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TREATING COMPLICATED BEREAVEMENT: THE DEVELOPMENT OF GRIEF THERAPY

When my father took his life on a cold January morning in Ohio, 10 days before my 12th birthday, one world ended, and another began. Awakening to the panicked voice of our mother—*Boys, boys, I can't wake up your father!*—my little brother and I scrambled confused from beneath the cowboy comforters on the matching beds in our shared bedroom and peered afraid around the door jamb of our parents' adjacent room as our mother tried once more to shake our father into wakefulness. The shriek that emerged from our mother's small frame as she withdrew her hand from his lifeless body shattered the life story we had lived until that day and launched us into another teeming with questions about the meaning of his suicide and the meaning our lives would have from that day on. In a certain sense, my career in thanatology represents a lifelong response to that traumatic tear in the fabric of our family narrative, embroidered as it has become with many other losses before and since.

And so, in the seemingly random but ultimately meaningful way that Jung termed "synchronicity," I entered college 6 years later primed to hear the call of thanatology when that path presented itself. And it soon did, in the form of training for a paraprofessional position at the Suicide and Crisis Intervention Center in Gainesville, Florida, and as I became a research assistant to Seth Krieger, a doctoral student pursuing dissertation research in personal construct theory and the threat posed by one's own mortality.[1] Although it would take another 20 years before this long engagement in death-anxiety research (Neimeyer, 1994) would begin to mature into a deeper engagement with bereavement, the course was set. The confluence of these various personal and professional tributaries continues to configure my current concern with meaning reconstruction in the context of grief therapy as I enter my fifth decade of research and practice in thanatology. This chapter places my own involvement in this work in the broader context of other contemporary approaches to grief therapy, as well as the models of mourning that help inspire them. But first, let's consider the historical backdrop against which the mid-20th century field of bereavement studies emerged into prominence, in order to appreciate its subsequent evolution and probable future.

A BACKWARD GLANCE

In the Beginning: The Psychoanalytic View

As detailed in Chapter 7 (by Bill Worden) of this book, the scientific attempt to understand the responses of bereaved people dates to Freud's (1917/1957)

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Mourning and Melancholia, published in the midst of World War I. In it he posited that, just as death was a universal fact of life, there were also universal dynamics involved in grieving the death of a loved one. Freud defined mourning as the nonpathological response to such bereavement. Its distinguishing features include painful dejection, withdrawal of interest in the outside world, loss of the capacity to love, and inhibition of all activity. The work of mourning is accomplished gradually as the mourner's psychic energy or *libido* once invested in the attachment to the lost person or "object" is systematically recalled, reexperienced, and then released, resulting in detachment from the lost object. This concept of emotional disconnection or *decathexis* as the natural end-point of mourning has had an enduring impact on the practice of bereavement counseling through the 20th century, as reflected in decades of emphasis on *Trauerarbeit* or "grief work," in the form of painful review of the relationship, *catharsis* through emotional expression, and the saying of a final "goodbye" to a loved one as the goal of grieving (Stroebe, Gergen, Gergen, & Stroebe, 1992).

Freud's second major contribution was his effort to delineate how processes of mourning can go awry and become unhealthy. *Melancholia* was defined as a pathological outcome marked by an insistent narcissistic identification with the lost object, in effect, a refusal to "let go." Instead, the mourner's self or *ego* incorporates the lost object into itself as a way of warding off the loss, while denying its reality (Freud, 1917/1957). This suspicion about the pathological implications of identification and "holding on" to the lost love object was carried over by subsequent psychodynamic theorists and researchers (Lindemann, 1944) and is only recently being contested by newer models. Thus, although Freud's grim realism about the need to mourn one's losses and "move on" can be seen as an understandable response to the catastrophic loss of life in World War I, it continued to shape practices in grief therapy for most of the 20th century.

