Features

6 Good Grief: A Contemporary Orientation to Bereavement Counseling

Robert A. Neimeyer with John Soderlund

14 A fate less than death: Supporting clients through non-death loss and grief

By Darcy Harris

20 Coming to grief: What you need to know about grief in DSM-5

By Phyllis Kosminsky

25 Getting grief working: A guide for the new grief therapist

By Dale Larson

Regulars

3 Drug Watch

4 Research

30 Book reviews

32 From the therapist’s chair

35 I’m a cake, you’re a cake

Editorial note: The content for this edition of New Therapist was coordinated and managed by Darcy Harris, one of the contributors. We are deeply grateful to Darcy for generously providing her astute and efficient editorial management of this edition.
**Drug watch**

**Janssen pleads guilty to allegations against Risperdal**

The U.S. Department of Justice announced a $400 million criminal fine in addition to a $1.25 billion civil settlement against Janssen Pharmaceuticals of Titusville, N.J. for introducing a misbranded drug, Risperdal (risperidone). Janssen Pharmaceuticals is a Johnson & Johnson company. The settlement was made on behalf of the U.S. Food and Drug Administration (FDA). The findings of the study appear online in *PsychCentral* in November, 2013.

The combined criminal plea and civil settlement agreement related to Risperdal totals $1,673,024 billion.

FDA Commissioner Margaret Hamburg says, “When pharmaceutical companies ignore the FDA’s requirements, they not only risk endangering the public’s health but also damaging the trust that patients have in their doctors and their medications.”

Hamburg says, “The FDA relies on data from rigorous scientific research to define and approve the uses for which a drug has been shown to be safe and effective. Today’s announcement demonstrates that pharmaceutical manufacturers that ignore the FDA’s regulatory authority do so at their own peril.”

The FDA approved Risperdal in 2002 for the treatment of schizophrenia and in 2003 for the short-term treatment of acute mania and for mixed episodes associated with Bipolar 1 Disorder.

In March, 2002 Janssen began to market the drug for the treatment of agitation associated with dementia in the elderly. The company told doctors that Risperdal was safe and effective for this unapproved indication and population.

The FDA maintains that physicians may, within the practice of medicine, use a drug to treat patients for symptoms or diseases even when the drug is not FDA-approved for such uses.

However, if a pharmaceutical manufacturer intends its drug to be used for a new use, not approved by the FDA, and introduces the drug into interstate commerce for that use, the drug is then considered “misbranded.” Introduction of that misbranded drug into interstate commerce is a violation of the law.

The U.S. Department of Justice action also alleges that Janssen and Johnson & Johnson were aware that Risperdal posed serious health risks for the elderly, including increased risk of stroke.

The companies, according to the government’s allegations, downplayed those risks by combining negative data with other studies in order to support a perception of decreased risk from using the drug.

Janssen had received repeated warnings from the FDA regarding its misleading marketing messages targeted to physicians. After a whistle blower complaint was filed, the FDA Office of Criminal Investigations initiated a criminal investigation into Janssen’s conduct.

Director of the FDA’s Office of Criminal Justice, John Roth says “Our investigators devoted considerable time and resources to this case, to help ensure that pharmaceutical companies do not mislead healthcare providers and the general public about the safety and efficacy of their medicines. We stand ready to take similar action in the future, if warranted, to protect public health.”

Janssen also marketed Risperdal for use in children with behavior challenges, despite known health risks to children and adolescents. Until late in 2006, Risperdal was not approved for use in children for any purpose, and the FDA repeatedly advised the company that promoting its use in children was problematic and could be evidence of a violation of the law.

Janssen and Johnson & Johnson will also submit to stringent requirements under a corporate integrity agreement with the U.S. Department of Health and Human Services’ Office of the Inspector General. The agreement is designed to increase accountability and transparency and prevent future fraud and abuse.
Obesity in children influenced by parent's relationship with their parents

The quality of an individual's attachment to their parents may increase their own children’s risk for obesity, according to researchers at the University of Illinois. The research findings appear in the *Journal of Developmental & Behavioral Pediatrics* in February, 2014.

Lead author of the study Kelly Bost says, "If your mother regularly punished or dismissed your anger, anxiety, or sadness instead of being sensitive to your distress and giving you strategies for handling those feelings, you may be insecurely attached and parenting your children in the same way. A child who doesn't learn to regulate his emotions may in turn develop eating patterns that put him at risk for obesity."

Bost notes that the study tracks the association between a parent's insecure attachment and their child's consumption of unhealthy foods, leading to weight gain.

Bost says, "We wanted to discover the steps that connect attachment and obesity. Scientists know that a person's attachment style is consistently related to the way he responds to negative emotions, and we thought that response might be related to three practices that we know are related to obesity: emotion-related feeding styles, including feeding to comfort or soothe; mealtime routine; and television viewing."

Bost explains that children form secure attachments when their caregiver is available and responsive. That attachment gives the child a secure base to explore his environment, protection in times of distress or uncertainty, and a source of joy in everyday interactions.

When that secure base isn't there, an insecure attachment can result, and children who are insecurely attached often experience feelings of anxiety and uncertainty in close relationships. As adults, they are especially at risk for ineffective parenting surrounding some of the factors that are implicated in pediatric obesity, she said.

The study comprised 497 primary caregivers of 2½- to 3½-year-old children. Participants completed a widely used questionnaire to determine adult attachment, answering 32 questions about the nature of their close relationships. They also rated themselves on a scale that measured depression and anxiety.

Parents then responded to questions about how they handled their children's negative emotions; whether they engaged in emotion-related, pressuring feeding styles known to predict obesity; frequency, planning of, and communication during family mealtimes; and estimated hours of television viewing per day.

Bost says, "The study found that insecure parents were significantly more likely to respond to their children's distress by becoming distressed themselves or dismissing their child's emotion."

That pattern of punishing or dismissing a child's sad or angry emotions was significantly related not only to comfort feeding but also to fewer family mealtimes and more TV viewing, which led to children's unhealthy eating, including self-reported sugary drinks, fast foods, and salty snacks, Bost said.

"One explanation might be that insecure moms are more easily overwhelmed with stress, find it more difficult to organize family mealtimes, and allow their children to watch more television as a coping strategy," she suggested.

The study's findings provide valuable information for health professionals who are working with parents and children, Bost noted.
The love between parents and teenagers—however stormy or peaceful—may influence whether those children are successful in romance, even up to 15 years later, according to researchers at the University of Alberta. The research findings appear in the Journal of Marriage and Family, in February 2014.

Lead author of the study Matt Johnson shares advice for those who had rocky relations with their parents while growing up: don’t let it spill over into your current romantic partnership. Johnson notes his co-authored study highlights a "small but important link between parent-adolescent relationship quality and intimate relationships 15 years later. The effects can be long-lasting."

While their analysis showed, perhaps not surprisingly, that good parent-teen relationships resulted in slightly higher quality of romantic relationships for those grown children years later, it poses a lesson in self-awareness when nurturing an intimate bond with a partner, Johnson comments. "People tend to compartmentalize their relationships; they tend not to see the connection between one kind, such as family relations, and another, like couple unions. But understanding your contribution to the relationship with your parents would be important to recognizing any tendency to replicate behaviour—positive or negative—in an intimate relationship."

That doesn’t mean parents should be blamed for what might be wrong in a grown child’s relationship, Johnson added. "It is important to recognize everyone has a role to play in creating a healthy relationship, and each person needs to take responsibility for their contribution to that dynamic."

The study comprised 2,970 individuals who were interviewed at three stages of life from adolescence to young adulthood, spanning ages 12 to 32.

---

Menopause experienced more acutely among women with HIV

Hot flushes, depression, and most of all, anxiety, affect the thinking skills of midlife women with HIV, so screening for and treating their anxiety may be especially important in helping them function, according to researchers at University of Illinois, Chicago. The study appears online in the journal Menopause in February, 2014.

The reproductive stage, whether it was premenopause, perimenopause or postmenopause, did not seem to be related to these women’s thinking skills.

The researchers analyzed data on 708 HIV-infected and 278 HIV-uninfected midlife women from the Women’s Interagency HIV Study (WHIS), a national study of women with HIV at six sites across the US.

US statistics show that nearly 52% of people with HIV/AIDS are between 40 to 54 years old. Because more women with HIV are now living to midlife and beyond, it is important to understand what challenges menopause poses for them. A study published in Menopause in July suggests that women with HIV face a bigger menopause challenge than uninfected women because they have worse menopause symptoms.

Large-scale studies of healthy women indicate that the menopause-related thinking deficiencies are modest, limited to the time leading up to menopause ("perimenopause"), and rebound after menopause. But in these women who underwent mental skills testing, menopause symptoms and mood symptoms did affect thinking skills.

Mental processing speed and verbal memory were more related to depression, anxiety, and hot flashes in both HIV-infected and healthy women than the stage of menopause. Hot flashes in particular correlated with slightly lower mental processing speed, a skill that is also affected by HIV. Depression correlated with decreased verbal memory, processing speed, and executive function (such as planning and organizing).

Of all the symptoms measured, anxiety stood out as having the greatest impact on thinking skills, and the impact was much greater on women with HIV. Anxiety particularly affected their verbal learning skills. So treating anxiety may be key to improving the lives of midlife women with HIV, concluded the investigators.

