



Techniques of Grief Therapy

Assessment and Intervention

Edited by Robert A. Neimeyer

Techniques of Grief Therapy

Techniques of Grief Therapy: Assessment and Intervention continues where the acclaimed *Techniques of Grief Therapy: Creative Practices for Counseling the Bereaved* left off, offering a whole new set of innovative approaches to grief therapy to address the needs of the bereaved. This new volume includes a variety of specific and practical therapeutic techniques, each conveyed in concrete detail and anchored in an illustrative case study. *Techniques of Grief Therapy: Assessment and Intervention* also features an entire new section on assessment of various challenges in coping with loss, with inclusion of the actual scales and scoring keys to facilitate their use by practitioners and researchers. Providing both an orientation to bereavement work and an indispensable toolkit for counseling survivors of losses of many kinds, this book belongs on the shelf of both experienced clinicians and those just beginning to delve into the field of grief therapy.

Robert A. Neimeyer, PhD, is a professor of psychology at the University of Memphis, where he also maintains an active clinical practice. Neimeyer has published 30 books, including *Techniques of Grief Therapy: Creative Practices for Counseling the Bereaved* and *Grief and the Expressive Arts: Practices for Creating Meaning*, the latter with Barbara Thompson, and serves as editor of the journal *Death Studies*. The author of nearly 500 articles and book chapters and a frequent workshop presenter, he is currently working to advance a more adequate theory of grieving as a meaning-making process. 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 given lifetime achievement awards by both the Association for Death Education and Counseling and the International Network on Personal Meaning.

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Contents

Figures and Tables	xiii
Preface	xv
How to Use This Book	xviii
Contributors	xx
PART I: FRAMING THE WORK	1
1. Toward a Developmental Theory of Grief ROBERT A. NEIMEYER AND JOANNE CACCIATORE	3
2. Grief is a Form of Love M. KATHERINE SHEAR	14
3. The Dual Process Model in Grief Therapy EMMANUELLE ZECH	19
4. Traumatic Bereavement CAMILLE B. WORTMAN AND LAURIE ANNE PEARLMAN	25
5. Finding the Evidence: Use of the CareSearch Site in Bereavement Care JENNIFER TIEMAN AND SARAH HAYMAN	30
PART II: ASSESSING BEREAVEMENT	37
6. Hogan Grief Reaction Checklist (HGRC) NANCY S. HOGAN AND LEE A. SCHMIDT	39
7. Integration of Stressful Life Experiences Scale (ISLES) JASON M. HOLLAND	46
8. Meaning of Loss Codebook (MLC) EVGENIA MILMAN, ROBERT A. NEIMEYER, AND JAMES GILLIES	51

9.	Grief and Meaning Reconstruction Inventory (GMRI) ROBERT A. NEIMEYER, JAMES M. GILLIES, AND EVGENIA MILMAN	59
10.	Inventory of Daily Widowed Life (IDWL) MICHAEL CASERTA, DALE LUND, AND REBECCA UTZ	65
11.	Perceived Life Significance Scale (PLSS) RACHEL HIBBERD	71
12.	Inventory of Complicated Spiritual Grief (ICSG) LAURIE A. BURKE AND ROBERT A. NEIMEYER	76
13.	Moral Injury Questionnaire—Military Version (MIQ-M) JOSEPH M. CURRIER	81
14.	The Two-Track Bereavement Questionnaire for Complicated Grief (TTBQ-CG31) SIMON SHIMSHON RUBIN AND OFRI BAR-NADAV	87
15.	Inventory of Social Support (ISS) NANCY S. HOGAN AND LEE A. SCHMIDT	99
	PART III: COPING WITH GRIEF	103
16.	The Grief River THOM DENNIS	105
17.	Self-Assessment of Tasks of Mourning J. SHEP JEFFREYS	109
18.	Mapping the Influence of Loss DAISUKE KAWASHIMA	113
19.	Strategies for Coping with Grief DONALD MEICHENBAUM AND JULIE MYERS	117
20.	Contextual Behavior Activation ANTHONY PAPA	124
	PART IV: ATTENDING TO THE BODY	129
21.	Welcoming What Is CHRISTINE H. FARBER	131
22.	The Relaxation Response HEATHER STANG	135

23. Meridian Tapping	139
CECILIA LAI WAN CHAN AND CANDY HIO CHENG FONG	
24. Yoga for Grief	144
HEATHER STANG	
PART V: WORKING WITH EMOTION	151
25. Disentangling Multiple Loss	153
ROBERT A. NEIMEYER	
26. The Healing Power of Guilt	157
CELESTE MILLER AND PAULA LORING	
27. Compassion and Loving-Kindness Meditation	161
HEATHER STANG	
28. Ambivalence in Grief	165
CELESTE MILLER AND PAULA LORING	
29. Loss Boxes	170
LARA KRAWCHUK	
30. The Grief Drawer	173
DARCY HARRIS	
PART VI: RECONSTRUCTING THE SELF	177
31. Building Self Capacities	179
LAURIE ANNE PEARLMAN	
32. Who Am I?	182
WENDY G. LICHTENTHAL AND WILLIAM BREITBART	
33. Healing through Internal Compassion	186
DEREK P. SCOTT	
34. Letters to Self	190
CYNTHIA ROLLO-CARLSON	
PART VII: RE-STORYING NARRATIVES OF LOSS	195
35. Dramaturgical Listening	197
GAIL NOPPE-BRANDON	

36.	Internet-Based Writing	201
	BIRGIT WAGNER AND ANDREAS MAERCKER	
37.	Spiritual Journaling	205
	MICHELLE J. PEARCE AND MELISSA A. SMIGELSKY	
38.	Thawing Frozen Grief	209
	CYNTHIA ROLLO-CARLSON	
39.	Time Revisited	212
	PATRICIA RUIZ AND KERRY MENN	
40.	Etched in Glass	216
	CHRISTINE H. FARBER AND STEPHANIE FIELD	
	PART VIII: REORGANIZING THE CONTINUING BOND	221
41.	Reintegrating Attachment After Loss	223
	ADAM ANDERSON	
42.	Relationship Review	228
	JOSHUA MAGARIEL	
43.	AfterTalk	232
	LISA BOGATIN AND LARRY LYNN	
44.	Singing an Imaginal Dialogue	236
	YASMINE A. ILIYA	
45.	Spontaneous Memorialization	239
	JANNA A. HENNING	
46.	Online Memorials	244
	ERIN J. STOLL	
	PART IX: RE-ENVISIONING THE LOSS	249
47.	Dignity Portraiture	251
	NANCY GERSHMAN AND KAT SAFAVI	
48.	Drawing Images of Violent Death	256
	FANNY CORREA	
49.	The Dual Rose	259
	AMY Y. M. CHOW AND KURTEE S. M. CHU	

50. Photographing Relationships for Remembering JUDY WEISER	264
51. Healing Flowers LARA KRAWCHUK AND TERRY STURMER	268
PART X: MOBILIZING SYSTEMS	273
52. Expanding the System AN HOOGHE AND LIEVEN MIGERODE	275
53. The Bereaved Sibling Interview ALBA PAYÀS	279
54. The Grief Spot LAURA L. HINDS	287
55. Family Coat of Arms JANET L. BRADLEY	290
56. Grief Etiquette Coaching DORIS CHAMBERS VAUGHANS	294
PART XI: FACILITATING GROUP WORK	297
57. Facilitating Safety in Group Work SIMON SPENCE AND UNA SMALE	299
58. Co-facilitating Bereavement Support Groups BEVERLY FEIGELMAN AND WILLIAM FEIGELMAN	303
59. Containing the Story of Violent Death ROBERT A. NEIMEYER AND DIANA C. SANDS	306
60. The Collaborative Poem NICHOLAS F. MAZZA	312
61. The Red Tent DIANA C. SANDS	316
62. Grief Ball ALISON J. BOMBA	320

PART XII: RECRUITING RITUAL	323
63. Playing with Ritual ELLEN G. LEVINE	325
64. Spiritually Based Healing Rituals JUDY H. F. CHEW	329
65. The Wise Elder DAMITA SUNWOLF LARUE	332
66. Bedside Singing JUDITH SPENCER WILLIAMS	337
Author index	340
Subject index	345

Figures and Tables

Figures

1.1	The organism–environment system presupposed by an epigenetic model of development	4
5.1	Step-by-step topic search in CareSearch for “self care in bereavement”	32
5.2	Step-by-step instructions for creating your own bereavement search	34
8.1	Comparison of MLC meaning category expression in the first session versus the termination session	53
8.2	MLC meaning category expression in the initial session: Category name, illustrative client quotation, valence, and relative frequency	54
8.3	MLC meaning category expression in the termination session: Category name, illustrative client quotation, valence, and relative frequency	55
9.1	Cheryl’s GMRI profile three months following her husband’s death by suicide	61
18.1	Yukie’s current map of the influence of her loss	114
18.2	Yukie’s future map of the influence of her loss	115
23.1	Steps for meridian tapping exercise	141
24.1	Savasana pose to facilitate relaxation	146
24.2	Meditation to promote mindfulness and guided inner wisdom	147
24.3	Child’s pose	148
29.1	Loss boxes constructed by group members living with cancer	171
39.1	The time machine with settings for date	213
39.2	The time travel booth	213
40.1	“This Must Be a Dream.” Etched glass by Linda Lichtman	217
45.1	Patrick’s ghost bike	241
47.1	Alia and Bella	253
47.2	The original dignity portrait of Alia, Bella, and Gabby as flight attendants	254
47.3	The retouched dignity portrait	254
49.1	The Dual Rose: Removing thorny and withered parts of the rose to reveal its inner beauty	260
49.2	The Dual Rose: The water basin with thorns and petals	261
50.1	Betty and Martin	266
51.1	Allison’s initial selection of papers to represent her life before her divorce	270
51.2	Allison’s pre- and post-divorce flowers, held side by side	271
55.1	Template for the Family Coat of Arms	291

xiv • Figures and Tables

59.1	Veteran group facilitators brainstorm procedures for containing traumatizing stories of the death	307
59.2	Steve's talking stick, used to hold both the pain of the event story of the loss and the memories and resources for embracing it	310
61.1	The Red Tent is used to support somatic narratives related to tragic loss	317
65.1	The wise elder. Visualized and depicted by Rachael LaRay Calton	333

Tables

1.1	A developmental model of grief	5
11.1	Demographic characteristics and mean PLSS scores of community and student samples	72
25.1	Disentangling Dorothy's multiple losses	154

Preface

Like the field of death studies or thanatology with which it is intimately associated, grief therapy is an inherently pluralistic enterprise. Arising as it does at the interface of the helping professions and the ineluctable reality of loss in (and of) human life, formal professional attempts to assuage the resulting grief inevitably carry the imprint of the many disciplines involved, from psychology and counseling, through nursing and social work, to spiritual care and the expressive arts. And yet, until recently, therapeutic efforts to support people struggling with often profound and prolonged life disruption in the aftermath of the loss were fairly informal and intuitive, and inadequately communicated to others joined in similar work. As a result, many creative practices have been shared only informally within the professional community, and many others have no doubt died with their solitary creators. Just as seriously, the lack of practical documentation of such practices has resulted in their being substantially ignored by researchers, who have instead given far greater attention to documenting the impact of bereavement than to studying therapeutic procedures to alleviate it. Researchers, no less than clinicians, therefore would benefit from a clear and practical description of methods of grief therapy, so that their possible contribution to the reduction of human suffering in the face of unwelcome change can be extended creatively and evaluated scientifically.