A Thoroughly Modern Model of Mourning: Stage Theory

With the advent of the death awareness movement at midcentury (see especially the Introduction and Chapters 1 and 2), popular and professional culture in the United States was ripe for a reconsideration of bereavement understood as a psychosocial transition, especially in the context of keen interest in end-of-life care. The most influential theory of grief to emerge from this focus stemmed from Elisabeth Kübler-Ross's (1969) book, *On Death and Dying*. From consultation interviews with patients hospitalized for terminal illnesses, she derived her framework, featuring five *stages* in the dying process: denial, anger, bargaining, depression, and acceptance (Kübler-Ross, 1969). Her concepts subsequently were generalized to describe how the reality of death—even for the bereaved, as well as the dying themselves—is assimilated gradually, rather than all at once, and then only after a series of psychological protests, delaying tactics, and mourning. As such, stage theory captures some of the ambivalence of accepting one's own death or that of another, while at the same time providing a simple framework for organizing the turbulent emotional responses that can be experienced in the process. Almost inevitably, given its fit with a modernist emphasis on clarity, efficiency, and positive outcomes, it soon became the dominant, if not the only, model of grief informing professional and medical education (Downe-Wambolt & Tamlyn, 1997), as well as hospice-based bereavement programs.

The intuitive appeal of stage theory notwithstanding, serious criticisms of Kübler-Ross's work have been lodged from several quarters. Critics argue that

its "one-size-fits-all" approach constitutes too narrow a formula to explain individual and cultural variations in bereavement experiences and that it focuses on emotions to the near exclusion of cognitive and behavioral responses to loss (Corr, 1993; Neimeyer, 2013). Most serious, it simply receives little support from studies of the actual adaptation of bereaved people, most of whom report high levels of "acceptance" from the earliest weeks of grieving, particularly when the loss is from natural, as opposed to violent, death (Holland & Neimeyer, 2010). As a result, bereavement professionals have turned to a new generation of theories to inform their research and practice (Neimeyer, Harris, Winokuer, & Thornton, 2011).

THE CONTEMPORARY LANDSCAPE OF LOSS

Coping With Bereavement: The Dual-Process Model

Rather than emphasizing universal stages or tasks, the dual-process model (DPM) put forward by Margaret Stroebe and Henk Schut proposes that people deal with loss dialectically, oscillating between *loss-oriented coping* and *restoration-oriented coping* (Stroebe & Schut, 1999, 2010). The former process entails experiencing and managing the negative emotions of grieving triggered by the death, missing and longing for the lost person, and reorganizing the attachment relationship with the deceased. Significantly, coping in this way entails temporarily denying or distracting oneself from the demands of the external world that has been changed by the loss. Restoration-oriented coping, on the other hand, entails attending to the many life changes required to adjust to one's world after the loss of a close person. These can include learning new skills, assuming new roles, reengaging changed relationships, and forming new ones. It is important to note that this sort of outwardly focused coping involves denying or distancing from the pain of grief in order to "learn to live again."

One of the distinctive features of the DPM is its implication that individuals normally self-regulate their bereavement by confronting their loss at times and, alternately, avoiding the emotional pain of grieving. Rather than proposing a phasic progression through grief, this model posits waxing and waning, an ongoing flexibility over time with loss-oriented coping dominant early on in bereavement and restoration-oriented coping more prevalent later. Finally, Stroebe and Schut argue that their model provides a means of understanding gender differences in bereavement, as women tend to be more emotion focused, and hence more loss oriented, whereas men tend to be more problem focused, and hence more restoration oriented in their coping behaviors. The DPM has proven attractive to grief therapists as well as researchers, suggesting that counselors help clients take a "time out" from preoccupation with their grief through greater restoration coping and mitigate brittle emotional avoidance through greater confrontation with the loss (Zech & Arnold, 2011). The development of a preliminary measure of this process of oscillation, the Inventory of Daily Widowed Life (IDWL), should contribute to both clinical assessment and substantive research in light of the model (Caserta & Lund, 2007).