"Unfortunately, HIV infection is associated with modest deficits in multiple domains of cognitive function, even in women who regularly take their HIV medications. These depression and anxiety symptoms add to those cognitive vulnerabilities, but can be treated," says senior author of the study Pauline M. Maki.
Good Grief

A Contemporary Orientation to Bereavement Counseling

Robert A. Neimeyer with John Soderlund
How do complications in grieving present themselves in the course of therapy with the bereaved, and how can practicing therapists respond to them? In this article one prominent grief therapist, theorist and researcher reflects on the emerging diagnosis of complicated grief in light of more adaptive trajectories through loss, and outlines the relational and technical features of demonstrably effective clinical interventions. Viewed constructively, loss challenges the taken-for-granted assumptions of life, and can prompt significant, and often salutary revisions in our life stories. Drawing on contemporary models and methods, counselors and psychotherapists can make a contribution to this outcome.

The field of grief therapy is in ferment. Increasingly, time-honored assumptions regarding grieving as a relatively predictable series of emotional stages that proceed largely on an intrapsychic stage and that eventuate in the breaking of bonds to the deceased are coming under review, and often revision or replacement. In their place, new, empirically informed models have gained currency, which view grieving as a multidimensional process of meaning making that unfolds not only within people but also between them, with adaptive outcomes embracing the reconstruction of attachment to the deceased rather than its relinquishment. In this interview, prominent bereavement theorist and therapist Robert A. Neimeyer answers questions about the upshot of these developments for therapists who encounter clients in the wake of life-altering loss. His humanistic belief in the reality of resilience notwithstanding, Neimeyer acknowledges the unique complications that can accompany the death of a loved one, and sketches the role of therapeutic presence, process and procedure in addressing the variegated needs brought to clinicians’ offices in the wake of tragic bereavement.
John Soderlund: Bob, the work of Dr. George Bonnano suggests that the majority of people who experience a significant loss react with a surprising degree of resilience, to the extent that the grief process can, in the longer term, be a positive experience for them. This tends to counter a prevailing, if rather archaic, view that counseling is routinely a valuable process to help people deal with bereavement. With this in mind, can you reflect on what variables therapists ought to bear in mind when first encountering somebody who has been referred to them on account of a recent bereavement?

Bob Neimeyer: Well, to say that the death of one’s child, partner, sibling, parent or friend could in the long run be considered a “positive experience” may be a bit of an overstatement; I’ve met very few grieving people who wouldn’t give back in a heartbeat any degree of personal growth they’ve achieved to have their loved one back physically in their lives. But at the same time, resilience is a clear reality for close to half of the bereaved, who manage to weather the storm of mourning surprisingly quickly, finding their footing in the world once again within a matter of a few months, even if they continue to miss their loved ones keenly. For many others, the loss more profoundly disrupts their mood and functioning for several months, but they too ultimately grieve adaptively, integrate the loss into their lives, and return to their emotional baseline while revising their life routines and goals accordingly. Another 25%, however, tend to fare worse, experiencing exacerbations of previously problematic patterns (e.g., of chronic depression or substance abuse), family- and work-related conflicts, or—of special interest in the present context—a condition known as complicated grief or prolonged grief disorder, experienced by about 10% of the bereaved. To give your readers a quick orientation to this significant clinical problem, I’ll include a “clinician’s toolbox” to help them identify its key diagnostic features (see Table 1). We can explore this condition a little more thoroughly with a focus on its assessment and treatment later in this interview. I guess the point I’d like to make at the outset is that grieving can lead to surprisingly different outcomes, only a minority of which are likely to benefit from psychotherapy. Of course, that minority is enough to keep us busy for the rest of our professional lives!

---

### Table 1. Diagnostic Features of Complicated Grief

<table>
<thead>
<tr>
<th>Features</th>
<th>Good Grief</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Duration of bereavement of at least 6 months</td>
<td></td>
</tr>
<tr>
<td>2. Marked and persistent separation distress, reflected in intense feelings of loneliness, yearning for or preoccupation with the person who has died</td>
<td></td>
</tr>
<tr>
<td>3. At least 5 of the following 9 symptoms experienced nearly daily to a disabling degree:</td>
<td></td>
</tr>
<tr>
<td>• Diminished sense of self (e.g., as if a part of oneself has died)</td>
<td></td>
</tr>
<tr>
<td>• Difficulty accepting the loss on emotional as well as intellectual levels</td>
<td></td>
</tr>
<tr>
<td>• Avoidance of reminders of the reality of the loss</td>
<td></td>
</tr>
<tr>
<td>• Inability to trust others or to feel that others understand</td>
<td></td>
</tr>
<tr>
<td>• Bitterness or anger over the death</td>
<td></td>
</tr>
<tr>
<td>• Difficulty “moving on,” or embracing new friends and interests</td>
<td></td>
</tr>
<tr>
<td>• Numbness or inability to feel</td>
<td></td>
</tr>
<tr>
<td>• Sensing that life or the future is without purpose or meaning</td>
<td></td>
</tr>
<tr>
<td>• Feeling stunned, dazed, or shocked by the death</td>
<td></td>
</tr>
<tr>
<td>4. Significant impairment in social, occupational, or family functioning</td>
<td></td>
</tr>
</tbody>
</table>

Adapted from (Prigerson et al., 2009) and (Shear et al., 2011)
Before shifting to more discussion of complicated grief trajectories, however, I’d like to loop back to your earlier implication about the upside of grief. Beyond resilience per se, which refers essentially to a rapid return to baseline following a significant stressful event, a surprising number of people also report substantial post-traumatic growth (PTG) in the long-term wake of loss. As defined by Calhoun and Tedeschi, PTG refers to a cluster of developments in the wake of a “seismic” life transition, which include a greater sense of strength and maturity, deepening of relationships and compassion for the suffering of others, keener appreciation for life, greater readiness to embrace possibilities, and often a renewal of spiritual and philosophical frameworks for living. Nothing about this is inevitable, of course, and our own research and that of others suggests that PTG is typically a hard-won outcome of a good deal of painful reflection and meaning-making, which is probably most accessible when the distress of bereavement is sufficiently intense to challenge life as usual, but not so overwhelming as to make constructive change impossible. Figure 1 depicts the sort of curvilinear relationship between the intensity of grief and the degree of personal growth that we’ve observed in our research.

John: Some of what you were saying about the different trajectories of bereavement reminds me that many medically inclined mental health professionals tend to roll grief into their list of pathological processes if the attendant emotions persist beyond a "reasonable" period. If the latest edition of DSM is anything to go by, what is considered a reasonable period of grieving is being steadily reduced. What, in your opinion, should be considered pathological in the grieving process and what should be considered normal variations in the process of grieving?

Bob: Well, truth be told, the DSM 5 probably isn’t the best source to go by! What I mean by that is that it seems to me to fail in at least three ways. First, many people, including major advocacy groups for the bereaved themselves, argue that it risks pathologizing normal grief as “major depression,” diagnosable by its criteria within two weeks following the loss. Whether or not this is scientifically legitimate on the basis of the consistency of depressive symptomatology following the loss of a loved one or another major stressor, it is likely to open the door to widespread prescription of antidepressants to mourners, even if specialized forms of psychotherapy have a stronger track record of efficacy when grief is, in fact, complicated. Second, it fails to recognize that grief as a form of separation distress has more in common phenomenologically and even neurologically with anxiety than with depression as such, and therefore often calls for different treatment. And finally, even though

Figure 1. The nonlinear association between prolonged or complicated grief and posttraumatic growth.
the DSM-5 includes “Persistent Complex Bereavement Disorder”—apparently an awkward attempt to combine the commonly used terms “complicated grief” and “prolonged grief disorder” into a single mouth-filling moniker—it classifies it as a “condition for further study,” even though the evidence base for it is considerably stronger than that for many of the conditions included in the manual. Moreover, it defines the condition with a hodge-podge of paraphrased and conjectural diagnostic features, rather than the scientifically established criteria summarized in Table 1. Thus, at minimum, the DSM-5 missed the opportunity to recognize what was uniquely difficult about complicated grief, while blurring its distinction from garden-variety depression.

Far more useful, in my view, is the approach to diagnosis of prolonged grief disorder (PGD) that appears to be moving forward in the current revision of the World Health Organization’s International Classification of Disease (ICD-11), which classes PGD with other “stress related disorders,” identified by symptoms that conform closely to those listed in Table 1. This means that common experiences of crying, missing a loved one, and so on in the aftermath of a death are regarded as normal and expectable reactions, whereas others like pervasive separation distress, profound disconnection from others, and sensing that the future is bleached of purpose a year or more after the loss, in the context of marked deterioration in the client’s social or occupational functioning, would be a cause for clinical concern. Alongside other possibly comorbid conditions such as depression, generalized anxiety or post-traumatic reactions (especially in the aftermath of sudden, violent or untimely death), this could call for clinical intervention.

John: Okay. So what should a practicing therapist know about intervention when grief is complicated or prolonged? For example, much is made of the practice of “presence” in grief counseling. Can you unpack what this means and why its so crucial to this kind of counseling?

