselling in Australia, and Aboriginal counselling is also a very new disciplinary field. We also acknowledge that traditional approaches to helping and ‘counselling’ have always existed, and continue to be practiced today – and we encourage the articulation of these cultural practices as well as the critique and decolonization of non-Indigenous approaches to the field.

To these ends, I have had initial discussions with several Aboriginal Australian people who practice various forms of counselling, including graduates and students in Aboriginal counselling programs I am aware of. These discussions suggest that folks love the idea and see the need, but are asking for specific support and infrastructure to assist in their learning how to write for this forum, and what the forum might look like. My efforts are to link people together in writing teams, where ideas can be shared and those whose strength is in weaving words can assist the others to articulate and learn new writing skills. We also wish to support the publishing of dual language texts – in Aboriginal or First Nations languages as well as in English. These types of projects need funding support, and we sincerely ask members of the public to consider donations toward this cause.

In regards to gathering an Indigenous Circle of Board Members, when we can gather a dynamic core team together we will begin further scoping of the project, and looking for funding sources to support this direction. cphJournal is prepared to assist an Indigenous Circle/Board in hosting and publishing a unique section of the website called ‘*cphJournal Indigenous*.’ Interested people please contact me and share your ideas and interests in developing this exciting and innovative project.

### **Additional information**

For your information, ACA is currently proposing a policy statement on evidence-based practice, which will outline some of the levels of strength of evidence that may be used to guide counsellors on various issues. The draft policy can be accessed in a forthcoming issue of *Counselling Australia*. Visit the ACA website for more information.

Several of the cphJournal Board Members have been involved in producing the first ever comprehensive counselling text book in Australasia, entitled *The Practice of Counselling*,

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with Thomson Publishers, Melbourne. Three of our Executive Editors acted as Editors of the book, and a wide spread of Australian based and affiliated authors contributed chapters to the work. For further information see the Thomson website <<http://www.thomsonlearning.com.au/higher/humanservices/armstrong/index.asp>>.

Congratulations to two of our Board Members, Professor Marie Battiste and Associate Professor Cathryn McConaghy in co-editing a special issue of the Australian Journal of Indigenous Education: Thinking Place: The Indigenous Humanities & Education, V34 – 2005, which was recently published during 2006. To learn more about this important journal visit <<http://www.atis.uq.edu.au/ajie/>>.

### **Australian counselling at the crossroads**

In a landmark and historic development for the counselling profession in Australia, and following three years of efforts extended by the Victorian Department of Human Services who sponsored a research grant that was awarded to PACFA, a decision was made regarding regulation of the counselling field. The project was to investigate issues of regulation, governance, and standards of practice in Australia. In a press release of the same day, ACA stated that, ‘on August 23, 2006 at a meeting of key industry stakeholders and government, it was concluded that no regulation of the counselling industry would occur.’

From my point of view, the decision signals to the field in Australia that professional associations could consider more collaborative approaches that move beyond rhetoric and that break down the barriers of competition that may have defined past relations between groups. For example, an academic and professional journal can be a means to unite people from diverse backgrounds, and in our founding vision for cphJournal we hoped to build bridges. We are happy to work with members of any association on the Board of Editors. This symbolic and practical gesture is significant to me, because as an educationalist and someone who works at a public institution my hope is to open up discussion and debate, freely share information, and allow individuals to make their own conclusions in regards to counselling, associations in the field, and in regards to the wonderful work that is being done by many associations and their members who are often passionate about their perspectives.

In the press release from ACA noted above, ACA highlights a significant insight coming from the review in regards to protection of the public:

*One of the core aims in investigating a self-regulated model for the Counselling Profession was to ascertain whether consumers of Counselling services would be better protected under a regulated model. This is of paramount importance to governments and fundamentally directs their decisions, as they are empowered by the public to implement policy in the interest of their safety.*

*The nature of Counselling results in very few complaints being brought against Counsellors. Counselling... is more about*

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*empowering clients to make their own decisions. Counsellors generally do not give advice, and do not deal with clinical issues. As such, the potential risk to clients from Counselling is extremely low.*

*Implicit in the decision of the Victorian Department of Human Services not to regulate the Counselling Profession is that customers of Counselling are not at significant risk; and that the current market driven model of the profession adequately mitigates risk to the consumer.*

In regards to educational and practice standards for counselling in Australia, the field currently relies on self-regulating associations to determine their level of education for entry and level of expertise to practice. From my point of view, there is nothing inherently problematic about this already self-regulatory model of counselling, which is grounded in the almost sacred nature of an incorporated association model which keeps the control and direction of the profession in the hands of the members of associations.

From my point of view, counselling as a field in Australia is greatly strengthened by the diversity represented in the many associations that exist, and the several peak bodies who stand at the national level. Indeed, when it comes to self-regulation counsellors who are members of an association are the best people to discern what is needed for their membership, and thus for the field of counselling. And apparently the Victorian Government agrees.

As no national regulatory standard is agreed among the many associations that exist in Australia, and the recent study has determined that the government has no interest to step into what could be considered by many to be a factional professional landscape, the question remains regarding what is the best level of education and expertise to practice counselling? I believe the debates around this issue will and must continue.

In the ACA press release it was stated that:

*The overwhelming majority of practicing counsellors maintain membership to an Industry Association. Membership provides them with professional affiliation; access to insurance; transparency of qualifications; a means for dealing with complaints; a Code of Good Practice; ongoing professional development and much more.*

*The industry has therefore established Training Standard benchmarks by virtue of Association Membership Levels. These levels reflect qualifications, experience, supervision and commitment to ongoing development. The vast majority of Counsellors have a vocational level qualification, such as a Diploma in Counselling. The decision of the government not to regulate Counselling implicitly recognises the Training Standards established through existing Association structures.*

While the Victorian Government Department may have implied through their decision to not regulate counselling in that state, and by inference, the Australian Government may be unlikely to regulate counselling in any other state, and while a government department might imply that the existing status-quo of professional associations is not inherently flawed (and more particularly, does not pose a threat to public safety), these outcomes do not suggest that counsellors will necessarily be content with the status quo for practice and training standards. The existing disparity of views on standards of practice and educational qualifications in Australia still needs to be addressed by the associations and their memberships. To do this people need to work together across party lines. My perspective is that the field in Australia is changing and developing faster than many people acknowledge, and that standards need to become more uniform across the sector to ensure that practice is grounded in the best possible outcomes for clients.

### **Australian counselling standards and governance issues**

There are many views of how to build and sustain the counselling field in Australia. The field enjoys great diversity of representation in many professional associations. At this time I wish to open up a debate by sharing my personal opinions on a few issues. It is important to acknowledge these are my opinions and analysis only, and are shared to encourage open debate. These opinions do not represent any other persons or groups.

For several years I have lobbied ACA to encourage its members to continue their education, and I have been encouraging members of other associations to do the same. Sooner than later, ACA will need to raise its standard from Diploma to Bachelor level. Soon after that, ACA will need to raise the standard to a Graduate Diploma, and then likely a Masters level to gain certification. In my view, this progression needs to occur sooner than later, and needs to be set on a public timeline that allows the majority of members to gain new qualifications. By so doing, ACA will signal to the public and to other associations in the field that ACA is committed to ensuring the highest standards of practice for counselling in Australia.

At the same time I have encouraged an acknowledgement that there are many questions that counsellors need to consider about the governance of the field in Australia. For instance, ACA was created under a legal entity of a Pty Ltd., and as such, does not constitute an incorporated association. This could raise many questions about the governance and particularly the financial accountability of the Association. To this end, I have strongly lobbied ACA leadership to change this situation, because it not only gives an incorrect message to the public about how ACA functions, but it also implies that ACA is a profit-making venture by those who own it as a business. I am told that ACA is about to change these legal frameworks, and they have openly admitted that it was a mistake to set up the organisation as a Pty Ltd. Fair enough, we learn from our mistakes.

Other questions arise when looking at the models currently being used in Australia. For example, PACFA was set up as a 'Federation of Associations,' but effectively appears to function as an Association, and indeed is an incorporated Association as such. They also

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have their own unique form of membership and revenues through maintaining a national register. It may be viewed by many people that every organisation will tend to promote its own self-interests, and as PACFA evolves over time these interests will also likely develop. This suggests that the role of a Federation versus an Association may blur the boundaries of responsibilities and may cause confusion, if not for the members then certainly for others. The study noted above suggests that such confusion may exist in the minds of PACFA members who may wish to delegate their structure as a regulatory model for all other associations in Australia when in fact they themselves are one association among many. Confusion regarding roles may also involve what an 'umbrella' organisation might take on versus what those who hold up the structure – member associations will take responsibility for. From a sociological view, delegation-based politics in a professional association context seems ill advised and adds additional layers of political and administrative burdens that raise questions about the sustainable nature of governance in counselling. This raises questions about ethical and legal accountability, the ability of associations and their members to directly influence the field, and at a time in Australia when clear and unfettered leadership is essential.

These issues are certainly open for debate! And we welcome letters to the Editor, which will appear in future on this page.

I wish you every peace and contentment,  
Dr Randolph Bowers

Selane P, Kamiru H, Ross M. (2006), Dimensions of the Fear of AIDS Scale among South African students, *Counselling, Psychotherapy, and Health*, 2(2), 1-14, July 2006.



## Dimensions of the Fear of AIDS Scale among South African Students

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### Abstract

**Background:** South Africa, with over five million people living with Human Immunodeficiency Virus (HIV), is the country with the highest number of people living with HIV. HIV transmission exploits one of the most complex areas of human life: sexual relationships. This in addition to its long asymptomatic phase and lack of imminent cure, have made it one of the most feared pestilence of our times. Youth in South Africa are particularly at risk of HIV infection. The **aim** of this study was to explore the structure of fears of Acquired Immune Deficiency Syndrome (AIDS) among students in South Africa using fear if AIDS Schedule (FAIDS) and test its cross-cultural validity with Australian and Nigerian findings. We **hypothesized** that the structure of fears of AIDS among Bellville, S.A. university students is similar to the structure of AIDS fears in Australian and Nigerian populations.

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**Methods:** The 38 item FAIDSS questionnaire was administered to a sample of 300 students in Bellville, Western Cape Province, South Africa. Data were entered, cleaned and analyzed using Statistical Package for Social Science (SPSS). The main statistical procedures performed were exploratory factor analysis, confirmatory factor analysis and internal consistency reliability.

**Results:** A five-factor structure (fear of loss of control, fear of sexual contact with groups perceived to have HIV, fear of sexual contact with outsiders, fear of infections, and fear of death and medical intervention) as found in the other study populations was replicated. All factors had internal consistency reliability of over 0.73 except fear of sexual contact with outsiders with alpha of 0.43. The factors were significantly correlated. Male subjects had significantly greater fear of infections while younger subjects had significantly greater fear of death and medical intervention ( $p < 0.05$ ). The study demonstrates that the FAIDSS has cross-cultural psychometric stability, and that the dimensions of fears of AIDS in South African adolescents is almost identical to those in Australian and Nigerian samples. The cross-cultural stability of the FAIDSS makes it a potentially useful tool for evaluating the effectiveness and informational impact of HIV/AIDS prevention programs.