Techniques of Grief Therapy: Assessment and Intervention was compiled to serve just this function. Like its predecessor, *Techniques of Grief Therapy: Creative Practices for Counseling the Bereaved* (Neimeyer, 2012), the present volume offers a cornucopia of practical means of addressing the challenges of loss, ranging from evidence-based strategies for restoring vital engagement with the world after a life-vitiating transition to novel processes and procedures for conducting therapy and enhancing its impact within and between sessions. As in the earlier book, I have attempted to recruit a large and diverse set of contributors, some of whom are among the leading theorists and researchers in the field, while others are practitioners “in the trenches” of clinical settings ranging from hospices and hospitals to private practices and specialized bereavement centers. All write with clarity and compassion about the concepts that animate their practice and the specific tools that give it shape.

Organization of the Book

The 66 chapters that follow are divided into 12 parts, each of which focuses on a shared objective, which finds expression in the several chapters that comprise it. Part I, *Framing the Work*, offers a range of contemporary and sometimes original perspectives on the work to follow, considering grief and grief therapy in the frame of adult developmental, attachment, coping

and trauma theories, and introducing a specialized website that helps practitioners find the scientific literature they need to add inspiration and rigor to their work. Part II, *Assessing Bereavement*, provides a great trove of measures for evaluating grief and bereavement, at levels that range from its negative and positive outcomes through the nuanced impact of loss on survivors' worlds of meaning to their ongoing attachment relations to the deceased and living support figures. Part III, *Coping with Grief*, extends this focus on evaluation in the direction of self-assessment and self-change, in the form of various models and methods for grasping more clearly where we are in the process of grieving, and how we might constructively move forward toward resilience.

Part IV, *Attending to the Body*, represents the first of nine sections to offer concrete and detailed clinical procedures targeting specific therapeutic objectives, in this case helping clients attune to the body's felt needs and address them with compassionate physical practices. Part V, *Working with Emotion*, assists counselors in teasing apart bereavement overload, and implementing ways of containing, exploring, and even using difficult emotions as guides to growth. Part VI, *Reconstructing the Self*, holds the mirrors of several methods to our clients' gaze, so that they can engage in the deep work of reconstructing their own identity in the wake of life-transforming loss.

In Part VII, *Re-storying Narratives of Loss*, contributors help therapists listen between the lines of the stories clients are telling themselves and others about the loss, and use a range of dramaturgical, technological, spiritual, poetic, imaginal, and reflective practices to reach toward fresh self-narratives. Part VIII, *Reorganizing the Continuing Bond*, recognizes the centrality of attachment at the core of grief, and discusses several means of reviewing and renewing the sometimes conflicted, typically loving ties that are shaken, but not sundered, by the death. Part IX, *Re-envisioning the Loss*, extends these narrative procedures through the power of imagery, conveying in detail novel prescriptive and expressive arts tools for rendering bonds and the challenges to them more visible to therapeutic attention.

Part X, *Mobilizing Systems*, recognizes a fact that is often strangely neglected in the field of grief therapy—namely that mourners grieve in a social field. Accordingly, contributors to this section offer guidance on involving family and other network members affected by a loss, and outline essential methods for fostering mutual support through the transition. Part XI, *Facilitating Group Work*, likewise conveys procedures for ensuring that support groups provide an empathic and manageable “holding environment” for shared pain, discussing detailed suggestions for their co-facilitation and specific structures for prompting the telling of healing stories. And finally, Part XII, *Recruiting Ritual*, underscores the role of spiritual, cultural, and creative practices in honoring those we love and restoring a sense of wholeness in those who remain. Taken together, the volume complements its predecessor, nearly doubling the fund of tools and techniques made available to grief therapists.

Acknowledgements

In closing, I want to express my gratitude to the scores of passionate colleagues who have contributed their enthusiasm and effort to this project, and particularly the “unsung heroes” of bereavement care in the role of front-line workers who are often given little opportunity to share the intelligent and inspired practices that inform their work with clients. No less than the leading theorists and researchers whose contributions also fill the volume, they have helped make grief therapy the vital and humane field that it has become. I am proud to call many members of both groups my friends.

I also would like to thank those colleagues like Anna Moore, my acquisition editor at Routledge, and Melissa Smigelsky, my doctoral student in clinical psychology, who have helped at many stages in the development of the volume, and whose unflinching efforts to

champion, index, produce, or market the volume have helped make it a reality. If “it takes a village to raise a child,” as the African proverb suggests, this is no less true of publishing a book of this magnitude.

And finally, I want to extend my sincere gratitude to the countless clients in my own clinical practice and that of most of the other contributors of this volume, whose willingness to share their stories, their pain, and their hope ground all of us in the reality of loss, just as it also underscores the nobility with which it can be borne. I am a better therapist and person for their teaching, and I hope that their stories, rendered in the scores of case illustrations to follow, will have a similar effect on other readers.

Robert A. Neimeyer, PhD
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How to Use This Book

Given the scope of the present volume, readers might well engage its diverse content in different ways depending on their personal and professional contexts of work. I will therefore offer a few suggestions for three potential audiences in particular: clinicians, researchers, and educators.

Clinicians, broadly construed to include psychologists, counselors, therapists, social workers, and others who facilitate grief support in different settings, can consider the volume as a source of orientation to the work of grief therapy (in Part I), which finds expression in the scores of useful methods described in detail and illustrated in case studies (in Parts III–XII). Drawing on constructivist, narrative, emotion-focused, cognitive behavioral, family systems, group, and expressive therapies, the dozens of technique chapters that constitute the core of the book then invite browsing for clinical inspiration, while also being organized into clusters of chapters that facilitate targeted searches for specific guidance. The substantial trove of assessment resources (in Part II) further extends the clinical utility of the book by making accessible highly relevant scales and questionnaires (with scoring keys) to aid practitioners in identifying client strengths, needs and vulnerabilities, as well as to document the efficacy of their therapeutic interventions.

Researchers can find in the material of Part I a helpful introduction to contemporary models of grief and grief therapy, extending surveys of this literature offered in previous volumes (Neimeyer, 2012; Neimeyer, Harris, Winokuer, & Thornton, 2011). Part II is likely to have particular value for this readership, conveniently including as it does a psychometrically informed presentation of many of the major measures that can help operationalize the proposed mechanisms of change in grief therapy, while also providing valid and reliable means to evaluate its efficacy. The remaining chapters, viewed from the standpoint of psychotherapy research, represent something of a handbook or manual of therapeutic procedures that invite further study, research that could be greatly advanced by the clarity with which they are conveyed. Thus, theoretically, technically, and psychometrically, the contents of the present volume, like its predecessor, should help sharpen the scientific agenda of the field as well as foster more creative practice.

Finally, *Educators* are likely to find the present volume, along with the original, to be attractive as texts for advanced undergraduate and especially graduate classes in bereavement and grief therapy. Beyond the useful introduction to contemporary theory provided in Part I, the remaining sections of the book offer detailed instruction in concrete methods of intervention, greatly alleviating the anxieties of students struggling to close the gap between theory and practice. Moreover, the structure of the book invites *experiential learning* through the assignment of readings of relevance to the students' own history of losses, as well as those of their clients. For example, the 12 parts of the book are amenable to incorporation as weekly readings

in a syllabus that scaffolds a typical semester (Part I in Week 1, Part II in Week 2, etc.), and students can be encouraged to actually try out one of the methods of their choice from each unit by considering its application to a loss of their own. A brief reflective paper on their experience in doing so—with appropriate safeguards regarding personal disclosure—can greatly deepen their lived understanding of a given questionnaire, process, or technique before they attempt to implement it in field settings, and can make for lively and often moving class discussions. The suggestions for further readings in each chapter also point students toward additional resources that could help scaffold a class paper or project.

In summary, I hope the structure and content of *Techniques of Grief Therapy: Assessment and Intervention* address the needs of different constituencies engaged in the fields of grief therapy and research, and promote greater integration of pedagogy, science, and practice.

Robert A. Neimeyer, PhD

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Part I

Framing the Work

Toward a Developmental Theory of Grief

Robert A. Neimeyer and Joanne Caciatore

At least in English, “grieving” can be understood as a verb rather than a noun, a static state or condition. This implies that, at least optimally, it represents a form of psychosocial and perhaps spiritual transition from the initial onset of a life-altering loss through a period of frequently tumultuous adjustment to a point of relative stability beyond the period of acute bereavement. Viewed in this temporal perspective, adaptation to the loss of someone or something central to one’s sense of security and identity can therefore be seen as a developmental process, one that is not simply reducible to a set of psychological symptoms, a psychiatric diagnosis, or a culturally defined social role—though it may be understood by some in these terms too. Our goal in this initial chapter is to sketch the possible outlines of such a developmental model of grief, suggest the social needs implicit for the mourner negotiating this transition, and gesture toward the sorts of therapeutic responses at each point that might best facilitate the mourner’s movement through the series of challenges or crises this process entails. We will begin by framing our general orientation toward such a developmental theory before outlining the model itself, offering occasional citations of relevant research and brief clinical vignettes to illustrate the model’s connection to clinical practice.