A straightforward example of the clinical application of the DPM arose in my second and third sessions with a young widow named Cheryl,[2] who consulted me 1 month following the suicide of her husband, Jeff. Although Cheryl had been remarkably stoic in managing this traumatic loss—made more horrific still by Jeff's having shot himself in their bed while his wife was at work and his two young children were at school—she struggled with the conflicting emotions of grief and anger, as well as with her withdrawal from the social world out of a sense

of shame and fear of stigmatization. Balancing attention to her conflicting feelings with the growing importance of reengaging extrafamilial relationships and work (as she was now the sole breadwinner), I first invited Cheryl to tell me the story of their family prior to Jeff's troubling descent into an agitated depression, perhaps bringing photographs to "introduce" him to me.[3] Cheryl readily accepted the invitation to lift the veil of silence that had descended over discussions of her husband since his death, and in the next session brought in her iPad to share a remarkable series of professional photographs showing him lovingly relating to his family, taken only 2 weeks before his tragic death. Responding to my earnest interest in coming to know Jeff in both his brighter and darker moods, she began to disentangle her own guilt and anger at him for his fatal decision from her genuine grief for the terrible loss of the man she deeply loved. Tracking her sensed need to reach out to others for both emotional and instrumental support, we then shifted attention in the following week to her selective engagement with friends and coworkers, considering which ones specifically would be able to offer practical advice or a simple break from the seriousness of her predicament and which could provide a compassionate willingness to hear the troubling questions and emotions that others might not.[4] Thus, in keeping with the DPM, we alternated attention naturally between loss-oriented processing of Cheryl's tragic experience and restoration-oriented rebuilding of a viable social world.

Reworking the Continuing Bond: The Two-Track Model

At the heart of bereavement is an existential conundrum: *we are wired for attachment in a world of impermanence*. Scholars have long recognized that humans have evolved as social beings whose sense of felt security depends critically on bonds with caregivers—typically their parents—in early life (Bowlby, 1980). From these early patterns of interaction, children develop "internal working models" that implicitly shape expectations regarding the availability of others as sources of security and support, and regarding their own resourcefulness and lovability in later relationships (Parkes & Prigerson, 2009). Given the powerful challenge to conservation of an attachment bond posed by the death of a loved one, it is not surprising that older widows and widowers who display an insecure and dependent attachment on their spouse tend to fare poorly across the first 4 years of bereavement (Bonanno, Wortman, & Nesse, 2004). Interestingly, however, avoidant attachment—essentially maximizing one's sense of self-reliance and minimizing one's dependence on others—seems to mitigate grief-related distress, at least until challenged by traumatic and violent losses (Meier, Carr, Currier, & Neimeyer, 2013). In general, however, insecure attachment seems to be one empirically established risk factor for complicated bereavement (Burke & Neimeyer, 2013).

The related continuing bonds perspective extends attachment theory by focusing specifically on the reformulation of the relationship to the deceased in the aftermath of bereavement. Once considered patently pathological by the psychoanalytic tradition, the retention rather than relinquishment of such attachment to the loved one is now regarded as normative (Klass, Silverman, & Nickman, 1996) and commonly associated with more favorable bereavement outcomes (Datson & Marwit, 1997; Hedtke, 2012). There is also some evidence that the character of the continuing bond evolves across the course of grieving, as frequently resorting to "continuing bonds coping" (e.g., consciously reminiscing about the deceased throughout the day) seems to be associated with higher levels of *negative* emotion in the early months of widowhood, whereas similar processes

are also linked to reports of more *positive* emotion after 2 years of bereavement (Field & Friedrichs, 2004).

One contemporary theory that accommodates such findings is the two-track model of bereavement (TTMB), which posits that grief proceeds along two avenues simultaneously, the first concerned with the mourner's *biopsychosocial functioning*, such as disruptions in mood, social behavior, physical health, and capacity for work, and the second focused on one's *relationship to the deceased*, not only before the death, but also in one's ongoing life (Rubin, 1999; Rubin, Malkinson, & Witztum, 2003). In the latter case, for example, the bereaved may access or avoid memories of times spent with the deceased, carry out public or private rituals of remembrance, pursue projects that extend the essential purposes of the loved one, or feel compelled to grieve as a sign of loyalty to him or her. The development of the Two-Track Model of Bereavement Questionnaire (Rubin, Malkinson, Koren, & Michaeli, 2009), which measures both symptomatic and relational tracks through grief as well as a third concerned with traumatic responses, helps operationalize the model for research and clinical application. One advantage of the TTMB is its capacity to conceptualize difficulties in adaptation that arise on one or both tracks of the model, serving as a useful guide to clinical assessment and intervention (Rubin, Malkinson, & Witztum, 2011), as illustrated in the following case study.