## **Introduction**

About five million people were infected with Human Immunodeficiency Virus (HIV) during the year 2004, three million died from HIV related diseases and a total of 38.4 million were living with the virus (UNAIDS 2004). Over 64% of the people living with HIV are from sub-Saharan Africa, making it the hardest hit region, though having only 10% of global population. The prevalence of HIV across sub-Saharan African however varies widely. Southern Africa is the most severely affected with over 16% of the population being affected followed by East African countries with an average prevalence of 6%, West and Central Africa 4.5% and Northern Africa, less than 0.1% (UNAIDS. 2004). The UNAIDS (2004) report indicate that half of all new infection occurs among youth (15-24 years age-group).

South Africa has a distinction of being the country with the highest number of people living with HIV-5,300 000 as at the end of 2003 (UNAIDS 2004). The estimated prevalence of HIV in South Africa is about 12% (World Fact Book 2005, Pettifor et al. 2004, UNAIDS 2004). The youth and the sexually active age groups are disproportionately more affected by the epidemic. Among pregnant women the prevalence rate is estimated to be 25.4% (UNAIDS 2004). Other predictors of HIV prevalence in South Africa are age, gender, geographical region and the rural/urban divide (Kustner et al., 1998).

HIV and its sequel, Acquired Immune Deficiency Syndrome (AIDS), remains a major health priority of our times. HIV transmission exploits one of the most complex areas of our human life: sexual relationships. HIV prevention campaign demands that these relationships, whether conjugal, or illicit be brought out into the open and confronted. This in addition with



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its long asymptomatic phase, and lack of imminent cure, has made it one of the most feared diseases of our time. This fear of AIDS permeates every structure of our society: for each infected person there are additional families, friends, and co-workers affected (TIHAN, available at URL). It is thought that fear of AIDS may be the driving force in the individual and corporate response to the HIV pandemic (Sher 1989).

National response to the HIV pandemic is also shaped by the prevailing culture of fear of AIDS in the society. Uganda, hailed as a HIV prevention campaign success story, has achieved this distinction due to political leadership openness to accept the reality of HIV (Wendo, 2004; 506 Zuniga, 1999). The converse may be said of South Africa; one report on South Africa describes “social stigma associated with HIV/AIDS, tacitly perpetuated by the government’s reluctance to bring the crisis out in the open and face it head on, prevent many from speaking out about causes of illness and deaths of loved ones...” (*Guardian* newspaper Feb 11<sup>th</sup> 2005).

Responding to the epidemic will therefore require an appropriate response to the fear of AIDS. This should include a thorough understanding of the impact fear of AIDS has at individual and corporate level; on patients as well as their carers, and on those at high risk of infection like the youth. Understanding how fear of AIDS shapes societal response to HIV/AIDS is an important armamentarium in the design of targeted intervention programs, a feat that will be difficult to achieve without valid, reliable, and culturally competent measurement instrument. From the point of view of health counseling, counselors need to understand the bases of AIDS fears and how they may impact not only preventive behaviors of clients, but also how they may impact the response of family members who are affected. Distress accompanying AIDS concerns in both infected and affected individuals can be more effectively dealt with if health professionals are able to understand the bases of this distress. Further, if it can be demonstrated that the underlying dimensions of AIDS-related fears are similar across cultures, it allows us to use approaches that have been utilized in HIV/AIDS counseling and prevention in other countries with more confidence that they contain culturally-generalizable underlying dimensions.

There is paucity of studies on fear of AIDS in sub-Saharan Africa and the few available studies have used proxy measure of fear of AIDS such as attitudes and risk perceptions. In a survey among youth in South Africa, youth had positive attitudes towards people living with HIV (Pettifor et al. 2004). Studies of perceptions about AIDS among students in university residences in South Africa found that the levels of knowledge and awareness of AIDS among students was high (Friedland et al., 1990; Matthews et al., 1990). This was, however not matched by a corresponding degree of risk perception, nor has attitudinal change and appropriate knowledge led to adequate behavioral change.

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Several scales have been used to measure fear of AIDS (Waldner, 1999; Wang, 1997; Wang, 1996; Arrindell et al. 1989). The Fear of AIDS Schedule (FAIDSS), developed and tested in three western societies (Netherlands, United States and Australia) in 1989 (Arrindell et al. 1989), is the more widely used scale in measurement of fear of AIDS. Cross-national stability was established in a Nigerian study where the 5-factor structure was replicated (Akande and Ross 1994). However FAIDSS has not received a wide cross-cultural validation in sub-Saharan Africa, despite the widespread devastation of the continent by the epidemic.

This study was designed to explore the hypothesis that the structure of fear of AIDS among Bellville, S.A. university students is similar to the structure of AIDS fears in other populations. The findings of the study will be compared to previous studies carried out in Australia by Ross and Hunter (1991, 1992) and in Nigeria by Akande and Ross (1994).

## **Method**

### **Study Population**

The study was conducted in Bellville, a large urban city in the Western Cape Province, South Africa. The schools of higher learning (university, technikon, high schools, and secondary schools) where data were collected are located in low socio-economic neighborhoods that have high crime rates and considerable gang activity. The study subjects (N=300) were 14 years and older and represented an approximately equal number of black, white, and colored respondents. Some of the subjects were studying for a university entrance qualification.

### **Field procedure**

Data were collected using a self-administered questionnaire. The questionnaire consisted of demographic section and a section on the 38-items fear of AIDS scale (FAIDSS). To solicit student participation, flyers were posted in school cafeterias, and one principal announced the study during morning congregation. Qualified students who volunteered to participate were asked to meet during their recess/break at the cafeteria. The students were informed that the research was intended to study South Africa's health issues and that the scale required ten to fifteen minutes to complete. Experienced research interviewers and trained teachers from the local schools carried out administration of the instrument. The teachers were not paid for the time they spent administering the survey. Participants were told that they could refuse to answer any questions, and that it would not affect their grades. Since subjects remained anonymous, the returning of the completed questionnaire was taken as evidence of consent. Confidentiality was stressed and identifying details (race, names) were not included in the questionnaire. The study was approved by the appropriate University of Texas Committee for the protection of Human Subjects.

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All completed questionnaires were collected from subjects, sealed in envelopes, and returned to the investigator for data analysis. Since this scale has been used on similar subjects in Australia (Ross and Hunter, 1991) and Nigeria (Akande and Ross, 1994) the subjects' fears of AIDS factor structure was compared to that of their counterparts in these countries.

### **Data analysis**

Data were entered on Statistical Package for Social Sciences (SPSS<sup>x</sup>) readable format for analysis on Personal Computer. The coding of questionnaire responses for the FAIDSS followed the published format. The evaluation of the FAIDSS consisted of three stages. In the first stage, validity issues were considered, by exploratory factor analysis employing principal components performed on the 38-items of the FAIDSS to establish whether the theorized factors were empirically supported. Following the exploratory factor analysis, confirmatory factor analysis specifying the five factors was conducted. The criterion estimation used was a maximum likelihood estimation followed by oblique rotation. Because cut offs of eigenvalues of  $>1$  leads to overextraction, decisions were based on the scree plot to the maximum number of factors with three or more loadings greater or equal to 0.30 as suggested by Arrindell et al. (1989). The five-factor rotated matrix indicated that the results were equivalent to the exploratory analysis, with five principal factors giving eigenvalues significantly greater than 1. The exploratory factor and five-factor procedure therefore indicated equivalent emergent factors, providing concurrent validity for the theorized subscale factors designed in the scale.

Subsequent to the factor analysis, each of the five subscales were assessed for reliability using Cronbach's alpha coefficient as the criterion for internal consistency (Walkey, 1985). Overall reliability indicators were calculated on the survey, followed by the item scale reliabilities for each factor, and they ranged from 0.40 to 0.90. Together, these five factors accounted for 47.8% of the overall total variance. The third stage considered differences among the factors produced by factor analysis, by gender and age. To evaluate these differences a series of linear models were constructed and tested for significant differences.

Factor scales were computed and constructed by multiplying the item scores by the loading, and means and standard deviations were computed for each scale and compared across gender, and age was split into two groups at the median using *t*-tests. Finally, correlations were carried out between factors of fear of AIDS using Pearson product-moment correlation coefficients.

## Results

### Factor Structure

Table 1 reports the factor structure of fear of AIDS in the Bellville students. The first factor extracted by the factor analysis is described as a fear of loss of control factor. Fifteen items on the instrument were loaded on this scale, ranging from 0.45 to 0.76. The highest item to load on the scale was becoming mentally ill, followed by helplessness (0.71). The second factor is a fear of sexual contact with groups perceived to have HIV. Five items loaded on this scale, with factor loadings ranging from 0.61 to 0.75. The highest loading, 0.75, was intimate contact with prostitutes. The third factor is a fear of sexual contact with outsiders or stigmatized groups. Seven items loaded on the scale with factor loadings ranging from 0.33 to 0.76. The highest loading was extra-marital sexual contact, 0.76. Fourth is a fear of infections. Five items loaded on the scale, with loadings ranging from 0.49 to 0.66. Fear of contracting AIDS had the highest loading of 0.66. The final factor was described as a fear of death and medical interventions. Seven items loaded on the scale, with loadings ranging from 0.37 to 0.64. Taking medical tests and dying had the highest loadings.

Factor scores on the five factors by gender are presented in Table 2 and by age in Table 3. The only significant difference ( $p < 0.05$ ) by gender was on the factor scale measuring fear of infections by gender; males had greater fear of infection. The only significant difference by age was on the factor scale measuring fear of death and medical intervention ( $p < 0.05$ ); younger respondents showed greater fear. The lack of differences by gender and age further confirms the literature by Arrindell et al., (1989) that there is no significant variation across samples by gender or age.

Correlations between factor scores are presented in Table 4 and illustrate that the factor solution was moderately correlated and this correlation was significant ranging from 0.14 to 0.61. Significant correlations included Factor 1 with Factor 4 (0.61,  $p < 0.001$ ), Factor 1 with Factor 3 (0.57,  $p < 0.001$ ), Factor 1 with Factor 5 (0.44,  $p < 0.001$ ), Factor 2 with Factor 4 (0.37,  $p < 0.001$ ), Factor 2 with Factor 5 (0.43,  $p < 0.001$ ), Factor 3 with Factor 4 (0.44,  $p < 0.001$ ), and Factor 4 with Factor 5 (0.34,  $p < 0.001$ ). Reliabilities of the five scales (Cronbach's Alpha) were Factor 1 (0.90), Factor 2 (0.74), Factor 3 (0.40), Factor 4 (0.77), and Factor 5 (0.73).