Bob: Certainly. When I think about grief therapy, or any responsive psychotherapy for that matter, I think in terms of three dimensions: presence, process and procedure. By presence, I mean the capacity to offer full availability and attention to the client’s concerns, undistracted by our own agendas. It is more about being than doing, allowing ourselves to “indwell” our clients’ narratives of loss, to feel ourselves into their stories, to be moved by their love for the deceased and touched by their brokenness. At the same time, this authentic and unflinching willingness to stand in the pain rather than merely rush to mitigate it provides a safe “container” for the client’s own exploration of his experience, ameliorating the sense of being alone in a silent story of nameless anguish. In this intersubjective field of vivid presence, characterized by the time-honored practice of client-centered listening and reflection, we in a sense take up residence in our clients’ meaning systems, understanding experientially the deep wellsprings of their grief, alongside their resources for living with and learning from it. Like Martin Buber’s concept of the I-Thou relationship, it is a fundamentally respectful stance that accords full humanity to our clients, prior to any preoccupation with their diagnosis or case conceptualization.

Within this relational frame, therapists then attend like delicately attuned instruments to the process of therapy, that speaking-turn-by-speaking-turn interaction in which we read between the lines of what clients tell themselves about the loss to discern the conjunction of their current need and readiness that identifies specific points of intervention. For me, grounding in process implies a lively alertness to our clients’ subtle and obvious displays of emotion—a slight break in speech, a welling up of sudden tears, a slowing down into reflective processing of an emerging awareness. By extension, it implies equal attention to verbal, co-verbal and nonverbal channels of communication, not only to what is said and how it is said, but also to the bodily movements or facial expressions that accompany it. This leads naturally to a “bottom-up” approach to therapy that is more experiential than psychoeducational, in a sense leading a client from one step behind toward clearer encounters with his or her emotions, relationships and possibilities, rather than directing therapy in a “top down” manner to speak the language of the therapist’s preferred theory, and be trained in our preferred techniques. But more broadly, responsiveness to process is essential even to more directive therapeutic approaches or strategies, as it tells us when a client is specifically primed to process the event story of a suicide or accidental death, for example, or when they are needing to revisit the previously unexpressed problems or unrealized potential in the relationship to the deceased. In this sense, presence and process provide a container for not only the client’s exploration of emotional meanings of the loss, but also for the therapist’s utilization of specific procedures.

John: What are some of those procedures? And have any of them actually been researched in the sense of having an evidence base that supports their use with clients suffering from complicated grief?
Bob: Well, the answer to that question would be a book in itself, and indeed I can recommend a few of them! (See Recommended Readings below.) Basically, as a constructivist therapist, I view clients in acute grief as struggling with two key narrative processes in their attempts to make meaning of the experience. On the one hand, clients often feel the need to process the “event story” of the loss itself, to in some way wrap their hearts and minds around what has happened, what it means, and what it portends for their lives going forward. On the other hand, they frequently need to access the “back story” of their relationship with the deceased, not only to sort out their “unfinished business” of conflicts or regrets in the relationship, but also to reconstruct their attachment bond with their loved one into a form that is sustainable now. In other words, clients need to make sense—visceral in their bodies, experientially in their emotions, conversationally in their families, and spiritually in terms of their abiding life philosophies—of a profound rupture in their life stories, as well as to re-write the terms of their attachment to the deceased. It’s a tall order for many, particularly when the death was traumatic, intentional, sudden or untimely, and when the relationship was complicated or eclipsed by the narrative of a violent death or a grimly progressive illness that threatens to overshadow the living image of the person we knew and loved.

---

**Table 2. Techniques for Facilitating Meaning Reconstruction in Bereavement**

<table>
<thead>
<tr>
<th>Processing and Integrating the Event Story of the Death</th>
<th>Accessing and Reconstructing the Back Story of the Relationship to the Deceased</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Retelling the Narrative of the Death</strong></td>
<td><strong>Introducing the Deceased</strong></td>
</tr>
<tr>
<td>Slow-motion review of the loss story to promote mastery</td>
<td>Reclaiming the deceased as a participant in one's ongoing life</td>
</tr>
<tr>
<td><strong>Chapters of Our Lives</strong></td>
<td><strong>Imaginal Conversations</strong></td>
</tr>
<tr>
<td>Situating the current loss in the landscape of previous experience</td>
<td>Visualizing the deceased while addressing unfinished business</td>
</tr>
<tr>
<td><strong>Virtual Dream Stories</strong></td>
<td><strong>Correspondence with the Deceased</strong></td>
</tr>
<tr>
<td>Creative writing about loss themes to facilitate their exploration</td>
<td>Inviting an “exchange” of letters to renegotiate the relationship</td>
</tr>
<tr>
<td><strong>Playing with Playlists</strong></td>
<td><strong>Chair Work</strong></td>
</tr>
<tr>
<td>Tracing the trajectory of love and loss in musical memoir on iPod</td>
<td>Choreographing deeply authentic conversation with the deceased</td>
</tr>
<tr>
<td><strong>Figurative Sand Tray Therapy</strong></td>
<td><strong>Life Imprint</strong></td>
</tr>
<tr>
<td>Constructing symbolic stories using figurines in sand world</td>
<td>Tracing the impact of the deceased on one's values and decisions</td>
</tr>
<tr>
<td><strong>Analogical Listening</strong></td>
<td><strong>Reviewing the Photo Album</strong></td>
</tr>
<tr>
<td>Focusing on bodily felt sense of grief and giving it expression</td>
<td>Consolidating memories with the therapist as a witness</td>
</tr>
<tr>
<td><strong>The Body of Trust</strong></td>
<td><strong>Prescriptive Photomontage</strong></td>
</tr>
<tr>
<td>Depicting impact of the death story in mixed media on body image</td>
<td>Constructing creative composite image of deceased’s role in life</td>
</tr>
<tr>
<td><strong>Directed Journaling</strong></td>
<td><strong>Memory Books and Boxes</strong></td>
</tr>
<tr>
<td>Diary work to consolidate sense-making and benefit-finding</td>
<td>Organizing mementos and messages that honor legacy of the lost</td>
</tr>
<tr>
<td><strong>Loss Characterization</strong></td>
<td><strong>Rituals of Connection</strong></td>
</tr>
<tr>
<td>Narrating overall impact of loss on one's sense of self</td>
<td>Symbolically validating continuing bonds</td>
</tr>
</tbody>
</table>

---

Indispensable survival guide for the thinking psychotherapist
Grief therapy often entails an interplay between two different kinds of interventions, one centered on the event story of the death and its larger implications for the client’s life, and the other focused on the lost relationship (see Table 2). I allow myself to be led by the client to what he or she most needs and stands ready to address, as explicitly requested or more commonly implicitly revealed by his or her presentation. For example, I may begin by inviting a widow to tell me how I can be useful to her, which tends to lead to an abbreviated account of the loss and her subsequent yearning for her husband or her sense of feeling lost without him. Alerted to the significance of the interrupted relationship, I might then invite the client to introduce me to the deceased, by sharing more about the character of their relationship or their family experience. This might naturally lead to evocative correspondence with the deceased or chair work to affirm their continuing bond or to address unfinished business in the relationship, or simply to memorializing the loved one in a photo album or meaningful ritual that preserves a sense of continuity and connection between the living and dead. All of these interventions and many others bear on the back story of the relationship, opening it to fresh readings in the present.

At other times, however, the client clearly needs to revisit the story of the illness or death itself, particularly when it was violent, unanticipated, and involved complicated human intention (as in suicide or homicide) or inattention (as in a fatal accident or medical malpractice). In such cases I join my client in restorative retelling, essentially a prolonged, fearless recounting of the circumstances of the death in slow-motion detail, giving voice to the horror of what the client witnessed or imagined, while helping him or her contain it, breathe through it, master it and modulate the associated emotions. Like the prolonged exposure therapies to which it is akin, this form of deliberative processing can help a client integrate a difficult experience, imagine the more empowered stance that he or she would have taken in comforting the loved one at the time of dying if this had been possible, and take steps to place the loss into the ongoing sequence of chapters of their lives, rather than view it as the end of the story. Alternatively, we can encourage our clients to engage in directed journaling, prompted by questions about the sense made of the loss or the unsought benefits or learning that might be found in it, or to make use of any of a number of metaphoric or creative practices to help them express and explore their grief to give it voice and validation. All of these procedures and a hundred others are described clearly and succinctly in the recommended readings, and illustrated with actual case studies of their use.

Finally, in response to your question about the evidence base for such practices, I am pleased to say that a growing literature is documenting the specific efficacy of retelling, exposure, imaginal conversations, directed journaling, expressive arts and other interventions in addressing the unique challenges of complicated grief. There is more to learn, of course, but the documentation of a wide range of creative procedures holds promise that we can offer something of relevance to a diverse community of clients grieving a wide variety of losses.

John: All right, let me finish with a big question suitable for this big topic. Various psychoanalytic writers, from Freud onwards, have paid considerable attention to how we think about, relate to and make sense of our mortality. This interest in death and how we negotiate the finite nature of our existence appears to have been driven from the prominent position it has held historically in many philosophical traditions. Do you think that we as a species are increasingly avoiding the issue? Do we have a pathological inclination to deny our own mortality and that of our most important others? If so, what are the implications of this?