At the age of 71, Carl was the quintessential family man, devoted to his wife, Beth, of more than 40 years, as well as his two grown children and their families, to all of whom he had passed on his love of the great outdoors. When tragedy struck in the form of the accidental drowning deaths of both his son Gary (38) and youngest grandson, Ben (7), when the small boat in which they were fishing somehow capsized in a sudden and violent storm, he fell into a deep, if silent, grief. Finally, after several months, Carl accepted Beth's encouragement to seek therapy to try to get his own life "back on an even keel."

In our first few sessions of therapy, we worked with the manifest biopsychosocial disruptions in Carl's life: his insomnia and nightmares, his ruminative preoccupation with the boating accident, his need to find some way to modulate the shared grief that would be triggered by his wife's evident distress, and their attempts to provide mutual soothing to one another. But the most therapeutic and memorable dimension of our work followed the relational track of the TTMB, as Carl conceived of and ultimately implemented a unique legacy project that both honored his son and grandson and sought to prevent similar tragedies in the future. Drawing on the drive and organization that had characterized him over the course of a long and successful career, he became a "crusader" for boating safety, beginning with the large state park bordering the lake in which his family members had drowned. Over a period of months in the course of our later therapy, extending to years following its completion, Carl tirelessly goaded park service administration, lobbied lawmakers, and spearheaded a substantial fundraising and publicity campaign. Ultimately these efforts garnered the permits and resources to let him install unique and eye-catching signage throughout the park featuring smiling images of his son and grandson holding up their catch, emblazoned with the headline, "Kids don't float," and briefly telling the story of their lives and deaths. The same signage featured special hooks for life-jackets in several sizes, offered in a free loaner program for all boaters, an intervention that was reinforced with public safety announcements, flyers to park users, and routine warnings by park rangers. Gradually Carl's mission expanded to lakes throughout the popular fishing region, as he continued to "work the circuit" of public lectures, school programs, and media appearances to promote boating safety. In

Carl's words, spoken tearfully in session, these efforts represented his "personal pact" with Gary and Ben to continue "working with them to spare other families the needless pain we have suffered." Keeping this pact across time helped him restore a sense of purpose and direction in his life, give voice to his grief in a way it could be heard, partner with his wife on the safety campaign, and in an important sense maintain a living bond with his son and grandson so that their deaths would not be entirely in vain.

The Search for Significance: A Meaning-Reconstruction Approach

A final contemporary perspective on bereavement is not so much a theory about grief as it is a metatheory, that is, an approach that can inform a variety of models by emphasizing that *a central process of grieving is the attempt to reaffirm or reconstruct a world of meaning that has been challenged by loss* (Neimeyer, 2002). In this meaning-reconstruction view advanced by Robert Neimeyer and his associates, the death of a loved one is seen as posing two narrative challenges to the survivor: (1) to process the *event story* of the death in an effort to "make sense" of what has happened and its implications for the survivor's ongoing life and (2) to access the *back story* of the relationship with the loved one as a means of reconstructing a continuing bond (Neimeyer & Sands, 2011). (See Tables 22.1 and 22.2 for typical questions that the bereaved implicitly engage in each of these domains, both in the context of grief therapy and in their daily lives.) In a sense, then, the bereaved are prompted to "rewrite" important parts of their life story to accommodate the death and project themselves into a changed, but nonetheless meaningful future, one that retains continuity with the "back story" of a past shared with the loved one. Such an emphasis on "relearning the self" and "relearning the world" in the wake of loss (Attig, 1996, 2000) is consonant with the narrative therapy approach to bereavement support championed by Hedtke (2012).