### Discussion

The purpose of the study was to confirm the structure and reliability of fear of AIDS scale and cross-culturally. There are several interesting findings. The data indicate that there are five identifiable dimensions of fear of AIDS among Bellville students. These are fear of loss of control, fear of sexual contact with groups perceived to have HIV, fear of sexual contact with outsiders, fear of infections, and fear of death and medical intervention. The study also

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found that the factor structure is very similar to that obtained by Ross and Hunter (1991) of the FAIDSS in Australian health professionals, and Akande and Ross (1994) among Nigerian students except that the scales were extracted in different orders. The results both enhanced and substantiated the hypothesis that the scale as a measuring instrument does conform to its theoretical specifications and that it is a reliable measure of five variables pertinent to the fear of AIDS domain across several different cultures.

In the Nigerian and South African data, loss of control subsequent to AIDS disease was the predominant fear expressed by students. The similarity could be explained by strong socio-cultural characteristics of both study sites. Both Nigeria and South Africa are resource poor countries with low per capita income, low resources allocation to the health sector, and virtually no welfare support services for the terminally ill, elderly, and mentally ill. Thus, most people would naturally be concerned about the socially dislocating and disabling aspects of AIDS disease, about being mentally ill, hopeless and helpless if they contracted HIV. Furthermore, AIDS patients are also predisposed to losing their self-respect since in these countries the culture stigmatizes and blames people with AIDS, and also shows a considerable measure of social distance from them. By contrast, health professionals in previous studies were found to be more concerned about HIV infection through blood, a difference that is probably due to heightened occupational focus, health education and information dissemination in the health profession.

The fears of AIDS in this sample therefore should be interpreted in the context of both traditional and modern attitudes toward deformity and disability in South Africa and with the implication that the level of fear may be higher given the level of support and acceptance of the disabled. Stigma of HIV infection via sexual activity, with its echoes in the literature on STDs, produces some very thorny obstacles for HIV prevention and care. It further hampers AIDS prevention work on another level. Because of the implications of promiscuity, it is possible for partners also to use the threat of AIDS to impose such sexual codes as fidelity or monogamy onto each other. Finally the notion of sexual stigma, with its associations of guilt and blame, contributes to a culture of silence around AIDS. As a result, infected people are less likely to come forward for testing or possible care, thus reducing the likelihood of much-needed support and management of symptoms. Similarly, traditional attitudes in Nigeria and South Africa encourages able bodied dominance and a subservient role for those with disabilities within the society, and discourages the participation of people with disabilities in social, political, and economic activities.

### **Limitations**

The results of this study should be accepted with some cautions for the following reasons. First, the subjects were a non-random sample of students attending schools of higher learning in Bellville, Western Cape, South Africa. Students attending these schools are usually privileged and are likely to be better educated than other adolescents. Findings, therefore,

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may not reflect the general trend about personal fears of AIDS in other regions of South Africa, particularly as the Cape region has one of the lower HIV seroprevalence rates in South Africa. The non-categorization of ethnicity is another limiting factor toward the generalization of the postulations substantiated in the study. Although social pressures may be the same for all students their cultural background and its influence on their perception of AIDS disease may differ. Secondly, since the study relied on self-reported questionnaires, and was administered by their own teachers, some students may have given socially desirable answers.

These data generated finding significant for several reasons. First, this type of study has not been carried out previously in South Africa. Earlier psychosocial studies have addressed AIDS knowledge but not fears about contracting AIDS. This study both establishes a baseline of students' personal fears about AIDS and provides an opportunity to repeat this type of study in the future to examine the change over time. Further, these data provide a means to examine fears about AIDS cross-culturally by comparison to previous and future studies. Such planning may aid in the planning of HIV prevention in South Africa, particularly intervention programs that target the adolescent avoidance of HIV exposure.

These findings confirm that a number of replicable and reliable dimensions of fear of AIDS exist in students, and that these cluster into five identifiable dimensions which could be helpful in assessing initial levels of fear about AIDS and determining changes over time in South African students. The clear comparability of the factor structure of FAIDSS in the present sample with previous samples enables direct comparison between fears of AIDS in other samples with similar population characteristics. Further, there were no differences on factor scores by gender and age, further confirming earlier reports in the literature that there is significant invariance across samples by gender and age. Factors in this sample suggest that the structure of fears of AIDS is relatively cross-culturally stable. Thus, a comparison of AIDS fears across cultures would appear to be possible.

### **Implications**

These results have important implications for both counseling and for prevention of HIV transmission in South Africa. Our study implicates the fear of AIDS, especially loss of control as the main area of concern for Belville students. This concern is a reflection of the general traditional African attitude, which encourages able-bodied dominance and discourages participation of the disabled members of the society (Akande & Ross, 1994). Thus, in transferring technology as health pertaining to HIV in health care settings to third world countries, issues pertaining to cultural sensitivity must be addressed so as to ensure that such programs achieve their desired objectives. It has been established that the factor structures are stable in Australia and Africa; so many aspects of adolescent education programs in countries with similar populations may be designed with common elements.

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Fear is a motivator of attitude change in moderate amounts (Rigby et al., 1989; Ross et al., 1990), but in larger amounts may move people into denial. These data specifically identify the clusters of fears associated with HIV/AIDS, which in turn enables us to identify those which may be useful in prevention campaigns. Such campaigns might usefully concentrate on the negative aspects of HIV/AIDS using decisional balance (the pros and cons of changing risk behavior) in maintaining a person's preventive action. Further, controllability of infection and fears of infection can be placed in the hands of the individual. At a positive level, irrational fears of contact with people with the HIV virus, and xenophobia, can be minimized through accurate information. This scale may be a useful evaluation tool to determine the affective impact of HIV/AIDS education.

Counseling those infected or affected by HIV/AIDS needs to incorporate the underlying dimensions of the fear, rather than simply the fear itself, in order to understand which dimensions of the fear are rationally based and which are less rational. Counselors dealing with individuals who are attempting to deal with their own infection, that of significant others, and response to the stigma often associated with HIV, need to be able to deal with the actual sources of fear rather than the generalized response. Finding cross-cultural equivalence in measurement of fears of AIDS in South African adolescents compared with previous data from Australia and Nigeria allows counselors to assume that the bases of counseling interventions for fear of AIDS in one culture may be sufficiently similar to be useful in other cultures.

In conclusion, these data demonstrate that the FAIDSS has cross-cultural psychometric stability, and that the dimensions of fears of AIDS in South African adolescents is almost identical to those in Australian and Nigerian samples. The cross-cultural stability of the FAIDSS makes it a potentially useful tool for evaluating the effective and informational impact of HIV/AIDS prevention programs and for understanding the bases of HIV/AIDS-related fears in health counseling settings. The finding that the underlying dimensions of AIDS-related fears are similar to Australian and West African findings makes it possible to generalize health counseling approaches involving AIDS-related fears with greater confidence across these cultures.

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**Table 1: Factor Structure of Fear of AIDS in South African Students**

FACTORS	ITEM	VARIANCE %	LOADING
<b>Loss of Control</b>	<b>Attitudes</b>	<b>17.12</b>	
	31	Becoming mentally ill	.76
	37	Hopelessness	.71
	38	Helplessness	.70
	36	Infecting others with one's illness	.69
	35	Loss of self-respect	.66
	20	Infection through blood	.64
	21	Infection through sexual contact	.63
	34	Becoming dependent on others	.59
	22	Infection through someone's illness	.57
	30	Inadequate (abnormal) behavior	.57
	29	Contact with blood of other human beings	.50
	28	Drugs or chemicals	.49
	33	Display of physical suffering of others	.45
	32	Becoming physically unattractive	.45
	25	Growing ill	.43
<b>Fear of sexual contact with groups perceived to have HIV</b>		<b>8.40</b>	
	12	No intimate contact with a prostitute	.75
	9	No intimate contact with bisexual men or women	.70
	7	Non-intimate contact with homosexual men or women	.70
	13	Physical contact with drug addicts	.61
	14	Physical contact with sick patients	.52
<b>Fear of sexual contact with outsiders</b>		<b>8.37</b>	
	15	Extra-marital sexual contact	.76
	17	Sexual contact with different partners	.75
	18	Frequent anonymous sexual contacts	.68
	11	Sexual contact with a prostitute	.59
	10	Sexual contact with bisexual men or women	.49
	8	Sexual contact with homosexual men or women	.33

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FACTORS	ITEM		VARIANCE %	LOADING
<b>Fear of infections</b>			<b>7.17</b>	
	1	Contracting AIDS		.66
	4	Contracting venereal disease		.66
	6	Viruses		.60
	3	Undergoing blood transfusion		.53
	2	Physical contact with a person with AIDS		.49
<b>Fear of death and medical intervention</b>			<b>6.74</b>	
	23	Taking medical tests		.64
	24	Dying		.64
	27	Death		.60
	16	Sexual intercourse		.53
	26	Foreigners		.44
	5	Getting an injection		.41
	19	Intimate contact with acquaintances		.37
<b>Total Variance</b>			<b>47.81</b>	

**Table 2: Mean Differences on Factors of the FAIDSS between Genders**

FACTOR	TITLE	MALES (n = )		FEMALES (n = )		t*	SIGNIFICANCE
		Mean	±S.D.	Mean	±S.D.		
	Fear of loss of control	54.35	11.99	53.53	12.96	.53	n.s.
	Fear of sexual contact with groups perceived to have HIV	11.04	5.12	10.96	4.56	.14	n.s.
	Fear of sexual contact with outsiders	23.84	5.89	23.68	6.37	.22	n.s.
	Fear of infections	17.48	5.12	16.34	5.18	1.84	p < .05
	Fear of death and medical intervention	17.27	5.70	17.13	5.74	.20	n.s.

\*ns = not significant at p < .05 May need (n=) to enable readers confirm the t-tests?

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**Table 3: Differences in FAIDSS Factor Scores in South Africa by Age**

FACTOR	TITLE	YOUNGER		OLDER		t*	SIGNIFICANCE
		Mean	±S.D.	Mean	±S.D.		
1	Fear of loss of control	55.35	10.73	52.51	13.88	1.87	n.s
2	Fear of sexual contact with groups perceived to have HIV	11.14	4.57	10.84	5.00	.53	n.s.
3	Fear of sexual contact with outsiders	23.60	5.63	23.80	6.63	-.27	n.s.
4	Fear of infections	16.71	4.54	16.86	5.67	-.24	n.s.
5	Fear of death and medical intervention	17.94	5.70	16.48	5.69	2.15	p < .05

\*ns = Not Significant at p < .05

**Table 4: Inter-correlations between FAIDSS Factors**

		FACTOR 1	FACTOR 2	FACTOR 3	FACTOR 4
FSC	Factor 2	.26			
FSCN	Factor 3	.57	.20		
FOF	Factor 4	.61	.37	.44	
FODMI	Factor 5	.44	.43	.14	.34

(All p < 0.001)



## **Anticipatory grief: Its nature, impact, and reasons for contradictory findings**

Linda Reynolds  
Derek Botha

### **Abstract**

A review of the published research literature that examined the consequences of anticipatory grief on post-death bereavement adjustment, found conflicting results. An analysis of the literature suggested that conceptualisation matters, the lack of a precise and consistent operational definition, along with a number of methodological issues were the main reasons for the inconsistent and contradictory findings. Until these research concerns are adequately addressed to coherently and meaningfully capture the impact of anticipatory grief on post-death bereavement adjustment, an understanding of the phenomenon is likely to be limited, and could affect the nature and type of interventions considered by mental health practitioners in this field.