An Epigenetic Framework

From an epigenetic systems perspective, both internal experience and external behavior emerge in development through coactions among multiple levels within an organism–environment system (Gottlieb, 1992). In biology, epigenesis stands in contrast to both preformationist theories, which view an organism’s structures, behaviors, and capacities as innate and fully formed, as well as in contrast to maturationist views that regard such structures or capacities as the predictable unfolding of a genetic potential. Instead, in a psychological context, an epigenetic approach understands all development and behavior as emerging from a person–environment, or ecological, system composed of hierarchically organized levels that transact (Mascolo, Craig-Bray, & Neimeyer, 1997), as depicted in Figure 1.1.

As applied in the context of bereavement, this implies that the development of mourners’ grief processes will be jointly shaped by (a) *bio-genetic* factors such as their dispositional temperament, genetic vulnerability to fluctuating affective states, and physical resilience; (b) *personal-agentic* factors such as their emotional awareness, personal philosophy, and

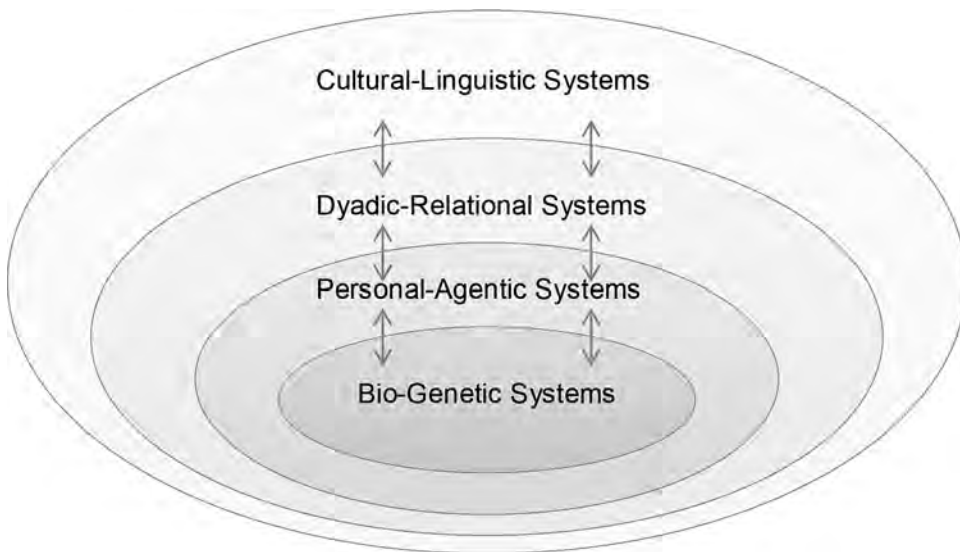


Figure 1.1 The organism–environment system presupposed by an epigenetic model of development

coping skills, (c) *dyadic-relational* factors such as social support, family convergence or divergence in grieving styles, and social connectivity, and (d) *cultural-linguistic* factors such as societal, gendered, or ethnic norms governing the expression of grief, cultural sanctions or disenfranchisement of particular forms of loss, and even the connotations carried by terms describing (or ignoring) the mourners' status as widows, orphans, or bereaved parents. The plethora of transactions *within* these levels (e.g., considering conflicting needs at the personal-agentic level) or *between* them (e.g., personal preferences for emotional expression being invalidated by a family or cultural prescription of stoicism) configure highly individualized expressions of grief and its evolution over time for any given mourner.

Viewed in this epigenetic frame, grieving can be seen as a *situated interpretive and communicative activity* (Neimeyer, Klass, & Dennis, 2014). It is “situated” in the sense that mourning always unfolds in the context of a given familial, social, cultural, and historical context; it is “interpretive” in that it inevitably entails attempts to make sense of a compelling emotional experience; it is “communicative” as it is intrinsically embedded in spoken, written, and non-verbally performed exchanges with others; and it is an “activity” in that it is an enacted process, not merely a state to be endured. Thus, a fuller understanding of the development of bereavement entails more than a summation of symptomatology or even a phasic transition through essential stages that merely vary in their order or progression as a function of individual psychology. It is to this more nuanced and contextual understanding of the development of grief that we now turn.

Toward a Developmental Model of Grieving

The individuality of grief arising from the epigenetic systems perspective notwithstanding, some broad continuities can be discerned in adult mourners who encounter various developmental challenges in the course of their bereavement, particularly when the loss involves an intimate attachment figure (such as a child, partner, parent, or other loved one, such as a best friend or close sibling). To describe these challenges we draw upon the classical scaffolding of Erikson's conception of development as a series of “crises,” each of which entails contending

with a dialectical tension between two poles (e.g., trust vs. mistrust; autonomy vs. shame and doubt; ego integrity vs. despair) (Erikson, 1968).

Like Erikson, we propose that satisfactory resolution of these tensions at a given point in development entails grappling with both poles of each dichotomy, and doing so in a given social field and historical and cultural context, which when done successfully permits fuller and less impeded engagement with subsequent challenges. Optimally, this process leads to a synthesis of the polarities of each crisis and establishes the ground for engaging the next. However, unlike Erikson, whose concern was normative “macro” lifespan development from infancy to death, our focus is at the “micro” level of adults facing the challenge of significant loss at a given moment in the life cycle.

For convenience, we describe this process in terms of three successive crises, which meld into one another over the course of bereavement. Here we will briefly outline these crises, underscoring the developmental challenge posed by each, the implicit questions that drive the ongoing quest for meaning in the experience, associated priorities as they arise and shift over time, and the psychosocial needs or supports that promote their satisfactory resolution.¹ More briefly, we suggest some illustrative therapeutic stances and strategies having special relevance to each crisis, pointing toward subsequent chapters in this volume for their further explication. Finally, we will anchor each in an actual case illustration that gives a human face to the developmental tensions that each period of grieving characteristically entails. Table 1.1 summarizes this developmental model.

Early Grief: *Reacting*

The earliest weeks of profound loss are typically characterized by a deep narcissistic wound: the seemingly impossible has happened, and it feels as if a part of the self has been ripped away with the loved one. Early during this period, the mourner often reacts with a sense of emotional anesthesia. He or she may remain in a suspended state of disbelief, or oscillate in and out of reality, for a prolonged period of time. Once the emotional anesthesia begins to wane, and the bereaved begin to feel the full weight of the grief, the pain of the wound feels unbearable. The mourner generally understands this is an irreversible wound, one for which there is no immediate remedy. As weeks meld into months and the numbness gradually abates, mourners may experience great difficulty with self-care, cognition, emotional regulation, physical health, sleep and diet hygiene, spirituality and/or faith, social transactions, and interpersonal

Table 1.1 A developmental model of grief

Period	Time frame	Crisis	Synthesis	Question	Priorities	Psychosocial needs	Therapeutic methods
Early grief: <i>Reacting</i>	Weeks after loss	Connection vs. Isolation	Self-acceptance	How and why did this happen?	Safety, Trust, Survival	Listening, Identification, Compassion	Emotion regulation, Containment
Middle grief: <i>Reconstructing</i>	Months after loss	Security vs. Insecurity	Continuing bond	Where do I locate my loved one?	Validation, Understanding	Audience for stories, Permission to maintain bond	Memorialization, Legacy projects, Imaginal dialogue
Later grief: <i>Reorienting</i>	Years after loss	Meaning vs. Meaninglessness	Posttraumatic growth	Who am I now?	Self-reinvention, Altruism	Permission to change, Signification	Directed journaling, Social action

relationships. It may be easier in this period to withdraw in order to protect oneself from well-intentioned but unhelpful others, particularly if the mourner has not received what he or she so desperately needed in the initial wounding.

This is a critical time for mourners. It is a time when their own wounds are fully recognizable and they also have the opportunity to notice that there are others who are wounded—sometimes by an analogous loss. Most often, mourners will seek out and find those whose stories closely mirror their own. They seek similarity in others' stories for validation of their own emotional state.

Psychosocial needs during this period include an opportunity to express difficult emotions such as anger, rage, guilt, shame, self-blame, despair, and other emotions that many others will deny. It is crucial not to have these emotions dismissed or bypassed. In essence, we bear a duty to provide a safe and nonjudgmental space for the griever to explore and express these states of deep desolation that so many others find unspeakable.

Developmentally, mourners in early grief therefore commonly struggle with issues of *connection vs. isolation*, as they feel that the unique anguish of their loss casts them outside the once “normal” world of relationships shared with others. At the same time, they contend with profound questions about the “event story” of the death, how it can be understood practically, existentially and spiritually, and what implications it carries for their radically changed lives (Neimeyer & Thompson, 2014). Just as they require patient tending and befriending in their grief-related emotions, mourners in this early period also need patient listeners who will join them in their quest to find meaning in the loss, without quickly resorting to their own preformulated answers.