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A good deal of research has demonstrated a link between an inability to find meaning (whether spiritual or secular) in the loss and intense, prolonged and complicated grief in groups as varied as bereaved young people, parents, older adults, and survivors of homicide, suicide, and other violent deaths (Neimeyer, 2014). Conversely, higher levels of sense making about the loss have been found to prospectively predict higher levels of well-being among widowed persons (e.g., interest, excitement, accomplishment) 1 to 4 years later (Coleman & Neimeyer, 2010), and success over time in integrating the loss into one's meaning system

TABLE 22.1 Sample of Implicit Questions Entailed in Processing the "Event Story" of the Death

- How do I make sense of what has happened, and what is the meaning of my life now in its wake?
- What do my bodily and emotional feelings tell me about what I now need?
- What is my role or my responsibility in what has come to pass?
- What part, if any, did human intention, inattention, or wrongdoing have in the dying?
- How do my spiritual or philosophic beliefs help me accommodate this transition, and how are they changed by it in consequence?
- How does this loss fit with my sense of justice, predictability, and compassion in the universe?
- With what cherished beliefs is this loss compatible? Incompatible?
- Who am I in light of this loss, now and in the future? How does this experience shape or reshape the larger story of my life?
- Who in my life can grasp and accept what this loss means to me?
- Whose sense of the meaning of this loss is most and least like my own, and, in the latter case, how can we bridge our differences?

TABLE 22.2 Sample of Implicit Questions Entailed in Accessing the "Back Story" of the Relationship to the Deceased

- How can I recover or reconstruct a sustaining connection to my loved one that survives his or her physical death?
- Where and how do I hold my grief for my loved one in my body or my emotions, and how might this evolve into an inner bond of a healing kind?
- What memories of our relationship bring pain, guilt, or sadness and require some form of redress or reprieve now? How might this forgiveness be sought or given?
- What memories of our relationship bring joy, security, or pride and invite celebration and commemoration now? How can I review and relish these memories more often?
- What were my loved one's moments of greatness in life, and what do they say about his or her signature strengths or cherished qualities?
- What lessons about living or loving have I learned in the course of our shared lives? In the course of my bereavement?
- What would my loved one see in me that would give her or him confidence in my ability to survive this difficult period?
- What advice would my loved one have for me now, and how can I draw on his or her voice and wisdom in the future?
- Who in my life is most and least threatened by my ongoing bond with my loved one, and how can we make a safe space for this in our shared world?
- Who can help me keep my loved one's stories alive?

is associated with a significant reduction in complicated grief symptomatology (Holland, Currier, Coleman, & Neimeyer, 2010).

A variety of carefully constructed scales have been devised to help researchers and clinicians map meaning-making processes as well as to reliably discern themes in the content of the specific meanings that result. For example, the Integration of Stressful Life Experiences Scale or ISLES (Holland et al., 2010) assesses the extent to which the bereaved respondent finds *comprehensibility* in the loss and retains or regains a secure *footing in the world* in light of it. A short form of this same instrument also has been shown to share its psychometric strengths, including its incremental validity in predicting health and mental health outcomes even after demographic factors, relationship to the deceased, cause of death, and complicated grief symptoms are taken into account (Holland, Currier, & Neimeyer, 2014). In addition, the Inventory of Complicated Spiritual Grief (Burke et al., 2014), a specialized scale assessing struggles in religious meaning-making following a loss, has been validated in a Christian context, with subscales bearing on Insecurity With God and Disruption in Religious Practice. Finally, investigators have constructed detailed and reliable coding systems for categorizing the meanings made by mourners (e.g., Valuing Life, Impermanence, Personal Growth) to study their relation to bereavement adaptation (Gillies, Neimeyer, & Milman, 2014; Lichtenthal, Currier, Neimeyer, & Keesee, 2010). A meaning-reconstruction view has also extended the range of creative strategies incorporated within grief therapy (Neimeyer, 2012c; Thompson & Neimeyer, 2014), as illustrated in the case study that follows.