### **Introduction**

Anticipatory grief is a term describing the grief process that a person undergoes before a loss actually occurs. The scientific study of anticipatory grief is a relatively recent phenomenon, with the first documented research by Lindemann (1944). The terms 'anticipatory mourning' and 'anticipatory grief' were used interchangeably in this article to conform to the researchers' varied usage of the term. During the sixty-year span that followed, not only did the quantity of research in the field of anticipatory grief increase, but also there were marked improvements in the levels of methodological and statistical sophistications, and standards of reporting. Nevertheless, the history of research on this phenomenon has been fraught with conflict ever since its emergence. Some researchers have even submitted that anticipatory grief does not exist. Despite these submissions, a large body of research has been undertaken to determine the effects of anticipatory grief on post-death bereavement. However, the results of this research have been contradictory.

The more research that has been undertaken to determine the consequences of anticipatory grief upon post-death bereavement, the greater the degree of uncertainty that has evolved. The question that must then be addressed is what are the reasons that could have led to the increasing degree of uncertainty about the nature and impact of anticipatory grief upon post-death bereavement?

With this background, a review of relevant reported research was undertaken to: ascertain the nature and impact of anticipatory grief on post-death bereavement; analyse the conflicting findings of the research; and to identify and investigate the factors that have contributed to

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the contradictory findings. This information could have implications for mental health practitioners when working with bereaved individuals.

This article was limited in scope to the experience of anticipatory grief of the dying person's intimates (family and/or significant others). The article was limited to adult studies, and, as such, did not address research on anticipatory grief of children. Further, it did not address any research with respect to anticipatory grief of losses of another nature, such as the anticipation of the loss of a major body part, or bodily function.

Presentation of the research review is as follows: Firstly, a brief background on the origin of anticipatory grief research is presented; secondly, the contradictory findings of relevant research studies are discussed; thirdly, the factors that contributed to the conflicting results are identified and examined. A brief summary concludes the article.

### **Background**

The origin of the study of grief and mourning can be traced to the publication of Freud's (1917) seminal work, 'Mourning and Melancholia'. However, it was Lindemann (1944) who introduced the concept of anticipatory grief in the brief final paragraph of his article 'The symptomatology and management of acute grief'. Lindemann first noted the phenomenon among soldiers' wives during World War II. In response to the threat of the death of their loved ones, the wives went through all the phases of grief. It was thought that this reaction would form a safeguard against the impact of a sudden wartime death notice. However, it became evident that grief work could be done too effectively in advance. When soldiers returned from the battlefield, they found that their wives had disengaged themselves and no longer loved them. This notion, that mourning and detachment could actually exist in people prior to the death event, stimulated a great deal of research and debate.

### **Contradictory findings**

The concept of anticipatory grief has inspired not only a great deal of research, but also considerable controversy. There is an accumulation of contradictory information concerning the possible effects of anticipatory grief on post-death bereavement.

### **Refutation of existence of anticipatory grief**

Some researchers challenged Lindemann's concept of anticipatory grief, arguing that it did not exist (Glick, Weiss & Parkes: 1974; Parkes & Weiss: 1983; Silverman: 1974). They contended that the phenomenon is impossible, submitting that grief is exclusive to a loss by death, and cannot be experienced in advance. For example, Silverman (1974: 330) contended that any experiences prior to the actual death of the person were not grieving in advance, citing that a rehearsal for widowhood was not the real thing, and analogising that '... engagements are not marriages'. Parkes & Weiss (1983) challenged the notion of anticipatory grief if the relative stayed involved with the patient throughout the illness. Glick et al. (1974) also contended that, although an opportunity to prepare for a spouse's death may have had a positive effect on recovery of the bereaved spouse, any benefits thereof were not derived from what Lindemann termed anticipatory grief, but rather, were derived from the subjects accepting the inevitability of the loss.

### **Positive effect on the recovery of the bereaved spouse**

For some, anticipatory grief is seen as an adaptive mechanism. It is thought that unexpected and sudden death tends to be associated with more severe bereavement reactions, whereas having some advance warning of impending death, and experiencing anticipatory mourning, mitigates the grief reactions of the family once the actual death occurs (Margolis, Kutscher, Marcus, Raether, Pine, Seeland & Chericco: 1988; Zilberfein: 1999). Within this paradigm,

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the bereaved are able to deal with any unfinished business, say their good-byes, clarify any misunderstandings, and prepare for social adjustments to come, thereby having a less distressful and disabling period of bereavement when the death does occur (Zisook: 2000). Therefore, it is believed that survivors of a chronic illness death will do better than survivors of a sudden death. Earlier clinical research (such as those cited in Rando: 1986; for example, Naterson & Knudson: 1960; Chodoff, Friedman & Hamburg: 1964; Friedman: 1967; Ablin, Feurstein, Kushner, Zoger & Mikkelsen: 1969; Fulton & Futlon: 1971; Futterman, Hoffman & Sabshin: 1972; Goldberg: 1973) found that anticipatory grief did have a positive adaptive effect by easing the intensity of grief for the bereaved after the actual death occurred. Later studies also determined the positive effects of anticipatory grief on post-death bereavement. For instance, Kramer (1996-1997) found that women who experienced emotional separation from their husbands during the period of anticipation of the spouse's death, did not do so at the expense of affiliation. Kramer's findings suggested that emotional separation during a period prior to the death event could have had a positive impact on post-death bereavement adjustment for the spouse, without it detracting from her, or her husband's, sense of affiliation in the present. These findings were in direct contrast to Lindemann (1944) who cautioned that a period of anticipatory grief could lead to premature detachment, and end in abandonment of the person.

Gilliland & Fleming (1998) found that anticipatory grieving had a potentially adaptive role in post-death bereavement. In their study, the spouses reported decreases in subsequent experience of some acute grief responses after the death occurred.

This body of research findings seemed to indicate that having time to anticipate death, and to prepare for the impending death, resulted in an easier period of post-death grief for the individual.

### **Negative effects on the recovery of bereaved spouses**

On the other hand, research has also found that anticipatory grief has had negative effects on bereavement outcome. For instance, Clayton, Halikas, Maurice & Robins (1973) found that subjects who experienced anticipatory grief, did worse in the first month of bereavement, and were no better at one year later, than those who had not experienced anticipatory grief. Levy (1991) found that anticipatory grief might have been a risk factor for poor early bereavement adjustment. His findings were consistent with that of Clayton et al. (1973).

Blank (1974) also found that a bereaved individual who had already completed their mourning during a lengthy period of anticipatory grief, because of an extended illness, was sometimes ready to return to their normal pursuits very shortly after their loved one's death. The bereaved person was then left with trying to come to terms with feelings of guilt because of their behaviour. Conventionally, others might have seen this as inappropriate behaviour after the recent death of the person's loved one.

### **Studies Presenting Mixed Findings**

In this category, for instance, Carey (1977) found that forewarning was a significant factor in positive adjustment in cases where the deceased spouse had experienced prolonged severe suffering, (more than 1 month), but not when severe suffering was missing. In addition, forewarning was found to be an important factor for those who had experienced a time of unhappiness in their marriage. However, this was a factor for widows, but it did not apply for widowers.

Gerber, Rusalem, Hannon, Battin & Arkin (1975) found that long, extended illnesses (6 months or more) were related to poor adjustment in bereavement when measured 6 months

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following the death. However, in the short-term illness group (less than 6 months), they found no significant effect on post-death bereavement adjustment. On the other hand, Sanders (1982-1983) found that a period of anticipation of impending death mitigated the effects of post-death bereavement for the short-term chronic illness group (less than six months) as this group made the most favourable adjustment to bereavement. These findings did not confirm the Gerber et al. (1975) study. However, Sanders' findings in regard to the long-term chronic illness death group (more than 6 months) did concur with Gerber et al. (1975). Saunders found that anticipatory grief did not have an adaptive value as this group sustained higher intensities of bereavement when measured at 18 months post-death.

In their report, Walker & Pomeroy (1996) indicated that the findings that a period of long anticipatory grief had negative effects on post-death bereavement were particularly relevant with respect to diseases such as Cancer and HIV/AIDS, as these were often associated with protracted illnesses.

The longitudinal study undertaken by Stroebe & Stroebe (1993) found that not having a period of anticipation increased the intensity of post-death bereavement of the spouses. However, the negative effects lessened over time. Furthermore, they found that those with a low internal locus of control suffered from higher levels of depression and somatic complaints at four to seven months after their loss, and improved very little over the two-year period of this study, while those with high internal control were less affected by their loss.

Thus, these mixed results in the research findings, under certain circumstances, suggest that anticipatory grief had the potential for both positive and detrimental effects on post death bereavement adjustment.

### **Unrelatedness**

Other studies have suggested that a period of anticipation is unrelated to the grief experienced after death. Hill, Thompson & Galligher (1988) found that expectancy of death was not related to later adjustment to bereavement, as did the research by Parkes (1970). Similarly, the study by Roach & Kitson (1987) found that forewarning had no effect on the adjustment of widows to the loss of their spouse by death.

### **Summary**

The findings on the effects of anticipatory mourning on post-death bereavement have been inconsistent. Many of the studies in the last 60 years have pointed to the positive effects of a period of anticipation on post-death bereavement, whilst other studies have produced findings that indicated a negative impact on this relationship. Still others have presented mixed findings. And finally, some studies have failed to find any relationship between anticipation and post-death bereavement.

### **Reasons for discrepancies**

An analysis of the reported research indicated a number of explanations that may account for the contradictory and inconsistent findings as to the impact of anticipatory grief on post-death bereavement.