Bob: Pathology, I suppose, is in the eye of the beholder. Is it more pathological for humans, like the other sentient beings who share our small planet, to orient our limited conscious resources toward avoiding the issue? Or do we have a pathological inclination to deny our own mortality and that of our most important others? If so, what are the implications of this?
anxiety. Existentialists would go so far as to say that we only live authentically to the extent that we courageously contemplate our ultimate nonbeing, and then return from peering into this “abyss” with a clarified will to live fully in the light of our highest values. Because we are soft bodies in a hard world, we also can appreciate more keenly our collective vulnerability to illness, injury and extinction, and live more prudently and compassionately as a result.

Finally, with respect to bereavement, we are forced to acknowledge another existential truth: we are wired for attachment in a world of impermanence. Even if more narrowly “medical” approaches to therapy ignore the fact, ultimately, every person, every place, every project and every possession to which we are attached we will one day lose, at least in an earthly sense. And so learning how to live with this looming reality, learning literally from loss, shapes who we become as individuals, families, communities and cultures… just as it can shape how we practice psychotherapy.

Recommended Readings


Neimeyer served as President of the Association for Death Education and Counseling (ADEC), and Chair of the International Work Group for Death, Dying, & Bereavement. In recognition of his scholarly contributions, he has been granted the Eminent Faculty Award by the University of Memphis, made a Fellow of the Clinical Psychology Division of the American Psychological Association, and been recognized as an Honored Associate of the Viktor Frankl Association, as well as a recipient of the Phoenix Award: Rising to the Service of Humanity by the MISS Foundation.
A fate less than death

Supporting clients through non-death loss and grief

By Darcy Harris
Introduction

After I had been in clinical practice for several years, I was asked to provide support to patients who were involved in treatment for infertility by a local center. As I began working with these clients, I became aware that many of them had endured months, sometimes years, of ongoing treatment, hoping for a baby and then having those hopes dashed when the treatments didn’t work. I noted that the language they used to describe their experience spoke of profound feelings of loss and grief. But, I also wondered, if they were grieving, who had died? After I devoted time and research to this topic, I came to the conclusion that their grief wasn’t related to who had died as much as what had been lost.

As clinicians, it is important to recognize grief in all of its forms and to understand how to facilitate the grieving process in our clients. In contrast to psychological disorders and disturbances, grief is basically an adaptive (albeit painful) process that allows us to heal after significant losses cause a tear in the fabric of our lives. Because of its adaptive function, the grieving process requires a different clinical approach than disorders that warrant therapeutic intervention.
Features | A fate less than death

Recent research has demonstrated that bereaved individuals often maintain an ongoing, continuing bond with their deceased loved ones after their death.

Evolution of understandings about grief

Initially, research in bereavement focused on Bowlby’s (1969) description of the attachment system and the ethological/instinctual basis for grief. Grief was seen as a form of separation distress that resulted from a broken attachment bond after the death of a loved one. However, recent research has demonstrated that bereaved individuals often maintain an ongoing, continuing bond with their deceased loved ones after their death (Klass, Silverman, & Nickman, 1996; Rubin & Schechter, 1997). It has become apparent that the grief response is more complex than simply a form of separation distress.

At a basic level, one’s expectations about how the world works begin to be formed from birth, through the development of the attachment relationships of the infant and young child. Bowlby (1969, 1973) posited that early-life attachment experiences lead individuals to form working models of the self and of the world. Parkes (1971) used the term assumptive world to describe the combination of these expectations and internal models.

Janoff-Bulmann (1992) described three categories of the assumptive world. Essentially, the assumptive world encompasses beliefs about the following:

1. How the world should work. For example, most people with relatively unremarkable childhoods in Western cultures tend to believe that the world is mostly benevolent, that there is more good than bad, and that people are generally trustworthy.

2. How people explain events that occur. This category emphasizes the ideas of justice and cause-and-effect relationships in certain aspects of life. This assumption often implies that we can directly control what happens to us through our own behavior. For example, it is common for people to assume that being a good person will afford protection from negative events, and the idea that you “get what you deserve”.

3. How we view ourselves and others. Typically, we are taught that human beings have intrinsic value and worth. We also learn about power dynamics in relationships and society, and our place within various social systems.

These fundamental assumptions about oneself, others, and how/why things happen allows for a feeling of safety and consistency as we navigate in the world around us (Janoff-Bulman, 1992; Rando, 2002). These same assumptions can be shattered by life experiences that do not fit into our view of ourselves and the world around us. Neimeyer et al. (2008) discuss events that “disrupt the significance of the coherence of one’s life narrative,” (p.30) and the potential for erosion of the individual’s life story and sense of self that may occur after such events. What is apparent is that the experience of a significant life event that does not fit into one’s beliefs can launch that individual into a state of significant disequilibrium. This discrepancy between how the world should work and the reality that it isn’t working in the way that was expected creates the need for some form of accommodation. Attig (1996) refers to this process as re-learning the world.

All significant loss experiences, death or non-death related, have the potential for an assault upon one’s assumptions about the world, and the process of adjusting to a world that is different from what had been thought or believed will involve a great expenditure of energy. This process of adjustment and accommodation is what we would refer to as grief (Harris, 2010).

Consider the following case:

Margaret, a 78-year-old woman, was diagnosed with dementia after her grown children noticed that she was becoming forgetful and confused. They realized that she was unable to continue to care for herself at home due to her forgetfulness and episodic confusion. Her family arranged for her to have assistance within her home, with meals being delivered to her daily, a housekeeper, and a personal care worker who would help her to bathe and do laundry three times a week. Margaret was able to cope with this assistance for
a while, but she became suspicious of the helpers, accusing them of stealing things when she couldn’t find them. After two episodes where she wandered out of her house at night and got lost, the family decided that she needed a more supervised living arrangement, and she moved into a secured retirement residence.

Margaret continued to decline. Once a very fastidious woman, she lost the ability to control her bowels and bladder. She would sometimes have excrement on her clothing when she walked around the hallway, and she often looked unkempt. She would sometimes recognize her children and grandchildren and at other times she would not. Once very social and outgoing, Margaret became reclusive and quiet. She died three years after the dementia diagnosis was made. The family felt sadness when she died, but most felt that they had “lost” her a long time before she actually died. They realized that they had been grieving her loss for a long time.

Many of the non-death losses that are experienced by individuals are very difficult to name, describe, or validate because there is no identifiable “death.” For many individuals, it may be unclear exactly what has been lost. The loss may or may not involve a person and there may not be a defining experience to denote where the loss actually originates.

In her development and exploration of loss experiences where there was significant ambiguity, Boss (1999) first used the term, ambiguous loss. Ambiguous loss occurs when either a person is perceived as physically absent, but psychologically present, or when a person is physically present, but psychologically absent, as in the scenario with Margaret. Ambiguous losses leave individuals with a sense of being “in limbo” as they struggle to live with the ambiguity and uncertainty.

Bruce and Schultz (2002) chose the term non-finite loss to describe a loss that retains a physical and/or psychological presence with an individual in an ongoing manner. The scenario with Angela fits the description of a non-finite loss. Angela’s future is now completely different from what she had planned, and her life will never be the same as before. She will spend the rest of her life accommodating her injured leg and secondary life choices.

Roos (2002) explored the concept of chronic sorrow as a response to losses that are ongoing in nature. In chronic sorrow, the grief is ongoing because the loss itself (along with continuous accommodation to the loss) is also ongoing. This is an important distinction from descriptions of prolonged grief disorder or complicated grief.

Discussion

Significant losses, death or non-death, involve the shattering or crumbling of one’s assumptions.

Ambiguous loss occurs when either a person is perceived as physically absent, but is psychologically present, or when a person is physically present, but psychologically absent.
about the world, causing us to feel deeply vulnerable and unsafe. The world that we once knew, the people upon whom we relied, and the previously held images and perceptions of ourselves and others are no longer relevant in light of what we have experienced. Certainly, the death of a loved one has great potential to cause such a disruption. However, other types of losses that may not involve death can also have the same outcome, with the need to re-build and re-learn one’s assumptive world in a way that preserves a sense of coherence and safety. At the core of all significant losses is the potential to lose our assumptive world, and there is support to suggest that this loss is the main overarching trigger for the grief response.

It is important to recognize the significance of these experiences, and to keep in mind the adaptive aspect of grief that facilitates accommodation in the majority of individuals. In general, grief is not something that requires treatment or intervention; rather, facilitation, support, and permission are more appropriate approaches. Too many clinicians assume that emotional distress means that they must intervene or treat the distress without realizing that doing so in this scenario may actually block the process and prevent the necessary adaptation from occurring.

Clinical implications

Name, acknowledge, and validate the experience

Doka’s (1989; 2002) concept of disenfranchised grief is highly applicable to the exploration of grief after non-death losses, as the tendency to not recognize these losses leads to a propensity to deny their potential significance, or to not recognize the degree to which these losses can affect an individual. A social overtone of dismissiveness is common, and this lack of social support can stunt the adaptive aspects of the process. Loss, change, and transition are universal, but also very subjective experiences. Not everyone will perceive the same experience in the same way, so it is important to listen to the client’s interpretation and descriptions. The ability to name and describe an experience fully provides the opportunity to reflect and consider its implications for future choices and daily living.

Learn how to offer presence to grieving clients before jumping in to intervene

Clinicians need to be able to learn to bear witness to the grieving process and give permission for the process to unfold before attempting to intervene. The need to grapple with life-altering loss experiences and to try to understand them (even if they initially seem beyond one’s ability to comprehend) is a key part of the human drive for understanding and meaning. Learning how to “be with” is much more productive here than trying to “do” something to intervene too early in a client’s process.