Thus, most crucial in the period of acute wounding is promoting a sense of safety and shoring up the conditions required for mourners' psychological survival, which may at times literally be threatened, as research on elevated risk of mortality in the early weeks of bereavement demonstrates (Stroebe, Schut, & Stroebe, 2007). For example, studies suggest that bereaved mothers who reported compassionate caregiving by providers experienced fewer negative, long-term psychological outcomes than those who felt that their needs to be upheld, heard, and treated with compassion were unmet (Radestad et al., 1996). Likewise, research documents that survivors of homicide loss fare better when their psychosocial needs for grief-specific support are met by others in their social network, whereas they struggle with greater complication as the number of negative, critical, or intrusive relations with others increases (Burke, Neimeyer, & McDevitt-Murphy, 2010). Mutual support groups of mourners suffering similar losses may be especially valuable during this period, providing a context for connection with others whose losses (e.g., of a child, or of a partner through suicide) closely correspond with the griever's own. When the mourner meets with empathic listening and identification from the social world, the crisis of *connection vs. isolation* can be more easily resolved in the direction of *self-acceptance*, that is, a compassionate self-awareness that one's own pain is understandable, legitimate, and mirrored in the lives of others who have suffered similar loss. Accordingly, high degrees of therapist “presence” and “containment” in the form of creating a safe “holding environment” for distressing affect is essential at this point (Neimeyer, 2012d), which may be reinforced by mindfulness as a medium for therapy as well as a prescription for client self-care (Cacciatore & Flint, 2012). Therapeutic techniques for promoting a client's “self-capacities” (Pearlman, 2015, Chapter 31) in the context of meticulous “dramaturgical” listening (Noppe-Brandon, 2015, Chapter 35), as through searching for the felt sense of clients' embodied emotional experience (Farber, 2015, Chapter 21; Neimeyer, 2012a), can advance this goal. Likewise, careful management of support group settings to ensure safety and to prevent re-traumatization (Neimeyer & Sands, 2015, Chapter 59; Spence & Smale, 2015, Chapter 57) can ensure the supportive interpersonal field required for participants to move toward emotion regulation and re-connection, ultimately promoting their self-acceptance of

both their pain and their humanity. A case illustration of a mourner in this early period of *reacting* to loss follows.

Case Illustration

Anna (aged 37) is a Hopi Native American single woman who suffered the death of her 4-year-old son to cancer nine months earlier after he was diagnosed at age 2 with neuroblastoma. Anna sought counseling at the insistence of friends from work who were concerned about her significant weight loss, changes in her physical appearance, and apparent social withdrawal after her son's death. During Anna's first session, the counselor focused on creating a safe space, careful to listen closely to the details of her son's treatment and ultimately his death. Anna expressed feeling anhedonic since his death but did not openly cry or express sadness. The counselor allowed Anna to guide the conversation during the first session, and she tended to focus on the specific details of his diagnosis and medical treatment, as she sought to make sense of the painful reality of her child's death. During the second session, however, Anna disclosed that she felt isolated from coworkers, particularly because many of her colleagues had school-aged children, and they frequently spoke of their activities at work. She found herself "hiding" in her office, and she often felt anxiety every morning while driving to the office. In addition, she also felt disconnected from her tribal family who, she noted, "doesn't allow us to talk about our dead . . . it's a taboo." It became clear that Anna lacked a safe place to talk about her grief, specifically, and she felt she was "sinking deeper and deeper" into a state of loneliness and despair. Her self-questioning was notable during the second session when she questioned whether she was "losing all sense . . . and was turning into that sad and depressed person no one wants to be around."

The counselor continued to listen deeply to her story, validating her experiences of isolation, and providing a relational home (Stolorow, 2007) for her trauma and grief. Rather than pathologizing her grief, the counselor helped Anna see more clearly her pattern of increasing isolation and self-doubt. She began to understand that others might not understand her experience of loss the way she'd hoped, and thus, she was able to gradually augment her expectations. She was also able to speak with a supervisor at work. He privately asked others to be more aware of Anna's sensitivity to discussions about their living children. Finally, as relational trust expanded, Anna began to access and express her grief during sessions. She began to trust herself—and her suffering—more every week. Eventually, she was able to speak with her family about how their tradition of silence felt hurtful to her. While they did not agree to change their cultural proscription, she did feel relief by merely engaging in open dialogue with them. By the end of the third month, Anna was ready to attend a support group for parents. Here, she found like-others with whom she connected and maintained close relationships for several years. While the grief remained palpable, Anna no longer felt so disconnected from herself, from others, or from her grief. She felt better able to tolerate the undulations of painful affective states.

Middle Grief: *Reconstructing*

As in Eriksonian theory, our model presumes that satisfactory resolution of the crisis of *connection vs. isolation* in early grief establishes a context for engaging later challenges that come into focus in the months that follow. As mourners contend with the permanence of the loss of a significant attachment figure, they may struggle with a profound sense of emptiness,

preoccupation with the loss, and yearning for that which eternity will not return—at least in the embodied human form they crave. As in Bowlby’s formulation of the attachment and caregiving behavioral systems, the bereaved may find themselves cut adrift from the secure mooring previously afforded by their bond with a living loved one who cared for them or to whom they provided care, or both (Bowlby, 1980). Lacking this tangible tether, mourners may struggle with substantial separation anxiety expressed in pining and yearning for the one who died, restlessness, hypervigilance, autonomic arousal, and susceptibility to panic. This crisis of *security vs. insecurity* is commonly accompanied by agitated concern with the question of where to “locate” their loved ones, spiritually, emotionally, and socially in the form of being able to speak their name, tell their stories, and find some ritual support for doing so in a creative or culturally sanctioned way. Thus, in addition to attempting to process the “event story” of the death, an imperative that commonly arises in the early weeks of bereavement, as time goes on grievors often struggle to access the “back story” of their relationship with the deceased in a way that restores their sense of attachment security (Neimeyer & Thompson, 2014).

Psychosocial needs of mourners during this period include the generous provision of validation for the loved one’s ongoing importance and “presence” in the mourner’s life, predicated on understanding the griever’s attempt to *reconstruct* rather than *relinquish* the attachment bond in a form that is sustainable in the deceased person’s physical absence (Klass, Silverman, & Nickman, 1996). This implies family, community, and cultural permission to conserve the connection, optimally by offering opportunities to “introduce” the deceased to others in conversation and find inspiration in the loved one’s life story or the story of their love (Hedtke & Winslade, 2004). Optimal negotiation of this developmental crisis can lead to a continuing bond to the deceased attachment figure, but like other healthy attachments, not one that precludes loving connection to others. Indeed, the network of other relationships also commonly is reaffirmed or reconstructed during this period, as the mourner strives to rebuild sustainable routines and patterns in a life narrative disorganized by the loss.

Mourners who struggle greatly with reconstructing a living bond with the deceased can benefit from all manner of creative therapeutic assistance, from symbolic correspondence and imaginal conversations with the deceased (Bogatin & Lynn, 2015, Chapter 43; Neimeyer, 2012b, 2012c), to creative practices for private (Harris, 2015, Chapter 30) and public memorialization (Henning, 2015, Chapter 45; Stoll, 2015, Chapter 46). In this way both intimate and communal spheres can assist with the task of locating the deceased as a figure having continued relevance for mourners and others who knew or who might yet come to know the deceased through stories that can be circulated with the living. The continuation of our case study illustrates many of the challenges of this developmental period and the psychosocial resources that facilitate their resolution.

Case Illustration

Anna continued in support group for 18 months after her son’s death. As others in her social world often did not acknowledge Anna as a mother, for example on Mother’s Day, friends from her support group consistently recognized her, an enactment of compassion that was received with gratitude on her part. In counseling, she learned and practiced “mothering” her son through public rituals, often enacted with the aid of other bereaved parents. On his birth and death dates, she and others visited his grave and decorated. She attended candle-lighting ceremonies and volunteered for other charities “to make him proud.” Prior to counseling, when asked if she had children, she would respond in the negative. Her response, since, had shifted. She now responded that she “has a son who

died in 2011” because she felt she was “still a mother, even if he died.” By the end of the 18th month, Anna no longer felt the need to ritualize him publicly and her ritual moved to the private sphere. This transition was not distressing for her; rather, it felt like the “natural” thing to do. Every morning, she lit sweet grass for him. She remembered him in her prayers. And she often connected with him through the natural world. He had a peculiar interest in owls, and she began collecting owl totems in his memory. She said they helped her feel “connected to his spirit.” She also created an altar in her home for his keepsakes and other mementos. Importantly, therapeutic intimacy deepened despite the relative infrequency of the sessions, which had now declined to once or twice every few months. Counseling, she said, gave her a place to “process feelings and feel validated as his mother . . . even after all this time.”

Later Grief: Reorienting

Finally, as the months meld into years after a life-altering loss, mourners frequently face the daunting task of revising their self-narrative: Who are they now, in the physical absence of their loved one? Insofar as the meaning of our lives is intimately interwoven with our closest relationships, their loss can stretch or rend the very fabric of our identity, necessitating its repair or reweaving through the projection of new goals that do not require the physical presence of the loved one. Mourners thus confront a crisis of *meaning vs. meaninglessness*, as they strive to restore or reinvent a sense of coherence between the person they were before the loss, the person they are now in its disorienting wake, and the person they will become as they move uncertainly into a rewritten future self-narrative (Neimeyer, 2011).

In this process of reorientation, mourners require something different from their families and social world—not so much support for where they *are*, which they might well have welcomed in early grief, but instead support for who they *might yet become*. When the bereaved receive permission to change in response to major loss, to reorder life priorities, and to live more in conformity with their often-altered core values, they may review and revise time-honored spiritual commitments, drawing on their experience of suffering to discover new strengths, to transcend their former place in the world. This is often done while recognizing that the price for such transformation was far too high. Met with this receptivity, the priority given to self-reinvention can energize posttraumatic growth in any of several domains, especially when grief is substantial enough to prompt a review of previous assumptions, but not so intense as to be overwhelming (Currier, Holland, & Neimeyer, 2012).

Perhaps the most salient feature of such growth in later grief is the broadening and deepening of compassion for the suffering of others (Cacciatore, 2014). Although mourning the death of a child, the premature loss of a parent or spouse, or another highly significant relationship can last a lifetime, the person who has been able to negotiate the crises of *connection vs. isolation*, *security vs. insecurity*, and *meaning vs. meaninglessness* is more likely to experience what the mystics consider transcendence or transfiguration. In this place, the hearts of grievers are softened and turned outward toward others, even others who are less like them (Cacciatore, 2014). Over time, for example, a bereaved parent whose adult child died may be able to find him- or herself relating to another grieving parent who may have experienced the death of a baby or young child. Gradually, the same parent might extend deep empathic concern to a person who lost a spouse or parent. As the heart turns more and more outward, the same person may ultimately recognize some version of his or her own pain in a homeless person, in those suffering terminal illness, or in people living in poverty in a distant country. Ultimately this compassionate stance may find expression in acts of loving kindness, perhaps done in memory of their deceased loved ones (Cacciatore, 2012). Therapeutically, forms of directed journaling

that encourage people in later grief to reflect on the unsought benefits in the loss (Lichtenthal & Neimeyer, 2012) or on the spiritual lessons it has conferred (Pearce & Smigelsky, 2015, Chapter 37) may help prompt or consolidate such growth, but this should never be hurried along by the therapist (Calhoun & Tedeschi, 2013). A Buddhist workshop focusing on the meaning of suffering, impermanence, and self-transcendence has shown promise in alleviating bereavement distress in later grief, as well as promoting personal growth in participants (Neimeyer & Young-Eisendrath, 2015). Anna's ongoing negotiation of this crisis provides the bedrock for altruism, meaning, and renewed life priorities.