### **Conceptual Issues**

One of the main reasons for the inconsistencies is the conceptual confusion of forewarning of loss with anticipatory grief (Fulton & Gottesman: 1980; Siegel & Weinstein: 1983), where anticipatory grief was often assumed to have occurred just because there was 'forewarning' of the impending death. However, the study by Vachon, Freedman, Roger, Lyall & Freeman (1977), using a sample of 73 women, found that 40% of those who had been told that their



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husband was dying refused to believe a fatal diagnosis. The researchers suggested that it was possible to perceive a terminal illness as 'lingering', so that death was not anticipated. It was thought that denial by the survivor 'blocked' against the fatal diagnosis, so that anticipatory grief was not experienced. Similarly, Parkes (1970, 444) found that there was a '...failure of most respondents to accept warnings of the imminent demise of their husbands'. This study suggested that the fact that a loved one was terminally ill did not mean that the death was actually anticipated by the other, nor did it mean that anticipatory grief was present.

### **Lack of Precise and Consistent Operational Definitions**

Another explanation for the conflicting results could be the lack of precise and consistent operational definitions. Since anticipatory grief is a complex subjective experience (Casarett, Kutner, and Abahm: 2001), and not easily quantifiable, it has not been consistently operationally defined (Fulton & Gottesman: 1980; Siegel & Weinstein: 1983). Significant factors that have had a bearing upon attempts to operationally define anticipatory grief are now addressed.

### **Length of illness**

One approach to the construct of an operational definition of anticipatory grief has been to use the duration of the patient's terminal illness (Fulton & Gottesman: 1980; Kramer: 1989). For example, the study by Gerber et al. (1975), with a sample of 81 widows and widowers, measured the presence of anticipatory grief according to whether the death was due to a short-term acute illness (less than 6 months), or a lengthy chronic illness (6 months or more). Three medical variables selected as a gauge of bereavement adjustment were: the number of office visits to the physician; the number of times illness occurred without contacting a doctor; and, the number of tranquillizer and antidepressant medications used. The results indicated that the bereaved of a lengthy chronic illness did worse than those bereaved of a shorter illness death, at six months after the death. They also found that short-term illness had no significant effect on post death bereavement adjustment. It was also found that in cases where there was lengthy illness, widowers did more poorly than did widows.

Clayton et al. (1973) also attempted to operationally define anticipatory grief by using subjects whose spouses had short terminal illnesses (six months or less), and in those whose spouses had longer terminal illnesses (more than six months), and in those whose spouses died suddenly (in less than 5 days). They compared the frequency of symptoms of 109 widows and widowers during the illness, and then after death. The subjects were interviewed 1 month after the death of their spouses, then again at 4 months, and then re-interviewed one year after the death. If subjects confirmed depressive symptoms during the terminal illness, this was considered '...an anticipatory grief reaction'. If symptoms were present following the death of the spouse, it was termed a '...normal depressive reaction'. Their data found few differences in the post-death bereavement of persons whose spouses had suffered either short or long-term illnesses. Anticipatory grief did not mitigate the post-death grief of the survivor. In fact, they found that subjects did worse in the first month of bereavement, and did no better, one year later, than those without any anticipatory grief reaction.

Hill et al. (1988) defined anticipatory grief as any grief that occurred before an actual death in which there was an awareness of the impending death. The classification of the expected death group was based on whether or not the husband had been seriously ill for at least 1 month before his death. They hypothesized that widows who expected the death of their husbands would adjust better to bereavement than those widows who did not expect the death. The sample consisted of 94 elderly Caucasian widows over the age of 55. Participants were given a structured interview and self-report measure at 2 months, 6 months, and again at 1 year following the death of their spouse. The expected death group consisted

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of 54 widows, while 41 widows made up the unexpected death group. The findings indicated that anticipatory grief was not related to the subsequent adjustment to bereavement.

Similarly, Sanders (1982-1983) operationally defined anticipatory grief by the length of the patient's fatal illness. She assessed grief reactions to determine if differences in mode of death had an effect on bereavement. Three modes of death were identified: sudden, unexpected death; short term chronic illness death (less than 6 months); and long term chronic illness death (more than 6 months). The sample consisted of 86 participants with a mean age of 52. They were interviewed an average of 2.2 months following the death, and again at 18 months. The findings indicated anticipatory grief did mitigate the effects of post-death bereavement as the short-term chronic illness group made the most favourable adjustment to bereavement. In the sudden death and long-term chronic illness death groups, anticipatory grief did not have an adaptive value as these groups sustained higher intensities of bereavement at 18 months.

### **Related aspects of anticipatory grief**

Rando (1986) submitted that when studies merely examined only one, or a few dimensions, the results could be expected to deviate, depending on the dimensions selected to study. For instance, Levy (1991) operationalized related aspects of anticipatory grief by examining thoughts, feelings and behaviours, by using a self-report inventory instrument. 159 male and female spouses of deceased cancer patients made up the sample. Participants were assessed at 6, 13, and again at 18 months after the spouse's death. Levy's data found that anticipatory grief might be a risk factor for poor 'early' bereavement adjustment. These findings were consistent with the earlier findings of Clayton et al. (1973). On the other hand, Kramer (1996-1997) examined affiliation, separation, and communication. The sample consisted of 107 women whose husbands had died from 6 months to 3 years prior to the time of the testing. The findings indicated that a period of anticipation was positive to post-death bereavement outcome. These findings however, did not concur with Levy's (1991) earlier findings.

### **Multidimensional approach**

Gilliland & Fleming (1998) conceptualised anticipatory grief as a multidimensional phenomenon, similar to grief. They empirically compared and contrasted the features of anticipatory grief and conventional grief, and addressed the effects of anticipatory grief on post-death bereavement. It was found that spouses of the terminally ill experienced anticipatory grief at more intense levels of acute symptomatology than conventional grief. Furthermore, it was found that anticipatory grieving had an adaptive role. The spouses in this study reported a reduction in their subsequent experience of some acute grief responses.

Sloan (1999) drew upon the work of Gilliland & Fleming (1998), and also examined the similarities and differences between anticipatory grief and post-death grief, and the effects of anticipatory grief on post-death bereavement within an elderly Australian sample. The findings supported those of Gilliland & Fleming (1998). They found that those experiencing anticipatory grief tended to have less intense and acute levels of symptoms during post-death bereavement.

### **Factors associated with protracted illness**

Siegel & Weinstein (1983) proposed that the relationship between anticipatory grief and the beneficial post-bereavement outcomes might be confounded by other factors, which are usually associated with a prolonged terminal illness. They cite factors such as emotional distress, physical exhaustion, social isolation, guilt, and depletion of emotional and financial

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resources that have the potential to artificially inflate post-death symptomatology, thereby negating any positive effects, which could have resulted from a period of anticipation.

The above analysis indicates that there has been no uniformity in the operational definition and measurement of anticipatory grief. Typically, it has been operationally defined according to the length of time of the patient's terminal condition. However, as pointed out, the fact that a death was medically viewed as inevitable was no indication that the prospective survivors anticipated the death, or that they would begin grieving prior to the death. Other studies operationalized related aspects of anticipatory grief concentrating on one, or just a few, dimensions of anticipatory grief and, depending on the dimension examined, discrepancies in the findings might have occurred. More recent studies applied a multidimensional approach. Furthermore, factors associated with protracted illness may have also confounded the findings. Given the lack of precise and consistent operational definitions of anticipatory grief, and the features of lengthy illnesses, it is therefore not unexpected to have found discrepancies in the results of the various studies.

### **Methodological Issues**

The contradictory and inconclusive findings, which have led to the uncertainty about the impact of anticipatory grief on bereavement adjustment, can also be attributed to the differences in methodological aspects that have prevented comparability (Fulton & Gottesman: 1980; Fulton, Madden & Minicheiello: 1996; Siegel & Weinstein: 1983).

### **Untested assumptions**

One cause of the incongruities and uncertainty in research findings may be untested assumptions (Fulton & Gottesman: 1980; Siegel & Weinstein: 1983). Two untested assumptions that may have contributed to the discrepancies in the findings were noted; firstly, that '...all those in a state of bereavement are experiencing a comparable volume of grief' (Fulton & Gottesman, 1980: 50). This assumption does not consider individual variations. For instance, there may be a difference in the grief experienced by the bereaved survivor of a couple who were emotionally close, and the grief experienced by the survivor of a couple who were not close. The second assumption was that '...once grief work has begun, the grief reaction is dissipated in a continuous and irrevocable route towards resolution' (Fulton & Gottesman, 1980: 51). Studies that have attempted to measure whether those who go through anticipatory grief dissipate their grief sooner than those who don't experience any forewarning of loss, appear to have expressed this assumption (Fulton & Gottesman: 1980). Failure to understand how individuals experience and respond to this phenomenon, prohibits knowing whether or not anticipatory grief is helpful to survivors during post-death bereavement.

### **Population variables: Age issues**

In a number of studies, there were significant differences among sample populations. The sample in Gerber et al. (1975) consisted of elderly individuals whose average age was 67. Similarly, the Hill et al. (1988) sample consisted of only those over the age of 55, with a mean age of 66.5 years. Sloan (1999) also studied an older sample where participants were required to be 50 years of age or over. Their age ranged from 50 – 88 years, with a mean age of 67.9 years. On the other hand, Carey's (1977) sample base was broader, with ages ranging from 28 to 70 years, having a median age of 57 years. The ages of subjects in the Kramer (1996–1997) study ranged from 38 to 81 years of age, with a mean of 63.2 years. Likewise, Gilliland and Fleming (1998) included individuals whose ages ranged from 28 to 81 years of age. A number of studies however, omitted the ages of their participants, either indicating only the mean age of their sample, or omitting the ages altogether. These included Clayton et al (1973), average age of 61 years of age; Levy (1991), mean age of 63.6 years of age;

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Sanders (1982-1983), mean age of 52 years of age; Stroebe & Stroebe (1993), mean age of 53.05 years; and, Vachon et al. (1997), mean age of 54 years of age. On the other hand, Parkes (1970) stipulated that his sample had to be under the age of 65; while Roach & Kitson (1987) made no reference to the exact age in their sample, but merely stated that the data included both younger and older women.

Although the significant differences in ages, age groupings, and age reporting in the various studies may be a contributing factor to the conflicting results, it was not clear whether or not age differentials were the only variable that may have impacted on the findings. Most studies also incorporated a number of other variables, which could have also contributed to the conflicting results.

### **Population variables: Gender issues**

Gender was another methodological issue that may also have accounted for the discrepancies in the research findings. There was no consistency with regards to the gender of the populations studied. Some research involved only women (Hill et al: 1998; Kramer: 1996-1997; Parkes: 1970; Roach & Kitson: 1989; Vachon et al: 1977), while other studies combined both men and women in their studies (Carey: 1977; Clayton et al: 1973; Gerber et al: 1975; Gilliland & Fleming: 1998; Levy: 1991; Sloan: 1999; Stroebe & Stroebe: 1993). It was also noted that in the majority of studies that combined both sexes in the sample, there was an unequal number of men and women. On the other hand, Sanders (1982-1983) made no mention as to the gender of the sample used.