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Several months after the tragic overdose of her 29-year-old son, Daniel, Susan sought therapy, as she anguishingly acknowledged that the "stages of grief" that she "knew in her head" failed to describe the deep and preoccupying grief in which she had been encased since the loss. From the opening moments of therapy, it was clear that she struggled both with the manner of her son's dying and with complications in the strong emotional bond that she maintained with him,

carrying his ashes in her purse wherever she went. I therefore invited her to take a step back, in a sense, from the trauma of his dying, and to introduce me to Daniel by sharing something of the boy he had been, and the young man he became (Hedtke, 2012). In response, Susan shared a compelling, if ambivalent, narrative of his life and place in the family, from the moment when "he came out of womb screaming" through a childhood of special intimacy with her in which he clearly "understood her in ways that even her husband did not." The story darkened with the advent of unsubstantiated sexual abuse of Daniel by a neighbor in middle school, introducing a troubled adolescence that was nonetheless marked by athletic achievement. Gradually, this pattern of vacillation coalesced into a stormy young adulthood of "working hard and drinking hard," with increasingly serious drug abuse interrupted but never overcome through his participation in a series of treatment programs. As Susan in her first session neared the conclusion of this story of maternal pride and despair, she stood at the brink of his dying, sobbing, "God, why did I have to find him dead?" She opened our second session explicitly asking us to "pick up where we left off last time, with going in to see him, find him," in his bedroom in their home, that fateful morning when the great rupture in her life narrative occurred.

Following procedures for retelling the narrative of the death (Neimeyer, 2012b), I first asked her where that tragic chapter in the story began. She immediately painted for me the scene of Daniel's car wreck the evening before his death, in which he had totalled his small sedan against a roadside railing, to be picked up, apparently unhurt, by his father as Susan herself was at work. Questions abounded regarding what had happened: Had he fallen asleep at the wheel? Was he high on cocaine? Using opiates? When she arrived home she saw her son doubled up in abdominal and psychological pain and "out of it," unable to answer the questions that still burned inside her. Tacking to the "back story" of their special mutual understanding, I invited her, eyes closed, to imagine what was going through his mind at that time. Instantly she gave it voice, ventriloquizing her son, and perhaps herself: "Why am I suffering like this? Why does God do this to me? What am I supposed to learn from this?" No easy answers were to be found, and returning to the slow, measured retelling of the story, Susan described how she had suggested "Let's all go to bed and get some rest." Turning in for a night of exhausted but fitful sleep, it was the last time she saw her son alive.

As the session continued, we shifted systematically between telling, witnessing, and gradually mastering the troubling imagery and events of that night and the still more horrific morning that followed, and interludes of imaginal dialogue (Jordan, 2012; Neimeyer, 2012a) with Daniel, prompted by Susan's dramatically ambivalent feelings toward him. For example, after giving voice to her sadness, compassion, and anger at him, she visualized him at my invitation in the empty chair opposite her, and asked, "You had it all. Why did you do this to yourself?" Taking Daniel's place and loaning him her voice, she replied, "I didn't care . . . no one gets it, the dark pain of my cravings. There was no hope."

Shifting once again to the critical scene of Susan's knocking first on her son's bedroom door, and hearing no response, entering the room, I metaphorically stood beside her as she related what she saw: his body, twisted in the sheets, torso trailing off the bed to the floor, with blood, blood, congealing from his mouth, spilt out upon the white sheets and carpet. Again I slowed her down into the moment, encouraged her to take a few deep breaths with me, inhaling and releasing slowly, while remaining in the scene. Resuming the story when she was ready, she related her panicked but futile attempt to find a pulse, and the anger that rose up in her,

and had scarcely subsided in the intervening months. "A reservoir of anger," I reflected, to which she responded, "That's a good image; there is such a great amount of energy behind that wall . . . I guess it tells me that I am still alive." "What would ease it?" I asked with hope. "That comes with an assumption," she slowly and reflectively answered, "that I *want* it to ease. Maybe I want to *punish* myself for not saving him. Maybe I'm not *ready* to be happy."