Case Illustration

By the middle of the second year post loss, Anna started to feel a pressing urge to help others, even those unlike her. She noted in one session that when she first started attending support group, she “only related to parents whose young children died of cancer.” By this point, however, she noticed her heart softening toward other parents whose children died of other causes and at varying ages. This opening of her heart “surprised” her in a “good way” and, thus, her connections and resources expanded ever more. She also decided to return to school for a graduate degree in social work, hoping to reach out to other Native American mothers whose children died. She stopped formal counseling once she started back in school but kept in touch frequently. Anna became a facilitator in her support group and also had a profound shift in her spirituality, which she accessed through poetry. She began to read and write poetry as a means to connect with the numinous. Anna also found herself committed to helping with animal rescue on the Indian reservation, an act of altruism that had never appealed to her. She didn't know how to explain this sense of duty toward the animals' suffering on the reservation, but she experienced tremendous reward in aiding them. Over the course of almost 4 years since losing her son, Anna has experienced depths of grief she never imagined. She would thankfully give anything in exchange for her son's life. Yet, she has returned to a place of equilibrium, acceptance of her new identity and life purpose, and feels that she has grown through the darkness of grief.

Developing Through Grief: Closing Reflections

Viewed through an epigenetic lens, grief can be understood not so much as a set of symptoms or stages, but instead as a developmental transition prompted by disruptions to the mourner's world of meaning occasioned by significant loss. Of course, seen as a situated interpretive and communicative activity arising in the context of a unique biology, psychology, social milieu, and cultural frame, grieving inevitably will be highly variegated in its form and its progression. But in this brief chapter we have also tried to sketch some broad continuities encountered by many of those adults who are faced with life-altering loss, linking these to normative crises (and opportunities) introduced by the death of a loved one, to the existential questions such crises raise, and to the personal priorities and psychosocial needs each entails. Here we will underscore a few further implications of this developmental view for both clinicians and researchers.

First, by describing broad challenges associated with grieving, we are not suggesting that these take the form of stages or phases that “turn on” or “click off” in some predetermined pattern. Instead, like other developmental capacities such as a child's learning to read, or to adopt the perspective of another person, the outcomes we envision (self-acceptance of one's grief, construction of a continuing bond with the deceased and posttraumatic growth) emerge

gradually and uncertainly over a considerable period, facilitated by a psychosocial system that supports their acquisition. Moreover, we recognize that each of the three periods we have outlined can only be located very approximately in time, each melding into the next as development moves forward from early reacting to eventual reorientation. And of course, nothing is inevitable about such movement; when the challenge posed by the loss is minimal, as when the death is expected, appropriate, or carries few implications for the attachment security or life meaning of the survivor, no significant perturbation may occur, and hence no developmental crisis may arise. Likewise, problematic transactions at or between any levels of the epigenetic system (bio-genetic, personal-agentive, dyadic-relational, or cultural-linguistic) can impede movement through the sequence, arresting optimal negotiation of each successive challenge and contributing to complications. It is for this reason that we acknowledged the possible role of therapy in confronting or circumventing such impasses to support the mourner's adaptive development through grief.

Second, we acknowledge that our sketch of the developmental trajectory through grief is offered in broad brush strokes, and that more refined renderings of this transition are possible. For example, just as Piaget's pre-operational stage of child development can be further differentiated into substages concerned with symbolic functions and intuitive thought (Piaget, 1971/1937), so too the developmental periods we have outlined might well be subdivided or supplemented to create a more detailed depiction (in fact, we hint at this possibility by noting a shift from numbing to keenly feeling the wound of loss in our description of early grief). Our preference to limit ourselves to a few more general periods is based partly on considerations of parsimony—not wanting to propound a highly elaborate theory where a simpler one will do—and also on our observations of the messy, nonlinear reality of grieving in the clinical context, where variations in any proposed sequence are the rule rather than the exception. Furthermore, we have not explicitly included children's grief in this model, because we suspect that the priorities of early grief to provide containment and security may predominate for very young children, and because the developmental capacities to support later processes in the model (e.g., to entertain imaginal dialogues with the deceased, pursue legacy projects, or turn grief toward altruistic social action) are themselves likely to emerge in the course of maturation, becoming more readily available in adolescence and adulthood. Of course, extension and refinement of the model to offer a more detailed or lifespan view are both feasible and welcome.

Third, we hope that this model offers some useful heuristics for other clinicians who seek to help clients struggling individually, in families, or in groups with the crises of isolation, insecurity, and meaninglessness that we have described. In linking these emotionally wrenching states to the quest for meaning implicit in each, as well as to the psychosocial resources that might be mobilized to support their positive resolution, we hope to suggest a range of therapeutic procedures relevant to this goal. Indeed, we believe that the present volume, like its predecessors (Neimeyer, 2012e; Thompson & Neimeyer, 2014), offers a cornucopia of affective, meaning-oriented, active, and ritualistic resources for engaging in this work.

Finally, we want to emphasize that the present developmental model, though consistent with current evidence, invites more trenchant empirical validation and modification. Recent years have witnessed the construction and validation of a trove of specific psychometric measures—many of them presented fully and conveniently in the following section of this volume—bearing on grief-related distress and symptomatology, meaning-making, the continuing bond, social support in bereavement, and personal growth. As these and other measures help operationalize many of the components in our model, they encourage research on its propositions, and also offer tools to clinicians seeking to evaluate a client's progress from grief to growth on any of several dimensions.

In summary, we hope that the reader will find in the model a useful, if partial, frame for understanding grieving as a process emerging from the interaction of several nested contexts.

Rooted in our embodiment as biological beings, evident in our personal quest for meaning in the wake of profound wounding, interwoven with our lives with others, and framed in geographically and historically circumscribed cultural discourses, grief can be viewed as a developmental transition, rather than merely a state to be endured or treated. Like the many other such transitions, welcome and unwelcome, of which life consists, we believe that with optimal negotiation of the challenges it presents, grief offers gains that at least partially compensate for the losses it inevitably entails.

Note

- 1 Thus, we focus here primarily on the middle layers of the epigenetic model, those concerned mainly with personal–agentic needs and priorities and dyadic–relational supports for their resolution. However, we recognize that these same needs presuppose bio–genetic factors unique to each mourner, and that the relational field is ultimately embedded in a broader cultural and historical matrix that constrains and enables specific social interactions.

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2

Grief is a Form of Love

M. Katherine Shear

The close relationships we develop with special people in our lives are at the heart of what we care about most deeply and bereavement brings our most profound experiences of pain. Each love relationship is unique, beginning with the earliest bonds between an infant and his or her caregivers and continuing with close friends, romantic partners, and one's own children and grandchildren. Romantic partners and children are the most important attachments for most adults and many of us hold especially close our relationships with parents, siblings, other relatives, best friends, or work comrades. Regardless of how many close relationships we have, and with whomever we have them, each person we love is unique and special in her or his own way. It follows that grief when we lose that person is also a unique experience. Yet there are commonalities in these universal experiences and these constitute a framework for understanding loss that can provide a helpful scaffold for those of us who work with bereaved people.

Grief counseling requires us to be deeply in tune with bereaved individuals and to stay present with them as their story unfolds. At the same time, we need to be Sherpa guides, separate from our clients, as we help them observe and navigate the challenging terrain of loss. We need to appreciate each person's unique experience, allow our clients to share their pain and their joy, and help them see possibilities for pathways of restoration. The purpose of this chapter is to outline some observations that derive from the idea that grief and love are inextricably linked and to use this framework for understanding bereavement, grief, and adaptation to loss in a way that can guide work with bereaved people. We begin with a brief discussion of love relationships.

What is Love?

Surely we all know the answer, yet the word love was the second most searched for term in the *Oxford English Dictionary* during 2013 (OxfordWords blog, 2014). Perhaps we intuitively know that we do not quite understand it. Researchers have been studying love for several decades and they have discovered interesting things. We review only selected highlights of the findings as the body of work includes thousands of studies—far too many to summarize in this brief chapter. Let us start with the idea that love is not one thing. The word is used as both a noun and a verb and either way it serves as a shorthand term for a complex multifaceted time-varying experience. For our purposes we will focus primarily on love as an attachment relationship and summarize some of the work done by attachment researchers. *Merriam-Webster*

defines attachment as a strong feeling of affection or loyalty, essentially the same as the definition of love. Attachment relationships can be operationally defined (what researchers need to do) as involving two people who find it rewarding to be together and prefer not to be separated and who provide each other with comfort and solace when one of them is feeling badly and serve as coaches and cheerleaders, capitalizing on things when they are going well.

We are biologically predisposed to seek, form, and maintain attachment relationships throughout our lives and to respond to their loss. The brain attachment system has been called a biobehavioral motivational system and the posited brain mechanism called an attachment working model (Mikulincer & Shaver, 2014). The existence of the working model is inferred from a body of work demonstrating that representations of close relationships are stored in long-term memory and are retrieved in a wide variety of situations (Bowlby, 1980). Importantly, memory and other functions of our internalized relationships exist in areas of the brain associated with implicit functions that are out of awareness, as well as in areas associated with explicit functions that are part of our conscious thoughts. The internalized versions of our close relationships have been shown to affect a wide range of cognitive functions, such as reasoning, problem-solving, cognitive control mechanisms, predictions of the future, and goal pursuit. In fact it seems that whenever researchers look at a psychological outcome to see if attachment affects it, they find that it does.