It was noted that Carey (1977) found that there was a superior adjustment of widowers, as compared to widows. These findings did not concur with Gerber et al (1975) who found that that widowers did more poorly than did widows. Stroebe (2001) also found that the effects of the loss of a marital partner were greater for widowers than for widows in the acute grieving period. On the other hand, Clayton et al. (1973) found no gender difference in bereavement outcome, nor did Stroebe & Stroebe (1993) who attributed the gender similarity of the findings to their selection process (selected only emotionally stable individuals).

Gender differences, as well as the emotional state of individuals, may also have been additional factors contributing to the contradictory results.

### **Population variables: Oversimplification of personal factors**

A lack of sophistication in the sense of an oversimplification of factors have also been reasons for the conflicting results in many of the studies (Rando, 2000). For instance, in a two-year longitudinal study, Stroebe & Stroebe (1993) found that personality variables were an important determinant for the survivors in their adjustment to unexpected loss. Their findings on a sample of 60 bereaved individuals indicated that those with a low internal locus of control suffered from high levels of depression and somatic complaints, and improved only slightly over the two-year period of this study. Those subjects with high internal control were less affected by the loss than those with low internal control. Thus, when examining the impact of anticipatory mourning on the survivors, personal factors may have lessened, or contributed to the inconsistency in findings (Rando, 2000).

### **Survey techniques: Instrument validity**

Some of the more recent research, which examined the multidimensional nature of the bereavement process, such as the Gilliland & Fleming's (1998) study and the Sloan (1999) study, used the Grief Experience Inventory (GEI) instrument. Levy (1991) used the Anticipatory Grief Inventory (AGI). These instruments were constructed using 'rational' methods of instrument development (practitioners and researchers choose the items for

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instruments), rather than using the procedure of 'empirically' deriving items from data collected from bereaved adults. According to Hogan (2001), instruments using 'rational' methods, rather than 'empirical' methods, can negatively affect instrument validity. Not only were different instruments used in the studies quoted by Hogan (Hinkin: 1998; Tilden, Nelson & May: 1990), but also it appears that questions regarding instrument validity could also raise doubts about the conclusions reached in the studies. These issues point to still other possible explanations for the discrepancies in the findings.

Again, it seems reasonable to submit that the impact of these various methodological differences and issues may have adversely affected any meaningful comparison of the findings.

### **Survey techniques: Variations in data gathering process**

The analysis of the studies found that the number of interviews and/or questionnaires given to the subjects, as well as the way in which they were administered, also differed. For instance, Carey (1977) interviewed all the subjects in his sample after 13 to 16 months of the death of their spouse. A structured 8 item self-report was administered to the respondents only once in their home. The procedure used by Clayton et al. (1973) was to interview all subjects 1 month after the deaths of their spouses. At 4 months, only some of the subjects were re-interviewed and then, after approximately 1 year, most of the subjects were re-interviewed again. Gerber et al. (1975) administered an open-ended questionnaire to their subjects measuring adjustment once, at 6 months after the death. Gilliland & Fleming (1998) administered a true-false answer self-report scale and 2 questionnaires, the first at approximately 36 days prior to the death of the spouses, while the second interview was given about 80 days thereafter. Hill et al. (1988) administered a structured interview and an 18 item self-report measure in the participants' homes at 2 months, 6 months, and again at 1 year following the death of the spouses.

On the other hand, Kramer (1996-1997) administered 5 questionnaires on only 1 occasion (the timing of which was not mentioned in the study), using 2 different approaches. Some subjects were requested to complete the questionnaires in a group situation, while others were mailed questionnaires for completion and return to the researcher. Levy (1991) used a semi-structured interview format, as well as a pencil-and-paper self-report instrument (Anticipatory Grief Inventory). 4 individual assessment interviews were conducted: the first 5 weeks after the death of the spouse, and then again at 6, 13, and 18 months. All interviews were done in the participants' homes. Parkes (1970) conducted a standardized interview with each subject in their home at 1, 3, 6, 9 and 13 months after bereavement. Sloan (1999) mailed out a questionnaire survey with a pre-paid return envelope to subjects whose partners had died 3 to 9 months previously. Sanders (1982-1983) administered a questionnaire and a 135-item true-false self-report inventory. Participants were interviewed in their home approximately 2.2 months following the death, and then again 18 months after the bereavement. Stroebe & Stroebe (1993) administered structured interviews as well as a self-report questionnaire at 3 intervals over a 2-year period. There was no mention in the study as to when the interviews took place over this 2-year period. The first 2 interviews were held at the home of the participants, but the 3<sup>rd</sup> interview was conducted by telephone.

These variations in the data gathering process may also have accounted for the differences and contradictions in the findings of the various studies. However, as with the other methodological issues referred to in this article, there are other variables that may have also confounded comparative research results.

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## Conclusion

A review and analysis of reported studies that examined the consequences of anticipatory grief on post-death bereavement adjustment found results that were conflicting. In some studies a period of anticipatory grief was found to have mitigated the effects of bereavement, while other findings indicated a negative impact on this relationship. On the other hand, some research studies presented mixed findings, while other studies failed to find any relationship between anticipation and post-death bereavement. The analysis of the literature shed some light as to the reasons for the inconsistent and contradictory findings surrounding research on anticipatory grief. The discrepancies in the results in the various studies appear to be a function of differences in the conceptualisation of anticipatory grief, the lack of a precise operational definition, as well as a number of methodological differences and shortcomings. Until these research issues are adequately addressed in order to coherently and meaningfully capture the impact of anticipatory grief on post-death bereavement adjustment, an understanding of the phenomenon will remain limited, and could affect the nature and type of interventions by mental health practitioners.

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Carter E. (2006), Pre-packaged guided imagery for stress reduction: Initial results, *Counselling, Psychotherapy, and Health*, 2(2), 27-39, July 2006.



## **Pre-packaged guided imagery for stress reduction: Initial results**

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### **Abstract**

A study into the use of pre-packaged compact discs (CDs) which incorporate Guided Imagery (GI) with suggestions and affirmations, indicates that the use of these CDs results in quick reduction of stress-related issues for all participants. Notable improvements were identified in general feelings of well-being (91% of participants), positive thoughts (82%) and ability to cope in stressful situations (73%). Decreases in incidence ratings were greatest for insomnia, anger and negative thoughts. Most commonly the *first* benefits people noticed were increased relaxation, decreased negative thoughts, and decreased stress. Despite the effectiveness of the CDs, improvements tended to be short-lived due to diminishing use of CDs (and relaxation techniques) over time. There was no long term commitment to the regular practice of the relaxation technique. Rather participants apparently sought speedy issue resolution from the CDs. Consequently not all improvements endured, with some participants needing to revisit the CDs each time symptoms returned.

Keywords:

**Guided imagery; relaxation; stress reduction; self-hypnosis; well-being; positive thoughts; compact discs (CDs)**

## Literature

Many people suffer symptoms of stress manifesting in a range of physical symptoms, of different levels of severity, such as headaches, bodily aches and pains, anxiety, and inability to cope with life generally (Jackson:1993). However, faced with these symptoms, what do we do? Initially, we may attempt to heal ourselves by taking self-prescribed medication (analgesic, tonic, multivitamin), improving our diet, decreasing alcohol intake, etc. and/or we may visit our general practitioner (GP). All these options involve treating the body rather than addressing the root cause, the stress, or, the state of the mind.

There appears no question that stress-related symptoms are real, and can be caused by an emotional imbalance, rather than a physical one (Clarke & Smith:2000), which is not easily treated in an effective manner within a traditional Western medical model based on biomedical science, which is evidence-based as well as being fundamentally analytical and reductive. The wide acceptance of this fact is evidenced by the increase in the availability of alternative therapies, eg relaxation techniques, yoga, Pilates, massage therapy, and self-hypnosis, in many forms and mediums such as therapy sessions, classes, videos, cassettes, CDs, DVDs etc.

The fundamental element in any therapy aimed at reducing stress and stress related symptoms is relaxation, and relaxation has been shown to be beneficial for a range of symptoms and health problems such as shorter hospital stays; decreases in pain along with the promotion of more rapid recovery (Blankfield:1991); quicker wound healing (Kiecolt-Glaser:2001); reduced depression, headaches, fatigue, and improved job satisfaction/performance; better relationships with supervisors/co-workers; and improved quality of sleep (Bellarosa:1997). Benefits also noted include reduction of nervousness; promotion of performance; enhanced selective attention and memory recall; promotion of self-control/self-actualisation and reductions in psychosomatic complaints (Krampen:1996). These techniques have been seen to assist in, (i) alleviation of insomnia and gastrointestinal disorders (McCubbin:1996); (ii) anger reduction (Deffenbacher:1995); (iii) decreases in irrational beliefs and increases of self-efficacy, (iv) reduction in hot and cold spells, along with (v) tension headaches, insomnia, anxiety, stress and excessive fidgeting (Kiselica:1994). Widespread benefits are noted in holistic terms, and may positively influence (i) improvements in mixed psycho-physiologic disorders (Blanchard:1991); (ii) reduced negative outcomes associated with ageing, (iii) reduced hospitalisation and admission rates; (iv) improved mental health and (v) increases in longevity (Alexander, Langer, Newman Chandler & Davies:1989). In addition to providing assistance for people with cancer and other terminal illness, stress-reduction approaches are known to generally help people cope with illness and chronic pain (Cupal & Brewer:2001).

The use of imagery and guided imagery (GI) in psychotherapy to induce relaxation is widely adopted and accepted (Ackerman & Turhoshi:2000; Bazzo & Moeller:1999; Complementary & Alternative Medicine:Guided Imagery:2004; Eller:1999; Gruzelier:2002; Hudetz, Hudetz, & Klayman:2000; Johnston:2000; Peck, Bray & Kehle:2003; Rossman:2000; Shames 1996; Syrjala & Abrams:2002; and Varlas:2001). Guided Imagery is a therapeutic technique allowing individuals to use their own imagination to connect body and mind to achieve

desirable outcomes (Ackerman & Turkoski:2000). GI induces a relaxed state and facilitates cognitive restructuring when 'suggestion' is included as part of the therapy (Syrjala & Abrams:2002). There is debate however that imagery and the associated suggestions are most beneficial when their utilisation is individualised. Evidence for and against individualisation has had mixed outcomes with a key element of success being mastery or competence of imagery technique (Enns:2001; Syrjala & Abrams:2002).

Arguments against individualisation for some professionals has popularised mass produced therapies available as tapes, CDs etc., incorporating self-hypnosis techniques, imagery and GI, with the same induction and training being presented to everyone using the CD or tape. This type of easily accessible and relatively inexpensive therapy is becoming more popular and is also being recommended to clients in therapy, to help clients relax (Bourne, 2001; Blanchard:1991).