Be aware of the unique implications for certain types of losses

There are obvious differences between death-related and non-death-related losses, evident in Boss’ (1999) descriptions of ambiguous loss and Roos’ (2002) elaboration of the concept of chronic sorrow. In situations of ambiguous or non-finite loss, there are seldom socially accepted rituals that provide acknowledgement or credence to the experience of an individual in the way a funeral might provide for a bereaved individual. The absence of a body does not mean the absence of grief; however, without an overt or outward manifestation of the loss, the level of social recognition and support is often minimal or absent. Thus, finding rituals for honoring these losses, normalizing the ongoing nature of grief when it accompanies losses that are ongoing in nature, and supporting clients as they search for meaning in these experiences should be the priority of the therapist (Boss, Roos, & Harris, 2011).

Cultivate awareness of your own loss experiences

Many of us have experienced significant losses that have shaped who we are and, perhaps, the career path we have chosen. While the concept of the wounded healer is valid in any profession where the therapeutic use of self is integral to the work, we are not immune
to social pressure to conform to a “norm” that isn’t always realistic or healthy. It will be challenging to facilitate the grieving process wholeheartedly in our clients if we have difficulties recognizing and honoring its presence in ourselves. Cultivating a practice of compassionately attending to our own loss experiences and struggles allows us to more deeply appreciate and honor the grieving process in our clients.

Conclusion

Grieving individuals often have to struggle for validation and understanding of their experiences, and therapists need to adopt an inclusive and validating approach for clients with a broad range of grief responses. We serve our clients best if we can facilitate the process of meaning-making and rebuilding with clients whose loss experiences of all types have disrupted their assumptive world.

References


Coming to grief
What you need to know about grief in DSM-5

By Phyllis Kosminsky
After fourteen years of deliberation: consensus, conflict and continuing debate, the latest version of The Diagnostic and Statistical Manual of Mental Disorders (DSM) has finally been released into the world, and with it, a Pandora’s Box worth of controversy. Changes regarding grief-related diagnoses have been the source of some of the most heated disagreement, with extensive media attention given to the ongoing debate about what constitutes normal grief, how grief differs from depression and other issues relating to diagnosis and treatment.

Anyone who has experienced grief, personally or professionally, knows that people who are grieving are often extremely sad, weepy, confused, exhausted and otherwise distressed. These behavioral manifestations of deep emotional pain are present, to one degree or another, in most of the people we see in treatment. As difficult as grief can be to bear, for many of our clients the acute pain of loss will subside, and with a little help, the bereaved individual will gradually integrate the loss and be able to re-engage with life. But what about the people for whom this is not the case? What about the client whose behavior falls outside the norm of grief? How do we identify people whose grief has gone off course, and how do we help them?

Deliberation concerning how to address grief in the DSM 5 (APA, 2013) revolved around this group, the estimated 10 to 15 percent of grievers whose grief is problematic, in terms of duration, intensity, or both. Two issues generated substantive and heated debate, the first concerning the creation of a formal diagnosis for problematic grief, “Persistent Complex Bereavement Disorder” and the second, elimination of the “bereavement exclusion” according to which neither adjustment disorders nor depression was to be diagnosed in the immediate aftermath of a significant death. The committee ultimately decided not to add a diagnosis for problematic grief at this time, although they did elect to include the proposed criteria as an appendix in the DSM for future consideration. They did, however, eliminate the bereavement exclusion from the descriptions of depression and adjustment disorders, a change that has been met with responses ranging from enthusiastic approval to vehement opposition. (Pies, 2013).

Critics of the change warn that removal of the bereavement exclusion will result in an increase in the frequency of diagnoses of depression among people who are bereaved, with an accompanying increase in the use of anti-depressant medication in this population. Advocates of the change argue that it reflects an acknowledgement that bereavement is a “severe psychosocial stressor that can precipitate a major depressive disorder in a vulnerable individual” and that in these cases delaying treatment “adds an additional risk for suffering feelings of worthlessness, suicidal ideation, poorer somatic health, worse interpersonal and work functioning, and an increased risk for persistent complex bereavement disorder” (APA, 2013b, p. 5). Thus, although
The point of the change is not to increase the diagnosis of depression, but to encourage clinicians to consider the possibility that a bereaved person may be clinically depressed.

the committee did not adopt a diagnosis for problematic grief, they acknowledge that grief can become chronic and disabling. The point of the change, in other words, is not to increase the diagnosis of depression, but to encourage clinicians to consider the possibility that a bereaved person may be clinically depressed. In these cases, delaying treatment may result in significant complications and prolonged impairment of functioning.

So what does the DSM offer by way of guidance for clinicians who provide counseling to the bereaved?

Implications for practice

Although much has been made of the changes in the DSM-5, the impact of these changes remains to be seen. The elimination of the bereavement exclusion allows clinicians to make a diagnosis of major depression even when someone has suffered a loss, but this may or may not make much of a practical difference. Experienced clinicians know that two months is only the beginning of grief for many mourners; they also know better than to think that all of these people should be diagnosed with depression. On the other hand, some people who are bereaved may also be depressed. They may have been depressed for some time prior to the loss, or the loss may have triggered a depressive episode.

While there is no question about the inadvisability of prescribing medication for everyone who is grieving after two months, it would also be a mistake to assume that medication is never indicated. Whether, in the clinician’s judgement, a recently bereaved person is exhibiting signs of grief, depression, or both, in cases where the severity of the client’s symptoms raises concerns about the possibility of self-harm, or where functioning is significantly impaired, medication can be considered, and the potential benefits discussed with the client. Again, the important point here is that the decision as to whether or not to suggest a referral for evaluation of the need for medication should be made based on the severity of the client’s distress, regardless of whether or not that distress can be definitively diagnosed.

Recognizing complicated grief

Although the new DSM (APA 2013) does not include a diagnosis for complicated or problematic grief, it does incorporate, in the appendix, criteria proposed by the working committee regarding such a diagnosis. These criteria define a range of problems that can arise in response to significant loss, and that can cause the mourner persistent and significant emotional distress, as well as impaired social and work-related functioning if not addressed in a timely manner. Symptoms include relational problems (“Bitterness or anger related to the loss[b], p.790); cognitive issues (“Maladaptive appraisals about oneself in relation to the deceased or the death, e.g., self blame”, p. 790); disruption of identity (“Difficulty or reluctance to pursue interests since the loss or to plan for the future”, p.790). There is also a suggested specifier for traumatic bereavement, characterized by “persistent, frequent distressing thoughts, images or feelings related to the traumatic features of the death” (p. 790). Clinicians are encouraged to take note of the proposed criteria, which constitute a thoughtful and well-conceived set of principles for the treatment of problematic grief.

Intervening with complicated grief

While many people who are bereaved want to know how long it takes to heal from a loss, or whether the extent of their emotional pain is “normal,” these are not easy questions to answer. The experience of losing a loved one cannot be reduced to a set of parameters, nor can its course be predicted with certainty for a single person or for bereaved people on the whole. That being said, clinicians need to be able to identify the significant number of bereaved whose grief, by virtue of its severity, persistence, or some combination of both, appears to fall outside the range of what is considered normative.

Many bereaved people question their ability to go on with their lives in the wake of a significant loss, yet we know from experience that most do. But for some people, the passing weeks and months bring no relief, no change in how they feel. The longer they remain in this state, the more likely it is that their sadness will be compounded by frustration.
and a sense of personal failure. That frustration, and the emotional drain imposed by prolonged grief, can easily lead to a sense of hopelessness. Thus, an important part of the bereavement therapist’s role is to identify these clients, and to intervene before hopelessness sets in.

A number of explanations have been offered for the complications that interfere with resolution of grief. It is generally recognized that traumatic loss is predictive of problematic grief (Stroebe, Schut, Boelen, and van den Bout, 2012) and that certain features of personality or attachment style are evident in many people who struggle after a loss (Burke and Neimeyer, 2013). There are likewise a multitude of approaches and techniques for addressing problems in healing from loss. Two relatively new models, The Dual Process Model developed by Stroebe and Schut, and Rubin’s Two Track Model, take a broad view of the causes of problematic grief and of how to help move a bereaved person forward. Stroebe and Schut’s model emphasizes that normal grief is characterized by an oscillation between a loss orientation and a restoration orientation. In this view, healing requires that a bereaved person be able to move flexibly between an awareness of the loss and the feelings associated with it, and a continuing involvement with the people, activities and roles that are still part of their lives. Problems arise when there is a lack of oscillation, as when a person is unable or unwilling to recognize and work through feelings, or alternatively, when feelings become a quicksand from which no escape or respite is possible. The role of the bereavement therapist in these cases is to help the client engage in whichever part of the process appears to be missing, for example, encouraging someone who has become socially isolated to begin to reconnect with friends.

The Two Track model posits that grief presents the mourner with two distinct and complex sets of tasks, the first having to do with their biopsychosocial functioning (Track I) and the second having to do with the nature of their relationship with the deceased (Track II). What distinguishes the two track model from earlier characterizations of grief and loss is that it combines the psychodynamic and interpersonal view of loss, which emphasizes the loss of the relationship with the living person, with an appreciation of the potential impact of loss on biological, behavioral, cognitive and emotional processes (Rubin, Malkinson and Witzum, 2011). In this model, the isolation of the person mentioned above would be seen as a biopsychosocial factor impeding resolution of grief. As this example suggests, although the focus of this model is different, the clinical implications in many cases will be the same.