The goal of the biological attachment system is attachment security defined as the belief that a loved one is available, sensitive, and responsive. Insecure attachment occurs when there is uncertainty about the availability of a sensitive responsive caregiver. The internalized representation of a secure relationship can serve proximity-seeking needs and contributes to mental processes important to self-regulation and self-concept. Close relationships are characterized by high levels of interdependence and are cornerstones in the construction of our self-concepts. In spite of the high cultural value we place on independence in the West, research findings suggest that our interpersonal self may be more fundamental to our self-concept than any inner-directed models of self (Cacioppo & Cacioppo, 2012). Strong, satisfying relationships that are mutually rewarding have the most impact on the sense of self. The better the relationship the greater the relational self-construal, the greater the sense of self-affirmation and self-authenticity, the greater the experience of self-expansion, self-concept complexity, and self-concept clarity. Plainly put, the people we love define who we are so when we lose them we are confused about our very selves, disoriented, and lost.

Positive, rewarding relationships that feel secure have also been found to influence a wide range of daily psychological processes, such as tolerance of ambiguity, emotion and attention regulation, empathy and compassion, and suppression of unwanted thoughts. Our relationships contribute to biological regulatory processes as well (e.g., sleep quality, eating behaviors, pain sensitivity, temperature sensitivity, hormonal and immune function, cardiovascular reactivity, and inflammatory responses). Losing a person with whom we have a close and positive relationship has a profound impact.

What does all of this have to do with bereavement? In plain language, people we love affect us deeply in ways that we know and also in ways that we do not know. This means that losing them also affects us deeply and in many ways that we are aware of and some that we are not. It is because our loved ones are so deeply and naturally intertwined in our lives that we experience such a profound and lasting disruption when they die. But there is more. The attachment system is closely linked to at least two other behavioral systems important in everyday life. One is the caregiver system that provides the motivation to provide a safe haven of support and reassurance when a loved one is under stress and to provide a secure base of encouragement and pleasure in a loved one's success. Adult love relationships are almost always reciprocal such that partners both provide and receive safe haven and secure base care. Moreover, existing evidence suggests that for adults, being an effective caregiver is even more important to

well-being than being the recipient of effective care. Losing a loved one registers as failure of effective caregiving and is often associated with self-blaming thoughts and feelings of guilt.

The second important behavioral system linked to attachment is the exploratory system. This system contains the desire to explore the world, to learn and grow, discover new things, and accomplish goals. The exploratory system is central to basic human needs for autonomy and competence. There is a reciprocal relationship between attachment and exploratory system activation. The attachment system is activated when there is a perceived threat to an important relationship. Losing a loved one is clearly such a threat and one of the consequences is to inhibit the exploratory system. Now let us look at the terrain of loss from an attachment theory perspective.

Bereavement

According to our attachment framework, the death of a loved one has a wide range of effects beyond the painful awareness that the person is gone. Bereavement registers in the attachment system as acute attachment insecurity—in other words, perceived uncertainty about the availability of responsive caregiving. Insecure attachment is a term used most often to describe a person's attachment style and refers to a characteristic way of experiencing close relationships that is rooted in a person's earliest experiences (Bowlby, 1980). An insecure attachment style is a risk factor for a whole range of psychological problems, including depression and anxiety and difficulty coping with stress.

Researchers have identified both a “generalized” attachment style that is like a personality trait and also a specific attachment style that characterizes each specific close relationship. People usually experience close relationships similarly so generalized and specific attachment style are usually the same, but not always. Sometimes we have an insecure generalized attachment style and a secure attachment to a specific person or vice versa. The term insecure attachment can also be used to describe the temporary reaction to a transition in an attachment relationship. Losing (or forming) a close relationship is a period in which it is very natural to be insecure about one's expectations of a loved one. In particular, when a loved one dies we are suddenly confronted with uncertainty about our relationship with that person. Needless to say this is especially difficult when we have had a strong positive relationship with the person. Loss of that person undermines our sense of self, our cognitive, emotional, and physiological regulatory functioning.

Regardless of which type of insecure attachment we are thinking of, this response is associated with activation of the attachment system with different consequences based upon whether reunion with the attachment figure is deemed feasible or not. If reunion seems possible, proximity-seeking behavior is hyperactivated in order to find and join the person. If impossible, an attempt is made to deactivate proximity seeking. In the initial period after a loss most people fluctuate between hyperactivating and deactivating behaviors. They alternate between a kind of irrational hope that somehow the person will return and awareness of the reality that the loss is final.

In addition to creating attachment insecurity, the death of a loved one registers as ineffectiveness of caregiving and signals a period of inhibition of the exploratory system. Put another way, bereavement creates profound destabilization, a little like an earthquake that shakes the foundation of our lives. Grief is our immediate, in-the-moment response to this destabilization. Grief is usually very intense and dominant in the initial aftermath of the loss and it is gradually reshaped over time. Adaptation to the reality of the loss reshapes grief. Adaptation entails learning (revising memories) what the finality and consequences mean, assimilating this information into the working model, and redefining our selves in order to restore our capacity to engage in life, regulate ourselves, rebuild connections, and discover new possibilities for

satisfaction and joy. Many call this adaptation process “finding a new normal.” Let us use this perspective to look a little more closely at grief and adaptation to the loss.

Grief

Grief is the response to bereavement, a natural response to loss of a loved one. Like the love that spawns it, grief is not one thing but rather a shorthand term for a complex multicomponent experience that varies and evolves over time and whose specific features are unique to each person and each loss. In this and other ways grief resembles love. Losing a loved one begs the question of what exactly happens when someone close dies. Does our love die too? Most people would claim that it does not. So if love does not die, does it continue unchanged? Again, the answer is surely no. We can love someone deeply after they die, but it is not the same as loving a living person. If love does not end and it does not continue unchanged, what happens to it? For one thing, it becomes infused with yearning and longing and sadness—the core features of grief. Other features of grief are also directly connected to love. Grief is the experience of the absence of the myriad functions outlined above that our love relationships provide. In other words we still love a person who died, but our love takes the form of grief. As such, grief is natural and inevitable. However, it is not static. In general, grief emerges after a loss and seeks its rightful place in the life of a bereaved person. The process of adaptation is the process of finding a home for grief where it is accepted and honored but is not the whole story of a person’s life. A grief story unfolds over time in a process that is not smooth or predictable, but there are some general principles that can help track and guide the process.

Adaptation to Loss

There is no timetable or progression through stages that describes adaptation to loss but in general the process entails learning what it means that a loved one is gone—the finality and consequences of this, learning how to have a new kind of continuing relationship with the deceased and envisioning new ways to have a meaningful life with the possibility of happiness even though a loved one is gone. In general these processes proceed in tandem (Stroebe & Schut, 2010). We begin to envision our lives even while we are still figuring out what the loss means. Bereavement is very often a period of highly activated emotions so there is a need for emotion regulation. Typical ways to regulate emotions during acute grief include oscillating attention between engaging with painful information and turning away, employing self-observation and reflection with reappraisal of troubling aspects of the loss, being open to meaningful companionship, and practicing self-compassion. In addition, positive emotions helpful in emotion regulation may be evoked by having warm, positive thoughts of the deceased, by allowing oneself times of distraction, amusement, pleasure, and pride, and by doing satisfying or pleasurable activities. Adaptation also requires reinventing oneself and this goes best if people follow principles of self-determination. This means attending to identifying intrinsic interests and values and planning ways to actualize these in feasible activities.

Researchers have been amassing evidence that much of our brain operates out of awareness. Among other things, there is evidence that we possess a brain mechanism that functions to protect us from threats to our psychological well-being. This “psychological immune system” is engaged automatically and is especially active when we find ourselves in a situation such as bereavement, which is permanent, out of our control, and highly threatening. However, we can get in the way of this adaptive process by trying too hard to ignore, avoid, or rewrite the painful reality. Examples of this are people who focus on second guessing a loss (e.g., thinking that if only someone had done something different their loved one would still be here), those who try to avoid any reminder of the loss, or those who try to escape from the pain of the loss

by spending too much time trying to feel close to their loved one by touching, smelling, hearing, or viewing things that belonged to the deceased. When adaptation does not occur, acute grief persists along with the interfering (complicating) processes, producing a recognizable syndrome of complicated grief. Our work has focused on helping grief counselors recognize complicated grief and help people resolve the complications and facilitate natural adaptive processes (Shear, in press; Shear, Boelen, & Neimeyer, 2011).

Concluding Thoughts

Grief is the universal response to the loss of a loved one because grief is the form love takes when someone we love dies. That does not mean that grief is one thing. Love is not one thing either. We love each special person in our lives in our own unique way. So too we grieve in our own way for each person we lose. Yet there are commonalities in love such as affection, proximity-seeking behaviors, and providing mutual support and there are commonalities in grief such as yearning and sorrow and insistent thoughts and memories. There are also common processes that underlie adaptation. Knowing about what is common in grief and being open to learning and sharing each person's unique experience can optimize our effectiveness as grief counselors.

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The Dual Process Model in Grief Therapy

Emmanuelle Zech

This chapter provides an introduction to the Dual Process Model of Coping with Bereavement (DPM) (Stroebe & Schut, 1999), with a description of two cardinal stressors and ways of coping with bereavement, the importance of coping flexibility (oscillation), and their relationships with attachment styles. It also outlines where difficulties can arise for the bereaved person and stresses the importance of therapeutic presence, attitudes, and relationship to facilitate acceptance, freedom of choice, and flexibility in grief processes and thus personal development.

The Dual Process Model of Coping with Bereavement

The DPM integrates cognitive stress theory and traditional grief theories. It was specifically developed to address two categories of stressors and their corresponding bereavement-related coping strategies, in particular when dealing with the death of a spouse. According to the DPM, effective coping with bereavement includes dealing with both loss-oriented (LO) and restoration-oriented (RO) stressors. LO stressors include coping with the loss of the deceased person (e.g., working through grief, searching for the meaning of the loss, thinking it through). They include situations in which the bereaved is confronted with the loss of the relationship and bonds to the attachment figure. Exposure to such stressors can be generated by external events, such as a conversation, or inner experiences, such as self-generated memories of the death. It also includes the painful uncontrollable emotions (e.g., yearning, loneliness) that arise from the loss and that need to be coped with. By contrast, RO stressors include coping with secondary stressors that come about as a consequence of the bereavement, are related to an altered life and psychosocial changes after the loss, and involve stressors such as financial, household, skills matters, shifts in identity (e.g., from wife to widow), roles, responsibilities, and interpersonal relationships.