The author conducted a research project on the effect of non-individualised GI CDs, or 'pre-packaged guided imagery' (PPGI) on life stress and stress related symptoms. The PPGI used in this instance was a series of CDs with associated written material (Guidebook), developed for a range of personal issues by practicing professionals (a psychotherapist and a peak performance coach). Although the CDs are for a range of issues, they all incorporate the same induction technique of relaxation training using GI followed by imagery incorporating suggestions and affirmations, i.e. 90% of the content of the CD's was the same except for the focus of the affirmations and suggestions.

Theoretically, the development of such CD's is in according with Jackson (1993), in that if there is an overall increase of positive thoughts through this technique and with additional positivity from affirmations in this instance, there should be a generalised increase of positive feelings and increase in good health. Thus, it is hypothesised that because of the broadness of the approach, regardless of the underlying issue, there will be an overall improvement across a range of issues.

The aims and objectives of the project were to assess by qualitative and quantitative methods, the following:

- perceived role of non-individualised PPGI (i.e. readily available CDs)
- expected outcomes versus actual outcomes of PPGI CDs
- associated benefits after undertaking GI training, and to
- identify any surprising or unexpected benefits.

## **Methodology**

From previous research already mentioned, a list of potentially stress-related issues and related questions was developed as the basis for a survey of people who had used the PPGI which incorporated specific issue-related suggestions and affirmations. Participants were obtained from a list compiled at the time of acquiring the product, of people willing to participate in a study relating to outcomes. Participants acquired at least one of the CDs from the set of 10 (titled respectively, 'Absolute Relaxation; Achieving Sensational Grades; Attracting People Magnetically; Busting Away Depression; Creating Abundant Wealth; Discovering Past Lives; Quick & Easy Weight Loss; Sleeping Like a Baby; Stop Smoking Permanently; Meditating Easily', Briggs & Green:2002). In all, 22 participants completed questionnaires either by phone or self-completion. The questionnaire consisted of open and closed questions. All participants received copies of the questions whilst engaging with the product.

## **Results**

Just over half of the participants were female 59%, and 41% were male. Participants ranged in ages from 19 to 67. Overall a wide range of CDs in the selection were used by the participants. The most commonly used CD was 'Absolute Relaxation' (27%), followed by 'Creating Abundant Wealth', and 'Sleeping Like a Baby' (18% each). Only 4 respondents had used more than one of the CDs individually. At the time of their interview, participants had begun using their CDs from between 2 to 14 months prior, with average usage period of 6.6 months.

From qualitative responses, 45% of participants were classified as being in "*Good Health*", describing themselves as "active", "healthy", "feeling great" etc., prior to starting the PPGI. The others (55%) were classified (by the author) as in "*Poor Health*", reporting a range of health issues such as "depression", "being overweight", "lethargic", "having poor eating habits", "suffering from headaches", "experiencing mood swings", being "anxious", "weepy", "uptight", "out of balance", "generally unwell", or suffering from "mental stress". All but one in this group reported multiple symptoms. Across all ages respondents reported health issues. Female participants reported more health issues than did males (see Table 1).

**Table 1. Overall Percentages of Participants Age and Sex by Health Classification**

	Overall	Good Health*	Poor Health/Multiple issues
<b>Age Ranges</b>			
Less than 30 yrs	18	9	9
30-39 yrs	32	14	18
40-49 yrs	27	14	14
50 or more yrs	23	9	14
<b>Sex</b>			
Male	41	27	14
Female	59	18	41
<b>Overall</b>	100	45	55

\* Percentages have been rounded.

### Perceived role of PPGI

Almost all participants had high expectations of success, believing that the CD would work. The reasons given for taking up the PPGI could be classified into 3 broad categories:

- a specific/identifiable problem targeted by one of the CDs (eg weight loss, insomnia) (50%)
- a general feeling of depression/anxiety manifesting in multiple health concerns (32%)
- self-development (18%)

All participants perceived that their problems were partly psychological or emotional, and for those experiencing symptoms, that these physical symptoms were caused by stress. Less than half (41%) of all participants had attended their GP to discuss their concerns. Those who were prescribed medication discontinued shortly afterwards, saying there were too many side effects or they just didn't want to take drugs (antidepressants, sleeping pills, etc.). Although all participants were optimistic about expected outcomes, only 9% of them followed the instructions as prescribed, even though many believed they had. A large proportion (73%) said that they followed the instructions of the program, but when qualitative information was analysed more specifically, it was found that only 14% initially practiced twice a day, as recommended. Most commonly, participants initially listened to the CD each day for one to four weeks. Nor did participants read the additional material at least once a week, as recommended. In fact, the written instructions and additional material were hardly ever referred to by 59% of participants.

From analysis of qualitative responses relating to initial interaction with the CDs, participants were grouped into 3 groups for further investigation: Initial Interaction with CD/material High (*High II*); Initial Interaction with CD/material Moderate (*Moderate II*); Initial Interaction with CD/materials Low (*Low II*).

### **Expected versus Actual Outcomes**

The expectations of participants were almost all directly in line with the titles of the CDs, i.e. “lose weight”, “get better grades”, “get a good night’s sleep”; one participant who purchased multiple CDs expected “a new me”. However, there was no evidence from the qualitative information that any participant expected any other improvements in their health or well-being.

When asked how they felt while they were listening to the CD, most often participants mentioned being “more calm” and “relaxed”, others mentioned being “de-stressed”, “switching off”, “feeling detached from the daily grind”, “sleepy”, and “nurturing to myself”. All participants reported an improvement with their concerns, with only one reporting a minimal change for the better. Regardless of the level of *Initial Interaction* in listening to the CDs, the improvements reported were moderate, with 36% of participants noticing improvements after listening to the CD for the first time, and 59% noticing improvements within 1 to 4 weeks. The remaining respondents were unable to determine how long before noticing an improvement. Improvement timeframe (speed of change) was as expected for 27%, faster for 36% and the remaining 36% had no expectations of speed of change.

Qualitatively, participants individually reported many benefits including:

1. feeling calmer/more relaxed;
2. sleeping better;
3. being more positive/having more positive thoughts;
4. having more energy/energised;
5. losing weight;
6. being more focused;
7. being more in control;
8. having less headaches;
9. stopping smoking;
10. having increased patience;
11. feeling more balanced;
12. having normalised blood pressure;
13. not feeling afraid;
14. being able to turn-off (i.e. no “busy brain”);
15. having reduced negative thoughts;
16. experiencing personality improvements (more understanding of other people);
17. improved listening skills;
18. experiencing diminished mood swings.

Participants were asked if they had noticed improvements in some specific areas. Not surprisingly, “*Poor Health*” participants were more likely to have noticed benefits for a range of issues (see Table 2).

**Table 2. Percentage of Participants with a noticed improvement in specific areas.**

Specific Area	Percentage of participants with a noticed improvement.		
	Overall	Good Health	Poor Health
General feeling of well-being	91	80	100
Positive thoughts about the future	82	60	100
Ability to cope in stressful situations	73	60	83
Feeling of optimism about the future	64	40	83
Confidence	64	40	83
Sleep	55	50	58
Concentration	55	50	58
Memory/recall of information	50	50	50
Reaction to situations where you would normally get angry	45	20	67
General health	41	20	58
Luck	36	10	58
Tendency to procrastinate	32	0	58
Weight (loss or gain)	23	10	33
Feelings of attractiveness	23	10	33
Finances	23	0	42

Improvement in “general feeling of well-being” and “positive thoughts” appears least likely for those in the following groups: ‘*Low II*’ and ‘*Used the CDs for less than 6 months*’. Participants were also asked to rate the incidence of certain common medical issues prior to listening to the CD and after listening to the CD, on the following broad 4-point scale: Often (4), Regularly (3), Sometimes (2), Never (1). All of the issues yielded an overall positive

difference in mean scores for before and after experiencing the PPGI, as reported in Table 3, i.e. all conditions improved. The highest differences, (i.e. greatest improvements), were noted for Insomnia, Anger and Negative Thinking. Even higher score differences were recorded for those in the “*Poor Health*” group. Interestingly, some of the biggest differences were noted for participants who were grouped into the “*Moderate II*” group.

**Table 3: Means Score differences of incidence rating of common medical issues, before and after using PPGI.**

Issue	Mean Score Difference before and after PPGI		
	Overall	Poor Health	Moderate II
Insomnia	0.89	1.09	1.80
Anger	0.79	1.08	1.00
Negative thinking	0.79	1.00	1.16
Fatigue/tiredness	0.69	0.86	1.00
Headaches	0.67	1.00	0.84
Irrational beliefs	0.66	1.09	1.17
Depression	0.64	0.91	0.67
Digestion	0.44	0.72	0.50
Viral infection	0.32	0.41	0.50
Blood pressure	0.28	0.45	0
Obesity	0.28	0.46	0.33
Aches/pains	0.22	0.37	0.17
Hair loss	0.22	0.37	0.33
Alcoholism	0.21	0.34	0.17
Hot/cold spells	0.17	0.30	0.20
Gastrointestinal problems	0.16	0.28	0
Decreased heart rate	0.05	0.09	0



A large proportion of the participants would like to continue using the CD (96%), and were still using the CD (83%). 46% of participants were still using the CD on a regular basis, 23% using the CD “as needed”, 14% “not often enough”, and the others (18%), “not at all”. However, in continuing to use the CD, 41% expect that this will only be “as needed”, 18% will continue “once a week”, 23% continuing “a few days a week” or “5 times a week”, with the other participants (18%) unable to specifically say how often they will use the CD.

### **Unexpected benefits**

When asked to identify any unexpected benefits, the following were each mentioned by one or more participants: motivation; stronger memory; needing less sleep; benefits applicable to other areas of life (work/family); stress relief; normalisation of blood pressure; decreased back and neck pain; no more fear; positive thoughts; improved communication skills; ability to control anger; ability to laugh again.

### **Associated Benefits**

Coincidentally, use of analgesics was reported to have decreased slightly over time from the 12 months prior to using the PPGI, and since using the PPGI (Mean Scores of 2.21 and 1.79 respectively, using the previously described 4 point relative frequency scale). Participants also reported that they visit the doctor less often, post PPGI, with an overall number of visits annually of 4.18, prior to PPGI, and after PPGI of 2.88 visits annually. However, these results should be interpreted with caution given that the average time since acquiring the CDs is only 6.6 months. Over half (59%) reported that others (friends/family/colleagues) had recognised improvements in performance and or their behaviour.

### **Discussion**

It seems that for these participants, many aspects of their lives improved because of the use of PPGI at least in the short term. More research is needed to investigate what, if any, benefits may exist in the long term from the use of PPGI. The key finding of this research is that listening to CDs incorporating the techniques of GI, suggestion, together with affirmations tend to assist people in feeling better by increasing their general feeling of well-being, increasing positive thoughts, and improving their ability to cope in stressful situations; in decreasing the incidence of insomnia, and in feelings of anger and negative thinking. These benefits may occur regardless of the reason for acquiring the CD in the first place. However, further investigation of the causal factors is yet to be seen, as it is difficult if not unlikely to facilitate a controlled sample without mitigating circumstances influencing the results of analysis.