Susan's phrasing alerted me to what my constructivist colleague Bruce Ecker refers to as a *pro-symptom position* (or PSP), that is, a construction of the *meaning* of problem—in this case, Susan's great reservoir of anger and unreadiness to let in any form of happiness—that makes it compellingly important to maintain, despite the real suffering associated with it (Ecker, Ticic, & Hulley, 2012). In the presence of such a meaning, initially held with minimal awareness, Ecker's approach is *noncounteractive*: simply to articulate the "emotional truth" of the client's position, with no attempt to change it. Asking Susan's patience, I simply wrote out the essence of what she had just told me on a blank sheet of paper: *I'm keeping my anger because it lets me know that I am still alive. If I let it go, I'd have to replace it with joy, and I'm not ready for that.* Handing the PSP to her and asking her to read it aloud, I listened rapt as Susan did so, with explicit permission to alter it as needed to make it more emotionally true. With tears in her eyes, she affirmed the spoken statement, adding, after a pause, a single word—*yet*. We then followed this with another written statement that she also read aloud: *The anger serves me because it helps me punish myself for mistakes I made—including in raising my son*. With a voice broken by painful sobs, she also affirmed that this captured her deep knowing, adding, "Yes. That is so true." I then drew on a technique Ecker calls *symptom deprivation*, simply asking her to close her eyes and imagine awakening to a day that did not begin in anger, that moved forward normally, but without sensing the press of that emotional reservoir. Wrinkling her brow, Susan slowly whispered, "Without the anger. . . I'd feel. . . naked. . . and vulnerable. . . ." "To?" I prompted. "The *unknown*," she responded, adding emphatically, "I'd feel *powerless*. . . . And if I woke up happy, I would have betrayed my son." In my own work with complicated grief, I often discover that the *meaning of mourning*—whether this takes the angry form that predominated for Susan, or any of a variety of other forms of desolation—suggests that it serves deep, if initially unconscious, purposes, which make it essential to retain, rather than relinquish, even if at very great expense.[5] Like Ecker (2012), I have found that simply holding these emotional truths consciously rather than unconsciously tends to promote their transformation, with no therapist interventions to "dispute" their rationality, as in more cognitive behavioral forms of therapy (Neimeyer, 2009a, 2009b). In Susan's case, she spontaneously returned to the image of the "reservoir of anger," saying, "That's a great word . . . it fits me where I am. But it takes so much energy to keep that wall up." Glancing quickly to "Daniel's chair," she continued, "I see Daniel and me in those two chairs, just *two lost souls*," elaborating on the pain and struggle of her own early life as an unwanted child, "pulsating with anger." "Something about that anger is very old, very familiar," I reflected. "Yes," Susan replied, "but I never *languaged* that before. . . . I am the wall of the reservoir, the locks, the water behind it." Looking over toward "Daniel," she continued, "Even in your death, your physical death, the loss of you is helping me touch pieces of myself I haven't languaged." As I encouraged the continuation and deepening of this spontaneous dialogue, Susan went on to express tearfully her deep regret that she could not save her son, "touching his cold body to find his energy gone." Taking her son's chair, she then extended genuine understanding for the limits of her power to save

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him, and, from each position, extended a touching statement of their "imperfect love," each for the other. In the remaining four sessions of our six-session therapy, Susan reported "making the choice to give up some of the anger," and with this, felt an uncanny sense of closeness to Daniel, in which she "felt him say that he was okay . . . at peace." Smiling, she commented on the character of our position work together: "It was smart of you to know that I wouldn't trust anyone's words but my own. Writing those down, speaking them, and talking to Daniel was a wonderful way to make things clear. I realize now that I am in charge of the reservoir." Though we continued our work to clarify the essential self-protective role of anger in her life, and the courage it would take to relinquish it, Susan had begun a process of change that now seemed irresistible, and her grieving for the sadness of her son's life and death began to move forward in more adaptive ways.