The specification that there are two categories of bereavement-related stressors implies shifts of attentional and coping focus from demands of one situation to another. An essential postulate of the DPM is thus that, throughout bereavement, bereaved people will oscillate between confrontation and avoidant coping strategies addressing LO and RO stressors as they occur in their daily lives (Stroebe & Schut, 1999). Oscillation was defined as a dynamic coping process of alternation between and within LO and RO, between positive and negative evaluations of the encountered situations, and between coping and absence of coping (resting, taking

time off from grieving). It is a process of confrontation and avoidance of the various stressors and situations associated to bereavement on a moment-to-moment basis. The DPM postulates that this process is essential for optimal psychological adjustment to the loss. Following this principle, the ability to effectively cope with the loss of a significant person implies an ability to remain flexible in dealing with both LO and RO stressors and in evaluating the situations as positive or negative. According to the DPM, deficits in flexible coping processes are assumed to contribute directly to the occurrence of either severe or absent grief reactions. Thus, on the one hand, individuals who focus exclusively on LO stressors, avoiding the RO stressors, should experience “chronic” or persistent grief. On the other hand, bereaved individuals who focus exclusively on RO stressors, avoiding the LO stressors, should experience little or no sign of grieving. These hypotheses have mainly found empirical validation (e.g., Caserta & Lund, 2007; Delespaux, Ryckebosch-Dayez, Heeren, & Zech, 2013).

DPM, Attachment, and Grief Therapy Strategies

In bereavement, the attachment behavioral system is activated because death signals the loss of an attachment figure. Accordingly, the types of affective, cognitive, and behavioral reactions and coping strategies characterizing the bereaved person can be explained by his or her attachment style (Stroebe, Schut, & Boerner, 2010; Stroebe, Schut, & Stroebe, 2005). Secure attachment is characterized by ease in being close to others, by feeling comfortable depending on others, and by people’s comfort in having others depend on them. It would be associated with flexible oscillation between coping strategies, integration of both positive and negative meaning-making within each dimension (e.g., experiencing both painful yearning and soothing memories of the relationship with the deceased), and related to an uncomplicated course of grieving.

However, there are three cases of insecure attachment that represent potentially problematic bonding after the death. First, people scoring extremely high on attachment-related anxiety (preoccupied) are known to show extreme dependence on their partners as well as elevated preoccupation with relational closeness. Thus, they should appraise the loss of their attachment figure in a very negative way and tend to focus exclusively on LO (e.g., yearning and rumination) as a result of which they are at greater risk to develop severe grief reactions. In fact, in this case, the bond would be too strong and tight and the bereaved would be too dependent on and cling too much to the tie to be able to recover from grief: they would be unable to loosen or relinquish it. The link established by empirical research between anxious attachment styles and severe grief reactions supports this argument (e.g., Delespaux et al., 2013; Meier, Carr, Currier, & Neimeyer, 2013). Second, people scoring extremely high on attachment-related avoidance (dismissive) keep a safe distance from attachment figures and develop compulsive independence. After the loss of a significant person, they would deny the need for grieving over the loss of an attachment figure, push away thoughts related to the loss, and maintain their ability to cope alone. In this case, the bond would be too loose or denied and the bereaved would avoid suffering and behave as if nothing had happened. They would be more prone to show few signs of grieving and absence of grieving in extreme cases. Existing evidence is less clear about whether dismissive individuals who sometimes downplay the impact of the loss mainly focus on RO, show resilience (e.g., Delespaux et al., 2013), and minimal expressions of grief in most circumstances, but evidence exists that sometimes they present more intense grief reactions (e.g., Wijngaards-de Meij et al., 2007) and negative health effects when the losses are very severe, as in cases of violent death (Meier et al., 2013). Third, people scoring extremely high on both attachment dimensions (disorganized or fearfully avoidant) want closeness with others but feel uncomfortable with it and fear rejection. Like those with an avoidant style, they find it difficult to trust others, but, like those with a

more anxious style, they would actually like closer relationships. Because of this complex and confused bond to the deceased (“I need you but I reject you”), they theoretically would show the most disturbed oscillation processes and grief reactions, with high levels of anxiety, depression, traumatic and grief reactions, as well as physical symptoms.

In line with the oscillation principle of the DPM, Stroebe and colleagues (2005, 2010) proposed that insecure preoccupied people could benefit from loosening their ties to the deceased, relocating the deceased, and rebuilding their lives more independently. Dismissive people could benefit from doing more loss-oriented tasks such as reviewing memories of the deceased, continuing their bonds, and reflecting on the significance of the deceased person in their lives. Fearfully avoidant people would benefit from being guided toward confrontation and continuation of the bond with the deceased in order to help them build a coherent understanding of the meaning of the past and current relationship to the deceased.

It should be noted that, in practice, dismissive persons are unlikely to show up in consultation because their strategy is precisely to avoid or suppress the idea or fact that there might be a problem and because they have a negative view of others, which may make them disinclined to seek help from another person. In contrast, preoccupied persons are likely to consult because of their intense suffering and need to express their emotions and grief. People with a disorganized attachment might show up in consultation but present complex interactions with the therapist, involving frequent breaches to the therapeutic setting due to their sudden intense reactions and needs to be helped as well as feelings that others cannot be trusted. Studies have indicated that attachment styles are related to therapeutic change processes and outcomes in clients (Levy, Ellison, Scott, & Bernecker, 2011) and to the way the relationship with the therapist will evolve over the course of therapy (Mallinckrodt, 2010).

Core Therapeutic Conditions

The relevance of the DPM for grief therapy is explicitly outlined in the model itself. Its most obvious application is that bereaved people should be guided toward flexible oscillation between different parts of the model (e.g., positive–negative meaning making, LO–RO tasks, coping–resting, confronting–avoiding, continuing–relinquishing bonds). Although this may suggest a psychoeducational and cognitive behavioral orientation to therapy, this is only one possibility, and not one that characterizes my own practice. There are several reasons for this that relate to who I am, my philosophical, scientific, and counseling background, and my experiences with bereaved clients. While I concur that oscillation and flexibility is also my objective, I mainly draw on the DPM to help me feel sure of the bereaved person’s self-development through the ever-present oscillations in her or his experience, as tiny as they might be. My understanding of research on the efficacy and effectiveness of psychotherapy in general (e.g., Norcross, 2011) and with bereaved people in particular (e.g., Currier, Neimeyer, & Berman, 2008) supplements and supports the DPM and its integration with attachment theory to give me greater confidence in the work.

At least as important, my contacts with bereaved people lead me to conclude that they most benefit from three therapeutic principles that fit with a less directive, more person-centered and experiential approach. First, for me, the therapeutic approach adapts to the dynamic, evolving grief processes, moment by moment, in the “here and now” (Zech, Ryckebosch-Dayez, & Delespaux, 2010). Grief and therapy are dynamic processes that evolve over time and fixed, presupposed, or rigid strategies, tools, or techniques should not be systematically used. To achieve more flexibility, the client needs a therapist who is flexible and nonjudgmental. Forcing a change will only heighten the person’s defenses, perhaps even leading to a deterioration of the mental health of the client. For example, most bereaved individuals will report ambivalence over the relinquishment or continuation of their bond to the deceased.

Understanding the positive and negative meanings related to retaining bonds to the deceased as well as those related to loosening them from the bereaved people's perspective is a better strategy, letting them choose to change (or not) rather than arguing in one or the other direction. Empathic understanding and unconditional positive regard will thus be essential.

Second, rather than applying common therapeutic strategies, tools, or techniques with bereaved people, the therapist should adapt to the idiosyncratic characteristics, expectations, and processes at hand with a particular client. Clients' grief experiences can only be understood in the general context of their lives and structures of their self. It is thus important to consider grief processes in the context of a holistic view of the bereaved person, including behavioral, emotional, cognitive, physical, spiritual and existential, social, economic, and cultural aspects. As central as it is, bereavement is simply a part of the client's complete life, which itself can contribute complications or resources for the client's adaptive efforts.

Third, the therapeutic approach implies building and maintaining a secure relationship with the client, which is particularly relevant in the context of bereavement (Zech & Arnold, 2011). Indeed, having a reliable, warm, empathic, supportive, accepting therapist will allow a revision of the client's insecure working models into more secure models. The therapist could become a safe haven and secure base from which clients could then explore their inner world, including painful or pleasant memories and emotions, destructive and protective defenses, and adaptive and maladaptive behaviors (see Mikulincer & Shaver, 2007). Thus, the therapist-client relationship should be structured in a way that the therapist shows presence, consistency, reliability, and emotional availability (Winokuer & Harris, 2012). As in all psychotherapy, the quality of the relationship with the therapist will be crucial for efficacy in grief therapy. To be able to offer a healing connection, in addition to the obvious importance of empathy and positive regard, the person-centered approach stresses the importance of congruence in the therapist as a core condition of client's change (Rogers, 1967). Therapists cannot fully be present, attuned to, and empathic with the client's experiences if they are incongruent, that is unaware of their own experiences as a person. Without such awareness, they could use their own frame of reference to consciously or unconsciously guide clients toward their personal "solutions" rather than the clients'. Therapists are above all persons with their own values, past and present experiences, and expectations, and they use themselves in accompanying the client. Being self-aware allows for a greater acceptance of their clients' own experiences, and this is expressed through greater presence and empathic understanding. These allow clients to become more aware, understanding, and accepting of themselves, and more free to make their own choices, and thus become more flexible.