This being said, regardless of the suggestion component (i.e. CD used) it appeared that the most common benefits people noticed were increased relaxation, decreased negative thoughts, and decreased stress; with a couple of exceptions, i.e., the first benefit for those using the “Sleeping Like a Baby” CD, was better sleep. Those people, who had only a moderate commitment initially, reported considerable improvements across a range of symptoms.

For current participants however, there was no long term commitment to developing a life-style that incorporates the techniques into their daily lives. The book associated with the CD was perceived to be of little importance to the treatment. For a lasting benefit there appears to be a need to be more committed and persistent in engaging with the CD, with a need to understand that relaxation therapy needs to become a way of life to bring about lasting changes. However, this is yet to be seen and requires further study. Also, participants did not appear to be looking for lasting benefits, but rather sought a 'quick fix' or speedy improvement of a problem. They saw the CD as the means to an end, with many of them expecting quick results and consequently getting them, but they didn't last. The influence of prior personal beliefs associated with the treatment modality poses interesting challenges in understanding therapy outcomes. These beliefs were challenged as participants often indicated that they had to keep revisiting the CDs when the problem arose again. The fact that the written material was hardly referred to by any participant indicates that when people choose treatment in the form of PPGI as a CD, they expect just to listen, and are not interested in reading. These factors may also suggest participant capacity and/or will to retain information, ideas, and beliefs associated with the path of recovery across various symptoms.

Also clear from the qualitative information is that participants have very little time to engage in such a therapy. Thus, it can be said that this type of program should be short and sharp. Participants in this study had trouble listening to a CD for 30 minutes once a day, let alone twice a day as was recommended for maximum benefit. Many respondents (96%) indicated that they would be continuing to practice the techniques, however, there is still an inclination to perceive PPGI within the medical model, and to treat it like a pill, i.e. listen to the CDs or to practice the technique as a 'quick fix' when things start to go wrong, and our mind needs a 'top up'. The idea or notion of keeping the mind permanently in good health by practicing regular relaxation is not yet instilled in the collective consciousness, even for those who have recognised the connection of mind/body. This type of therapy may require some sort of self-checking or monitoring component which would enable individuals to gauge their level of relaxation and progress. These mitigating factors including cultural dispositions to holistic health require greater sensitivity in future research design, particularly in a field like counselling, and psychotherapy, where the whole person tends to be the object of analysis.

Results related to frequency of visits to the doctor and use of analgesics were inconclusive given the timeframe between participants having acquired the CDs and the conducting of the research and the fact that most of the respondents were generally relatively healthy. Some participants reported positive comments from family and friends. This is interesting as the social aspect of increasing positive outlook in people's lives is often overlooked in similar research, which tends to focus on the individual exclusively. However, this is an area where further investigation could contribute constructively in developing group or family therapy approaches that incorporate some aspect of PPGI. Comprehensive long-term follow-up with people who have used this type of CD or therapy (both successfully and unsuccessfully) would be beneficial in understanding how they can be used for the greatest benefit.

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## The Nature of Tobacco and Cigarette Information on the Internet

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### Abstract

Every day thousands of youth light a cigarette and try tobacco for the first time. Many of these youngsters will become addicted to nicotine and will have their quality of life lessened and die of smoking related illness. Many influences come to play on a youth's decision to use tobacco or not and may include personal factors, role models, peer influences, advertisements, and available information on smoking and tobacco. The Internet, specifically the World Wide Web (WWW), has become a popular information resource and leisure activity over the last decade. Many now regularly search the WWW for information on a variety of topics. The young are especially enamoured with the WWW and thus the information gleaned by the young off of the WWW could prove to be especially influential. The present study examined the nature of tobacco and cigarette information on the WWW. It was determined that the majority of information on tobacco and cigarettes readily found using search engines was commercial in nature and promoted the use of tobacco. Indeed, few sites were located that actively discourage smoking. Recommendations are provided regarding how to help youth access more appropriate WWW resources relating to tobacco and cigarettes.

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Every day thousands of youth light a cigarette and try tobacco for the first time. Many of these youngsters will become addicted to nicotine and will have their quality of life lessened and die of smoking related illness (Melendez, 1999). There are many reasons why youth use tobacco and it is likely that prior to their actual use they engage in an evaluation process which ends in their decision to use tobacco or not. Many influences come to play on a youth's decision to use tobacco or not and may include personal factors, role models, peer influences, advertisements, and available information on smoking and tobacco (Geldard & Geldard, 1999). The Internet, specifically the World Wide Web (WWW), has become a popular information resource and leisure activity over the last decade. Many now regularly search the WWW for information on a variety of topics (Davison, 1997; Grohol, 2000; Melendez, 1999; Sacchetti, Zvara, & Plante, 1999). The young are especially enamoured with the WWW and thus the information gleaned by the young off of the WWW could prove to be especially influential (Melendez, 1999; Pelling 2004).

The WWW provides its users with a convenient way of accessing information while allowing others to disseminate a variety of information. As stated by Sacchetti, Zvara, and Plante (1999, p. 1117) "It holds limitless potential as a teaching tool." However, while anyone can create a web page and publish on the WWW, few are able to accurately evaluate the information they obtain. The present study explores the general nature of tobacco and cigarette information on the WWW, assesses the impact of this information, and makes suggestions regarding tobacco related information on the WWW.

### **General Internet Overview**

To understand the logic behind the methodology used in the present study a basic understanding of the WWW is required. Thus, some basic information on the WWW is provided here as a brief introduction for the uninitiated or review for those who are Internet savvy.

The Internet is used for advertising, as an information source, and as a communication tool. Thus, the Internet has become an important part of the general media over the last decade. The Internet is used by adults and particularly youth and has the potential to influence perception and one's knowledge base.

The most popular but least interactive of online resources is the World Wide Web (WWW). Through the WWW one can easily gain access to a variety of information, some not very valuable. The WWW is comprised of web sites or home pages that have addresses called Uniform Resource Locators (URLs). People explore the WWW via Web Browser software such as Netscape and Internet Explorer. Using this software one can type in various addresses to go to those homepages or "click" on highlighted text or graphics called links. Clicking on links and going from web site to web site is surfing. However, most WWW users will not blindly surf the WWW but will use search engines to find specific information. Using a search engine is the most popular way of getting information off of the WWW (Grohol, 2001).

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Search engines use software called spiders or robots to find relevant web pages. To use a search engine one types in a few words and clicks on the search button. Pages are returned in order of relevancy which is determined differently by different search engines but usually involves the use of the words in your search on the various web pages found. Search engines use boolean logic just like library searches (terms such as and/or/not can be used in searches) (Grohol, 2000).

### **Method**

The WWW was searched separately for the terms (a) tobacco and (b) cigarettes with three different search engines: Alta Vista (<http://www.altavista.com/>), Google (<http://www.google.com/>), and Go.com (<http://www.go.com/>). The search engines used were utilized because they were the most highly rated by Grohol (2000), in his review of search engines, as providing useful and relevant information. From each search the top ten most relevant sites obtained were examined. Thus, sixty web sites were obtained and examined.

The web sites obtained were examined for origination, form, and basic content. Specifically, web pages were assessed regarding their creator (commercial, government, and not for profit), number of printed pages of information, appearance (text only or text and pictures and if the pictures were likely to appeal to youth), and if the pages were commercial in nature whether price information and warnings about the dangers of tobacco use were present.

### **Results**

Out of the sixty sites examined, forty-eight were unique and twelve were duplicates in which the different search engines found the same web pages. Out of the forty-eight unique web pages 30 (62.5%) were commercial in nature and sold tobacco, cigarettes, and quit smoking programs. Six of the sites were governmental (12.5%) and twelve originated from not for profit agencies (25%).

For the forty-eight unique sites there was a total of ninety-nine pages of information. The web pages ranged from one to seven pages of information with an average of two pages of information per site (Mean 2.1, SD 1.3). Twenty-eight of the web pages contained pictures (58%), including five that youth would find engaging. Twenty sites were pure text (41.6%).

### **Commercial Sites**

Commercial web pages averaged 2.2 pages (SD 1.5) in length (range 1-7). Of the commercial web sites obtained 66.6% contained pictures (20 sites), including four that youth would find appealing. Ten web sites contained pure text (33.3%). Most of the pages sold tobacco but four sold quit smoking products and one sold drug testing equipment. Twelve (40%) of the pages contained price information and three had warning regarding the dangers of tobacco. The majority of information examined appeared to be geared towards adults, but written in simple English.

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### **Government Sites**

Government web pages averaged 1.8 pages (SD .9) in length (range 1-3). Of the governmental web sites obtained 33.3% contained pictures (2 sites), none included pictures that youth would find appealing. Four pages contained pure text (66.6%) and one page contained predominantly legal information. The majority of information examined appeared to be geared towards adults and quite complex in nature.

### **Not for Profit Sites**

Not for Profit web pages averaged 1.8 pages (SD.8) in length (range 1-3). Of the not for profit sites obtained six contained pictures (50%), including one youth appealing picture. Six pages contained pure text (50%) and three of the pages contained predominantly legal information. One page contained quit smoking information. The majority of information examined appeared to be geared towards adults.

### **Discussion**

Based on the results of this study, it would appear that the majority of web information to be found by searching the two terms (a) tobacco and (b) cigarettes is commercial in nature. Moreover, the commercial information is likely to contain pictures, contain pictures that are attractive to youth, and lack warnings regarding the dangers of tobacco. Even the majority of quit related information discovered on the WWW was commercial in nature. Additionally, the majority of governmental and not for profit sites examined did not contain pictures, or pictures attractive to youth, and tended towards legal and complex information. As a result, the information readily found by searching the WWW for tobacco and cigarette information could be said to be promoting the use of cigarettes and tobacco, as individuals searching the WWW for such information are likely to be confronted with information on the ease of cigarette purchase and attractive sites related to the business of tobacco versus easily understandable information regarding the dangers of same.

### **Recommendations**

A greater and more appealing not for profit and government presence is required on the WWW regarding tobacco and cigarettes to promote tobacco abstinence and accurate information. Additionally, having governments mandate visible warnings regarding the dangers of tobacco on commercial web sites could also help warn web explorers of the dangers of tobacco. Specifically, additional information regarding quitting smoking and tobacco appears needed along with youth positive anti-tobacco information. Finally, as searching for information on tobacco and cigarettes is not likely to be fruitful, it is suggested that governments and not for profit agencies advertise specific web sites relating to tobacco and cigarette information in other media. If this occurs it is possible that youth will seek out such sites for information versus search the WWW in a haphazard manner that the current results indicate could result in information hazardous to one's health. Such sites could include those reviewed by Melendez (1999) or those deemed appropriate for promotion in specific communities.



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