Therese Rando argues that when mourning is not progressing it is almost always because of the mourner’s inability to accept some truth relating to the relationship or the death. A son may be unable to accept the truth that he was never able earn his father’s love. A wife may not be able to accept the truth that her marriage was not what she dreamed it would be. The survivor of a family member’s suicide may not be able to accept the person’s decision to take his/her own life. In all of these cases, the bereavement therapist’s role is to help the client identify the unrecognized or unacceptable truth, and to come to whatever resolution is possible, so that emotional energy can be redirected from suppression or denial to engagement and restoration (Rando, 1993).

Early attachment, affect regulation and adjustment to loss

With regard to our understanding of complicated grief, we note that there is increasing recognition of the role of early trauma and lesser forms of problematic early attachment in the etiology of a range of psychological problems, including problems in bereavement (Lanius, Vermetten and Pain, 2010). Fifty years ago, Bowlby identified the instinctive need of human beings, at every stage of life, to establish and sustain connection with other humans, and their propensity to experience distress when significant connections are lost (Bowlby, 1969). Bowlby believed that the quality of early attachment had a direct effect on how well such disruptions were tolerated, an idea that was successfully tested by American psychologist Mary Ainsworth. Based on her observations, it is generally recognized that traumatic loss is predictive of problematic grief and that certain features of personality or attachment style are evident in many people who struggle after a loss.
Ainsworth extended Bowlby’s model to address the impact of abuse or neglect on attachment security, and identified a group of infants who became extremely dysregulated or shut down in response to separation from their caregiver (Ainsworth, 1978). Ainsworth attributed the response of these infants to the unpredictable and non-contingent behavior of their mothers, a high percentage of whom were found to have been abused or neglected as children. Subsequent investigations have validated the lasting impact of early maternal care and the persistence of regulatory deficits in children and adults who do not receive adequate caregiving (Schore and Schore, 2012). Thus, it is not surprising to find that insecure attachment is associated with complicated grief (Lobb et al., 2010) and that early mistreatment is reported by many of our clients who struggle with bereavement.

Treatment of bereaved clients who have problems relating to early attachment, including difficulty in tolerating strong emotion, requires particular sensitivity on the part of the bereavement therapist, who in effect functions as a transitional attachment figure. Special consideration must be given to the difficulties inherent in working at the edge of what the client can tolerate with regard to emotion in order to avoid treatment failure or premature termination of treatment. While the challenges of establishing a strong therapeutic bond with clients who have a history of abuse or neglect are not insubstantial, the potential rewards, for the therapist as well as the client, are considerable. For these clients, the loss of a loved one may be the catalyst that moves them to embrace a deeper and ultimately more satisfying emotional life. The opportunity to do this kind of work with people who are at the juncture between who they were before and who they will be in the future brings light into our professional lives and a clarity of purpose that encourages us, as well as our clients, to carry on.

References


American Psychiatric Association (2013b). Highlights of Changes from DSM IV-R to DSM 5. Author: Washington, DC.


Getting grief working:

*A guide for the new grief therapist*

By Dale Larson
Bruce, a Silicon Valley engineer, confronts the unimaginable: the loss of his beloved 7-year old son to a cerebral hemorrhage. Mary, a mother of two, struggles with the loss of her 30-year old husband to an aggressive adult leukemia. These are my clients. Is there something different from my everyday approach to psychotherapy that I need to know and do so that I can be optimally helpful to them? My answer is a resounding yes.

Although my everyday approach to psychotherapy has served well for the many loss-related experiences my clients present with, whether a disappointment at work, a midlife crisis, a failed relationship, or the absence of an empathic caregiver during childhood, I have learned that counseling for the loss of a loved one asks more of me both personally and professionally, emotionally and technically. In this brief article I try to capture some of this learning in quick and rather bold advice outlining some core principles—some do’s and don’ts—that guide my personal approach to grief counseling.

My approach to grief counseling is shaped by my basic understanding of grief as a natural condition—the human reaction to loss—that can generally be expected to abate over time and, frequently, to lead to psychological growth. The role of grief counseling, then, is to accelerate or unblock this natural healing process—to get grief working—particularly if this process is moving more slowly than expected or if the reaction to a loss is severe or protracted.

Offer a Supportive Therapeutic Relationship

A deeply empathic, caring, and inviting therapeutic relationship may be the fundamental criterion for effective grief counseling (Larson, 2013). The healing power of the therapeutic relationship, a significant mechanism of change in all psychotherapy, takes on even more significance in work with grieving clients.

Why is this so? First, grieving persons are often dealing with trauma, ruptured attachments, and shattered assumptions about the world being a predictable and orderly place. The therapeutic relationship provides a secure base or holding environment that enables clients to confront, integrate, and transform trauma and loss as they move forward in their changed lives and worlds.

Second, grieving persons can feel painfully alone in their loss. They often no longer have the very person they would normally turn to for support in times of stress. This sense of aloneness can also result from a widening gap between their inner experience and others’ expectations, e.g., “Isn’t it time to move on?” If we can be fully present as companions to clients when they feel most alone, grief begins to work, and distress over separation and loss lessens.

Finally, grievers’ naturally occurring support systems are often quickly exhausted or lack a nonjudgmental listener unafraid to be present with the intense and often unsettling emotions, thoughts and changes in identity that accompany grief. In-depth discussions of the impact of losing your child are not, as I like to say to my graduate students, Starbucks conversations. It is also well documented that powerful social constraints (Lepore, Silver, Wortman, & Wayment, 1996) make disclosure of loss and trauma in one’s social world both risky and unlikely—another reason a therapeutic relationship can be such an invaluable resource for the bereaved.

Practice balanced empathy

As a grief counselor, you must find a way to achieve a balanced empathic stance toward intense emotional experience. Not doing so leaves you vulnerable to compassion fatigue and burnout. From a Buddhist perspective, this balanced stance can be described as a mindful, nonattached, yet fully engaged witnessing of the client’s experiencing (Gehart & McCollum, 2007). Others term it “exquisite empathy” (Harrison & Westwood, 2009), but I prefer Carl Rogers’s (1957, p. 99) description: ”To sense the client’s private world as if it were your own, but without ever losing the as-if quality—this
is empathy.” Losing the “as-if” quality leaves us more vulnerable to vicarious traumatization, countertransferential reactions, and personal distress that derailed our therapeutic focus and pulls us into what I call the Helper’s Pit (Larson, 1993). Lacking this balanced stance, repeated confrontations with death and grief can push perhaps our most powerful emotional button—fear of our own mortality—and cause us to distance ourselves from our clients.

Don’t scratch where it doesn’t itch

Our empathy must not only be balanced, it must be accurate. Two common errors in empathy are overresponding and underresponding to our clients’ distress. As recent research tells us (Bonanno & Kaltman, 2001), many bereaved persons do much better earlier on than we might anticipate. If we probe the depths of these persons’ psyches for existential anguish, or aggressively recruit them for our counseling services, we are scratching where it doesn’t itch.

Don’t trivialize distress

Many bereaved persons, however, are doing less well than we might expect. It is not uncommon for friends, family members, coworkers, and even trained psychotherapists, to not recognize this and to instead emphasize the positive side of things, thus trivializing their distress. When encouraged to be “more resilient” or on “grief’s journey” clients may conceal their distress because they see it as a sign of their failure to cope.

Accurate empathy, in contrast, gets grief working: Clients are able to accept and make sense of their loss experience, allow the emotions of grief to guide their adjustment to loss, clarify and integrate new experiences of self, and discover new meanings in the painful events. They begin to convert what is often termed “pathological” grief (grief not working) into normal grief (grief working), and establish continuing bonds with their lost loved ones that are not maintained when they are struggling with the pain of loss. For therapists, accurate empathy leads to an expanded concept of the variability of normal grief, and also prevents taking a one-size-fits-all approach.

Do your homework

Your work with grieving persons will be considerably enhanced and more rewarding if you dedicate time to exposing yourself to recent developments in the field. Become thoroughly acquainted with current grief models, especially Worden’s task model (2009), Stroebe and Schut’s (2010) dual-process model, and Neimeyer’s constructivist approach (Neimeyer, Burke, Mackay, & van Dyke Stringer, 2010). In addition, an extensive and fascinating literature on grief-related constructs and issues deserves your attention, including work on continuing bonds (Klass, Silverman, & Nickman, 1996), disenfranchised grief (Doka, 2008), differing grief trajectories (Bonanno & Kaltman, 2001), complicated grief (Stroebe, Schut, & van den Bout, 2013), posttraumatic growth (Tedeschi & Calhoun, 1995), anticipatory mourning (Rando, 2000), the interaction of trauma and grief (Fleming, 2012), grief across the life span (Walter & McCoyd, 2009), retelling of violent death (Rynearson, 2012), gender and mourning styles (Doka & Martin, 2010), the role of rituals in grief and mourning (Imber-Black, 2004), grief in an online world (Sofka, Cupit, & Gilbert, 2012), and cultural factors (Rosenblatt, 2008).