A SCIENTIFIC CODA

As has been true for me, many of those professionals who are drawn to the field of grief therapy have been animated in part by the impulse to come to terms with the losses in their own lives as they attempt to help their clients do likewise. Thus it is not surprising that the resulting sense of "calling" that we feel does not, at first blush, easily accommodate the evidence that the majority of bereaved persons do not require professional grief therapy for uncomplicated bereavement. That is, when grief therapy is offered "universally," when the only criterion is that recipients have lost a loved one, there is very little evidence that they benefit more than those receiving no assistance, as most members of the latter group improve of their own accord, drawing on their personal resilience and that of their families and communities (Currier, Neimeyer, & Berman, 2008). However, this is not to deny that bereavement counseling and support might be an entirely humane and appropriate service to offer when the bereaved seek it (Schut, 2010). In light of these findings, and the reality of human resilience, it may be more respectful to ask the bereaved some version of the simple question, "Are you having trouble dealing with the death?" or "Are you interested in seeing a grief counselor to help with that?" (Gamino, Sewell, Hogan, & Mason, 2009–2010). When the answer to either question is positive, there is a high probability that the bereaved respondent will find grief counseling helpful.

Similarly, when specialized grief therapy is "selectively" offered to high-risk groups, such as parents who have lost children, or to survivors of a loved one's death by inherently troubling causes, such as suicide or homicide, reliable differences favoring treatment begin to emerge. But the clearest evidence for the efficacy of grief therapy derives from its application to "indicated" clients, that is, those who are demonstrably distressed at clinically significant levels for a prolonged period (Currier, Neimeyer, & Berman, 2008; Neimeyer & Currier, 2009). Such clients are often recognized, of course, by providers of bereavement support who see that some people need assistance beyond what they offer. Taken in conjunction with research indicating that approximately 10% to 15% of bereaved persons suffer from prolonged, complicated grief reactions (Prigerson et al., 2009), it therefore seems that contemporary grief therapists have something of value to offer to the significant minority of grieving people who truly need professional therapy.

But what more does research teach us about the sort of practices that have been found effective in mitigating the distress associated with complicated bereavement? Writing from attachment, coping, cognitive behavioral, and constructivist perspectives, Shear, Boelen, and Neimeyer (2011) recently reflected

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on their various evidence-based approaches to grief therapy and concluded as follows:

> Notwithstanding differences in the three approaches, we were struck by convergence in: (1) fostering confrontation with the story of the death in an attempt to master its most painful aspects and integrate its finality into the mourner's internalized models of the deceased, the self and the world, (2) encouraging engagement with the image, voice or memory of the deceased to facilitate a sense of ongoing attachment while allowing for the development of other relationships, (3) gradually challenging avoidance coping[6] and building skill in emotion modulation and creative problem solving, and (4) encouraging the bereaved to review and revise life goals and roles in a world without the deceased person in it. We believe these commonalities can serve as principles to guide clinicians and that the differences in our three approaches indicate that there is not just one way to follow these principles. (pp. 158–159)

In short, the evolution of bereavement studies in the half century following the advent of the death awareness movement has begun to generate demonstrably effective practices, which continue to grow in their variety and evidence base (Neimeyer, 2012c). As this fund of grief theory and therapy develops in richness and relevance, it gives us reason to hope that we may offer something of genuinely therapeutic value when clients struggle greatly in the wake of life-altering loss.

NOTES

1. For an account of my personal participation in this work, and the research program on death anxiety to which it gave rise, see Neimeyer (2009a, 2009b) and Neimeyer, Wittkowski, and Moser (2004), respectively.
2. All cases discussed in this chapter have been redacted to protect client confidentiality, and all names replaced with pseudonyms.
3. For more detail on use of family photo albums in the context of grief therapy, see Gamino (2012). Readers interested in a broader discussion of "re-membering" the deceased as a counseling practice can consult Hedtke (2012).
4. For a simple technique used to facilitate a client's identification of support figures who represent a mix of "doers," "respite figures," and "listeners" in the context of bereavement counseling, see Doka and Neimeyer (2012).
5. For a video demonstration of accessing and beginning to transform a pro-symptom position with a bereaved mother, see my work with Darla, whose "suffering" offered the most compelling connection to her son, Kyle, following his death from cancer (Neimeyer, 2004).
6. Recent controlled research on behavioral activation as an antidote to behavioral avoidance in bereavement further supports this point (Papa, Sewell, Garrison-Diehn, & Rummel, 2013).

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