Use grief-facilitating microskills and interventions

Finding ways to communicate your empathy that get or keep grief working for your clients is a creative challenge because grieving clients take diverse pathways. I find that a more person-centered style is best—fewer questions, less advice, and more (elegant and evocative) reflections of feeling and meaning (Larson, 2013). Use of metaphors can also be helpful (“It’s like being in an earthquake”); however, the test for any intervention is whether it assists your client to discover his or her personal pathway through grief.

Interventions I find helpful include displaying a photo of the
As a grief therapist, you must find a way to maintain your compassion and emotional involvement while courageously assisting clients to live with hope in a world in which loss is inescapable.

Be multiculturally attuned

As Paul Rosenblatt says, culture shapes grieving (2008, p. 79). Cultural background makes an important contribution to individual differences in the grieving process. These cultural considerations become even more paramount when theory is translated into practice and we strive to match the type and level of intervention to the needs of a particular client.

Take self-care seriously

Find what works for you and do more of that, whether it is exercise, meditation, a good consultation group, your faith, or your friends. The to-do list here could quite lengthy, but self-care most importantly requires taking the time and making the commitment to doing it. Ongoing exposure to grief, loss, and trauma requires finding a balance between giving to your clients and giving to yourself.

When difficult clinical interactions create self-doubt or personal distress, don’t conceal these experiences and do allow them to become stress-enhancing helper secrets (Larson, 1993). Instead, find a confidant who understands the work and its vicissitudes and can offer you quality social support.

Get grief counseling to all who need it and desire it

In the past decade, a pessimistic view of grief counseling has emerged, with claims that it is ineffective or possibly harmful with normally bereaved clients. Don’t let these claims keep you from providing grief counseling to all those who need and seek it. The claim of harmful effects, based on a single unpublished dissertation, has been shown to be invalid (Larson & Hoyt, 2007), and no other evidence of a pattern for harmful effects has appeared (Stroebe, Hansson, Schut, & Stroebe, 2008, p. 598). Grief counseling, like other therapeutic interventions, tends to be effective for those who seek it out (Hoyt & Larson, 2010; Larson & Hoyt, 2009).

Who should receive grief counseling? Gamino and his colleagues (Gamino, Sewell, Hogan, & Mason, 2009-2010) offer probably the best answer when they conclude that grief counseling is appropriate for all bereaved persons who answer yes to the following two questions: “Are you having trouble dealing with the death?” and “Are you interested in seeing a grief counselor to help with that?”

Conclusion

Describing the qualities of the therapeutic relationship necessary for deeper therapeutic work, Diana Fosha reflects that “the emotional atmosphere should be one in which the patient feels safe and the therapist brave” (2000, p. 213). As a grief therapist, you must find a way to maintain your compassion and emotional involvement while courageously assisting clients to live with hope in a world in which loss is inescapable. This challenge is best met in an authentic and caring helping relationship between a therapist who believes in the client’s healing capacities and a client who is motivated to engage these capacities, get grief working, and move into the future without relinquishing the past.

References


It is not often that an author anticipates that their book is not going to be well received, and especially not an author with Christopher Bollas’s illustrious publishing record. This is not a false modesty on his part, but rather a concern that his approach with analysands who are about to have a breakdown will be seen as not conforming to what is usually understood as psychoanalytic practice. He remarks that in formal presentations to groups of psychoanalysts over the years he has been accused of “violating the frame”, of being “seductive and gratifying to the analysand”, and that his approach amounted to “an enactment within the transference and countertransference that goes unanalysed” (p 7).

His concern about the novelty, or transgressive radicality, of his approach with pre-breakdown analysands, is evident in his interview discussion with Sacha Bollas in the final chapter, when he (Christopher) says that he has been using this method with patients for over 30 years, and is only writing about it now: “To have remained silent in the face of what I have discovered might have been convenient—I hardly expect this text to serve me well with my colleagues—but I think I have no choice but to get it out there, and let others see what is to be made of it in time.” (p 116). It is somewhat of an indictment about the conservatism and punitive boundary-monitoring that characterises psychoanalysis, that such an eminent and respected analyst such as Bollas only felt able to publish these views on his practice now, and even so, hesitantly!

Bollas has a number of important things to say about how he understands the psychology of breakdown. For instance, he says that “for
those who understand breakdown as a profoundly human experience, distracting a self from the meanings of their frailty produces a particular new form of loss” (p 2). He emphasises this point regarding loss by suggesting that if a breakdown is not transformed into a potential breakthrough, then people become what he terms “broken selves”. Coming from his work with seriously disturbed individuals he wants to affirm the generative and positive aspects of working psychoanalytically with someone about to have a breakdown.

In adopting this approach the first thing to do of course is to assess that the person is in fact about to have a breakdown, and has become too fragile to cope with the ordinariness of their everyday lives. Bollas would at this point assess whether the person just needed some extra sessions during the week, or whether all-day sessions were required. At this point Bollas makes a whole range of practical arrangements. He agrees to see the person for full-day sessions, for as long as it takes. Full days mean starting at 9.00, having a break for lunch, and ending around 6.00 if he feels that the person is able to go home on their own. Remarkably he tells us that in all his years of working this way it is been extremely rare that the full-day sessions have exceeded three days! He also arranges for a GP that he works with, or the analysand’s psychiatrist if they have one, to be on standby should his three days or so of intensive work not be enough and the person requires medication or hospitalisation. He also arranges for social services to assist the person with any domestic issues, like meals, transport, and so on.

Bollas’s argument throughout his book is that his approach is not an abandoning of psychoanalysis, but in fact following psychoanalytic principles precisely. He says that his commitment to psychoanalysis as the treatment of choice for someone having a breakdown is why he offers them more (all-day sessions), not less, psychoanalysis. Bollas is advocating “an alteration in the analytic frame, but not the process. The new structure is set in place temporarily, in order to help the analysand through a crisis and then allow a return to the reliability of the ordinary contract.” (p 103).

However, while Bollas says that what he is doing is just offering more psychoanalysis, there are some interesting features that particularly characterise these all-day sessions. For instance, he notes that the silences are much longer than in ordinary one-hour sessions, and sometimes there can be a silence of a few hours. His theoretical argument about this is that the person needs time and quietude to process their emotional experience (chapter 9), and to feel contained by the holding environment of these all-days sessions. Bollas is not suggesting that the therapist should not interpret, but that too much interpretation will interfere with how the analysand reflects on, and makes sense of the “unthought known”.

There is a difference between how we might struggle to put into practice Bollas’s approach in the contexts within which we work in South Africa, and arguing that his approach is in principle problematic, or that ultimate putdown: whatever it is, it isn’t psychoanalysis! Even if psychotherapists aren’t going to follow Bollas’s method there are still some very fascinating and challenging ideas in his brief book. It is also one of his more personal books as it is the writing of a working and thinking therapist with a focus on the practicalities of therapy. There are three fascinating chapters devoted to the case studies of analysands (Emily, Anna, and Mark) that he has worked with in this way. While focused on the therapeutic process and case studies, it is by no means an un-theoretical book as Bollas also discusses the psychological processes of breakdown, and what the psychoanalysis of breakdown amounts to.

Lost and found

The evolution and eventual reversal of borderline dynamics as demonstrated in one patient’s life narrative

By Robert Waska

Abstract

Continuing the ongoing story of a long term patient in psychoanalytic treatment, the author highlights points in this patient’s development where the borderline or paranoid-schizoid experience seemed to have solidified. At the same time, there were critical moments of internalization and identification that either helped to balance the more persecutory perspective or added an element of idealization. In illustrating these points, the author shows how the Kleinian approach considers the ongoing relationship between external and internal and how the intra-psychic elements of attachment and phantasy are shaped by projective identification processes. The point of this ongoing column is to highlight the therapeutic nature of allowing the patient to tell his story and to have an unique chance to hear from the patient their own view of their life, the evolution of their pathology, and the way external life imprints upon internal life just as internal phantasy shapes the experience of external life.
Going on with his story about his new roommate situation, John told me that he continued his sad ride into oblivion “with drinking all the time and drugs whenever I could get them. I fancied myself as a nature lover so I would take long walks in the hills behind our house. I would smoke as much pot as possible and bring a six-pack of beer with me. Then, I would just wonder around in the woods looking at the trees and feeling free and easy. A mellow nature lover was an easier identity to take on than to admit to myself I was a lonely loser with a drinking problem. My roommates grew to not respect me as I would have black outs and say or do things that offended them. They grew to see me as the kids in high school did, a drug addict out to get high at everyone’s expense. I had nothing to give and only wanted what I wanted. I was not able or willing to be social so I seemed very withdrawn and selfish.

During this time, I was with a couple of women for a short period of time. One example was a prostitute I picked up when she and her eight year old daughter were hitchhiking. They were homeless and poor and I invited them to stay at my place. Another time, there was a sweet younger girl down the street who was smitten with me. Then, I would just wonder around in the woods looking at the trees and feeling free and easy. A mellow nature lover was an easier identity to take on than to admit to myself I was a lonely loser with a drinking problem. My roommates grew to not respect me as I would have black outs and say or do things that offended them. They grew to see me as the kids in high school did, a drug addict out to get high at everyone’s expense. I had nothing to give and only wanted what I wanted. I was not able or willing to be social so I seemed very withdrawn and selfish.

During this time, I was with a couple of women for a short period of time. One example was a prostitute I picked up when she and her eight year old daughter were hitchhiking. They were homeless and poor and I invited them to stay at my place. Another time, there was a sweet younger girl down the street who was smitten with me. Then, I would just wonder around in the woods looking at the trees and feeling free and easy. A mellow nature lover was an easier identity to take on than to admit to myself I was a lonely loser with a drinking problem. My roommates grew to not respect me as I would have black outs and say or do things that offended them. They grew to see me as the kids in high school did, a drug addict out to get high at everyone’s expense. I had nothing to give and only wanted what I wanted. I was not able or willing to be social so I seemed very withdrawn and selfish.

During this time, I was with a couple of women for a short period of time. One example was a prostitute I picked up when she and her eight year old daughter were hitchhiking. They were homeless and poor and I invited them to stay at my place. Another time, there was a sweet younger girl down the street who was smitten with me. Then, I would just wonder around in the woods looking at the trees and feeling free and easy. A mellow nature lover was an easier identity to take on than to admit to myself I was a lonely loser with a drinking problem. My roommates grew to not respect me as I would have black outs and say or do things that offended them. They grew to see me as the kids in high school did, a drug addict out to get high at everyone’s expense. I had nothing to give and only wanted what I wanted. I was not able or willing to be social so I seemed very withdrawn and selfish.

During this time, I was with a couple of women for a short period of time. One example was a prostitute I picked up when she and her eight year old daughter were hitchhiking. They were homeless and poor and I invited them to stay at my place. Another time, there was a sweet younger girl down the street who was smitten with me. Then, I would just wonder around in the woods looking at the trees and feeling free and easy. A mellow nature lover was an easier identity to take on than to admit to myself I was a lonely loser with a drinking problem. My roommates grew to not respect me as I would have black outs and say or do things that offended them. They grew to see me as the kids in high school did, a drug addict out to get high at everyone’s expense. I had nothing to give and only wanted what I wanted. I was not able or willing to be social so I seemed very withdrawn and selfish.

During this time, I was with a couple of women for a short period of time. One example was a prostitute I picked up when she and her eight year old daughter were hitchhiking. They were homeless and poor and I invited them to stay at my place. Another time, there was a sweet younger girl down the street who was smitten with me. Then, I would just wonder around in the woods looking at the trees and feeling free and easy. A mellow nature lover was an easier identity to take on than to admit to myself I was a lonely loser with a drinking problem. My roommates grew to not respect me as I would have black outs and say or do things that offended them. They grew to see me as the kids in high school did, a drug addict out to get high at everyone’s expense. I had nothing to give and only wanted what I wanted. I was not able or willing to be social so I seemed very withdrawn and selfish.
From the therapist’s chair

my best to blot those feelings out. Nevertheless, I was aware enough of my chaotic reality to end up feeling like I was watching myself careen through a sad series of events without brakes or steering wheel. Like watching a scary movie, you want to yell at the character to “watch out for the monster around the corner” but you know they won’t hear you.

My drug dealer was a really nice guy, a noted musician “back in the day”, whom I would sit around with and chat for hours, fairly easy when you both are high on a stimulant. I was at his house so often I felt like family.

He and his girlfriend were interested in my college endeavors. First I was enrolled in a nursing program but now I was studying psychology. On the surface it seemed we were having nice scholarly discussions about academic matters although I never let on that my life was completely out of control and I was barely passing my classes. In school, I was usually hung over, trying to stop a drug-induced nosebleed as the teacher called on me to answer something I had no idea about, since I had chosen to go to a the bar instead of the library. The quizzes might well have been written in another language, they seemed so foreign. I felt ashamed to be sitting there, smelling like stale beer and pretending to take a test that that I didn’t know anything about.

So, on one level, I felt cool to be hanging out discussing my psychology program with my friend the famous rock musician, his beautiful hippie girlfriend, and their cute five-year-old daughter. But, my mind was still hanging on to enough bits of reality to painfully notice the other side of this study in denial.

In fact, my friend/drug dealer was the former drummer for a famous 60’s band that hadn’t really done much in twenty years. He lived in a house bought back when he had money and fame. It looked like a quaint cottage at night when I went to pick up my goodies but in the light of day, it was a rundown dump with a sagging roof and a rusted washing machine sitting in the front yard. He hadn’t recorded anything in over a decade and only practiced occasionally in order to jam at the local dive bar once a month. He still knew other luminaries from the 60’s music scene so when they came to buy drugs I got to meet people I had seen in Rolling Stone magazine. But, most of them were still making records and were buying cocaine for recreation, not dealing it for a living. When I saw my dealer’s five year old daughter watching him prepare the scales to weigh out the cocaine, I knew something was terribly wrong. But, that is the painful life of a drug addict. You know you are living ugly but you don’t walk away, you hang in there over and over, becoming part of a sick distortion.

My dealer’s girlfriend was a quiet woman who looked like the stereotype of a California flower child, now a bit wilted. She seemed to be drawn to me and over time we developed an unspoken attraction for each other. It was clear that if her boyfriend wasn’t in the picture, we would have become involved. One day, when driving around town, I saw her walking along by herself. I stopped and we talked for a while.

I had two distinct feelings. I wanted to ask her to come home with me. She would have said yes, we would have gotten high, had sex, and had a great time. I envisioned the union of two hipsters, me the bright college student and her the sophisticated older woman who used to be married to a famous Berkley beat poet and now living with the rock star. The other part of me realized that this would probably get back to my drug dealer/rock star, ruining my chances for any more bundles of blow on credit.

But, the sober little man that lived in the back of my head was whispering in my ear. I was painfully aware that here on the side of the road was a washed up, aging woman who lived with a drug dealer and looked like a bunch of dried flowers, a faded remnant of what used to be vibrant and alive. Chatting her up was a terribly confused drug addict completely adrift and desperate for love and comfort. So, I said goodbye and made my way to the liquor store for my nightly six-pack and half pint, with the hope of ignoring the empty void that was tunneling into my soul.
Simmering to Satisfaction

By Sandra Wartski

Simmering is an efficient food preparation technique in which foods are cooked in hot liquids kept at or just below the boiling point. Simmering provides generally gentler treatment than boiling as it prevents food from toughening or breaking up. Simmering can be used to cook proteins (such as poultry and meats), often in the form of poaching (cooking in enough liquid to cover the food) and braising (cooking in a small amount of liquid).

A slow cooker, also known by its trademark name of Crock Pot, is a countertop electrical cooking appliance that is used for simmering. This terrific invention allows unattended cooking of certain dishes at a relatively low temperature for hours. The heating element heats the contents to a steady temperature in the 79–93 °C (175–200 °F) range, with the lid being essential to prevent vapors from escaping and to allow flavors to be circulated. The low temperature of slow-cooking makes it almost impossible to burn food, though some types of meat or vegetable can be over-cooked. There is also the bonus of using just a single pot, as clean up time is significantly reduced.

Just as simmering foods allows them to become moist and fork-tender over time, the process of traditional psychotherapy allows clients to warm up slowly and to allow issues to be exposed gently. Unlike some of the short-term or “shock therapy” approaches, a simmering style can be therapeutically effective with certain presenting problems. When more time is available and emergency responses are not required, a simmering approach allows more of the individual essence to emerge for a fuller, more flavorful effect. Clients of a more delicate nature often respond to a style that attends to the work gently and slowly, while clients of a tougher disposition also benefit from the simmering style, which facilitates increased elasticity with hardened lifestyle habits. Key issues, childhood events and personality patterns are stewed down to a simpler, more concentrated form in the therapeutic relationship. As in the Crock Pot simmering process, which allows the fat from the cooked protein to float to the top to be skimmed off easily, rather than stirred back in, slow therapy allows more of the unnecessary to come forward and be released, rather than repeated.

There are also lovely surprises associated with the use if a slow-cooker style. The slow approach allows for a satisfying blend of listening and reflection, acceptance and change, positive and negative, past and future. The flavors may be stronger and more pungent at times, but this method ultimately provides more clarity, meaning and power. The final product looks quite different from the way it appeared at the start, but there is adaptive value in looking back to remember the place from which one has come. The healing nature of time and patience is always reinforced. And much of the work may occur between sessions, unattended by the clinician, as it gently percolates in the adaptive heat of the psyche.

About the author

Sandra Wartski, Psy.D. is a psychologist in Raleigh, North Carolina, USA. She is also a mom who has special interest in feeding her family nutritiously and efficiently.
Savory and Hearty Beef Barley Stew

Ingredients:

2 cups baby carrots
10 ounces fresh mushrooms, sliced
1 1/2 pounds boneless beef chuck steak, cut into 1-inch cubes
2 teaspoons minced onion
1 teaspoon onion powder
1 teaspoon salt
29 ounces beef broth
14-1/2 ounces diced tomatoes, undrained
2 cups water
3/4 cup uncooked pearled barley
1 cup frozen green peas
1/4 teaspoon black pepper

Directions

1. In a slow cooker, layer carrots, mushrooms and beef.
2. In a medium bowl, mix the onion, onion powder, salt, tomatoes, water and barley. Pour mixture over beef.
3. Cook, covered, on low 8 to 10 hours or until beef is tender.
4. Stir in peas and cook, covered, for a further 5 minutes, or until heated through. Season with ground black pepper and serve.

Recipe adapted from www.momswhathink.com