A Tale of Two Therapies

Loss of a Father

After several months of grief therapy, a 50-year-old single woman who had lost her father confided to me that, on the day of the funeral, after everyone had left the cemetery, she had returned to the communal field where the ashes of her father had been dispersed following his will. She was upset that he had not been buried or at least kept in an amphora and so had taken a small box to collect and keep some remaining ashes for herself, hiding this "guilty" behavior from other family members. I listened to the significance of this behavior for her and the underlying bonds to her father rather than evaluating the appropriateness of the behavior itself. Understanding its meaning, I reflected my understanding of her fear, emptiness, and sadness not to have him close, to have no concrete access to him, and how important and special he was in her life. After

a few more sessions of active listening to her life, values, and relationships with others and her father, she told me about her intention to return to the graveyard and throw the ashes where “they had to be.” She now felt that she could live without them and allow him to be whole and at peace, relinquishing the concrete part of their bond. She did so, with great relief, the following week.

An Unexplained Accident

Another case was that of an 18-year-old woman who had suddenly lost her boyfriend in a single-vehicle accident. I met her two months after the death, on her mother’s request. Although the client did not want to be there, her mother had insisted and was worried greatly because her daughter had refused to attend school for weeks and stayed in her room, which was filled with her boyfriend’s belongings. The young woman feared that I would align with her mother’s wishes, and push her to return to “normal” life (i.e., go back to school, leave her room). Instead, I tried to understand, setting aside my own beliefs and values about probable academic failure, and focused on her. For her, it seemed so unfair that she and others, in particular her classmates, could continue living (going out, smiling, having fun) while he was dead. With his parents—with whom she was in frequent contact—she felt she was the only one who still really cared, and if she had not, she felt, all trace of her boyfriend’s existence would really be lost. And so she was clinging to the suffering, belongings, and memories. The more others wanted her to “recover,” the more she had to suffer and cry for injustice. I am convinced that my acceptance, warmth, nonjudgmental attitude, and expressed empathy led her in 5–6 sessions to free herself from external social and family rules and advice, accept her inner experiences, and achieve more flexibility in her behaviors. Ultimately, she progressively went back to school and relinquished several boxes of his belongings, keeping some cherished mementos to remind her of the young man she had loved.

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4

Traumatic Bereavement¹

Camille B. Wortman and Laurie Anne Pearlman

One hot summer day when she was 6 years old, Emily discovered her father's lifeless body hanging in their garage. It was a grisly scene, replete with horrific sights and smells. Thereafter, Emily saw a succession of therapists. Each one addressed her reactions to losing her father, and the resulting abandonment that she experienced. In addition, each helped her to mourn the many losses she sustained. While she improved over time, Emily continued to struggle with such symptoms as emotional numbness, an exaggerated startle response, and increased agitation in hot, humid weather. It was fully 25 years before one therapist asked Emily, "Exactly what did you see when you found your father?" Finally, someone had begun to tap into Emily's experience of the grotesque circumstances associated with her father's death, not solely the deprivations it had caused.

Following the sudden, traumatic death of a loved one, survivors like Emily may face what we term "traumatic bereavement," which is characterized by enduring symptoms of both trauma and grief. In this chapter, we discuss the distinctive challenges that arise for mourners who experience traumatic bereavement and for the therapists attempting to help them. We then outline a comprehensive treatment approach developed specifically for survivors of sudden, traumatic loss.

Traumatic bereavement is more likely to occur following certain kinds of deaths, including those that are sudden and unexpected, are untimely, involve violence, are caused by a perpetrator with intent to harm, involve damage to the loved one's body, or that the survivor regards as preventable. Other deaths likely to bring about traumatic bereavement include those in which the mourner believes that the loved one suffered, and those in which the survivor regards the death, or manner of death, as unfair and unjust. Situations in which the survivor witnessed the death, their own life is threatened, or they encounter multiple deaths may also give rise to traumatic bereavement. Sudden, traumatic deaths are the most prevalent kind of death among those between the ages of 1 and 44 (Heron, 2012). The specific types of deaths most likely to trigger traumatic bereavement include accidents, homicide, suicide, disasters, and military combat.

There are several reasons why the sudden, traumatic death of a loved one is typically more devastating than a death stemming from natural causes. First, the initial impact of the loss is likely to be more destabilizing. In most cases, mourners' defenses are completely overwhelmed by what has happened. It is common for survivors to feel that their whole world has been

turned upside down. As one person expressed it, “It was as though someone cut my insides out.” Second, survivors of traumatic loss experience a different constellation of symptoms. Individuals whose loved one died of natural causes typically experience grief symptoms, such as yearning for the loved one or feelings of deep sadness. For survivors of traumatic loss, these grief symptoms are overlaid with symptoms of posttraumatic stress disorder (PTSD) such as flashbacks, disturbed sleep, and avoidance of reminders of the loss. Following a traumatic loss, survivors face the dual tasks of mourning the loss and coping with the trauma that accompanied the death.

Third, following a traumatic loss, attempts to recollect the loved one are often associated with distressing memories or images, such as what happened during the loved one’s death. These images are so disturbing that many individuals try to avoid thinking about their loved one, making it more difficult to process the trauma and mourn the loss.

Fourth, traumatic losses bring about a host of troubling issues that can interfere with the mourning process. In most cases, traumatic death shatters the survivor’s basic assumptions about the world—for example, that the world is predictable, controllable, meaningful, and operates according to principles of fairness and justice, and that one is safe and secure. Survivors also find it difficult to grasp the finality of their loved one’s death. In one study (Lehman, Wortman, & Williams, 1987), individuals who lost a spouse or child in a motor vehicle crash 4–7 years previously were questioned about whether they had accepted that the death had occurred. Forty percent of bereaved spouses or parents stated that they sometimes felt that the death was not real, and that they would wake up and it would not be true. In addition, survivors of sudden, traumatic death often report that they are unable to make any sense of, or find any meaning in, what has happened. The mourning process is especially painful for those who search for meaning but do not find it. It is also common for survivors of traumatic loss to question their faith, and sometimes to abandon it altogether. Survivors may also become preoccupied with the question of what caused their loved one’s death, and who should be held accountable. As Rando (1993) has indicated, it is common for mourners to be obsessed with ideas about how to retaliate against the person who killed their loved one. As one survivor said, “I wanted him to experience the terror and physical pain that my daughter experienced.” Mourners may also struggle with powerful feelings of guilt, questioning themselves mercilessly about things they did, or failed to do, that may have contributed to their loved one’s death. Finally, it is common for survivors to be preoccupied with whether and how much their loved one suffered. As one father expressed it, “I have nightmares about how my son struggled with his killer.”

Fifth, there is no doubt that survivors of sudden, traumatic loss struggle with the ramifications of the death far longer than those whose loved one died of natural causes. In their work on the impact of losing a spouse, Jordan and Litz (2014) maintained that, “in the weeks and months after a loss, this grief typically begins to abate” (p. 180). They reported that most people who lose a spouse show a natural resilience and are able to move forward after a few months. In contrast, it is typical for survivors of a traumatic loss to experience debilitating symptoms that show little improvement over time. This was the case in the aforementioned study by Lehman et al. (1987), which focused on people who lost a spouse or child in a motor vehicle crash 4–7 years previously. Despite the time that had elapsed, bereaved respondents evidenced higher rates of depression, lower quality of life, worse job performance, and higher mortality than respondents who did not suffer a loss. They were also more likely to experience intrusive thoughts about what happened and worry that something bad would happen to them or someone in their family. Individuals who lost a spouse or child reported more conflict with their relatives. An overwhelming majority of respondents reported problems in dealing with surviving children. Those who lost a child were more likely to divorce. Similar results have been reported in many studies of traumatic loss. Taken together, it is clear that in most cases,

survivors struggle with the consequences of traumatic losses for many years, often for the rest of their lives.

Treatment

In developing this treatment approach, our goal was to bring together the accumulated wisdom in the fields of grief and trauma. This approach comprises three core components: (1) building a survivor's internal and interpersonal resources, (2) processing the traumatic death both cognitively and emotionally, and (3) facilitating the processes of mourning.

Build Resources

Many survivors will need to build resources in order to face the challenges of processing the trauma (Cloitre et al., 2010). The *ability to regulate emotion* is one such resource. It includes helping the client learn to recognize feelings, or sense an emotion as it arises; tolerate feelings by being open to experiencing, rather than blocking, them; and modulate feelings by controlling their intensity so they are not destabilizing (Saakvitne, Gamble, Pearlman, & Lev, 2000). A second useful resource is *social support*, the ability to develop and draw on connections to others. The client explores the kinds of support he or she needs at this time and ways to obtain it. Another important resource is learning how to deal effectively with *bereavement-specific challenges*. These situations trigger painful and often unanticipated feelings of grief. For example, a man whose son was killed may be caught off guard when asked how his son is doing in college. Survivors will also benefit from developing *coping skills* such as breathing retraining and self-care. Finally, *clarifying values and developing goals* to reach them can help survivors to create a life worth living. For example, one mother who lost her older son decided that what she valued most was to be the best possible mother to her surviving son. "I arranged a sleepover for my son. I cooked him my favorite dinner. It made me feel good," she said.

Trauma Processing

Because sudden, traumatic death can bring about PTSD symptoms, our approach to trauma processing is based on cognitive behavioral therapy. We use elements of cognitive processing therapy (Resick & Schnicke, 1996) to help clients first identify *distressing automatic thoughts* about themselves, others, or the world, such as "I'm a failure as a parent." The next step involves challenging such thoughts to reduce their impact upon clients' mood and behavior. For example, the therapist asks the client to consider evidence for and against the belief he or she is a failure as a parent. Clients also engage in *emotional processing*, based on prolonged exposure (PE) therapy (Foa, Hembree, & Rothbaum, 2007), in which they confront painful emotions that they have avoided.

Therapists typically employ two kinds of exposure: imaginal and *in vivo*. Imaginal exposure might involve developing a detailed account of the death and reading it daily. With *in vivo* exposure, clients collaborate with the therapist to develop a hierarchy of anxiety-provoking situations. The therapist then supports the client in moving through the list at his or her own pace, starting with a mildly distressing situation. Facing these situations helps clients to process and habituate to their emotions. PE has been shown to be remarkably effective, conferring lasting benefits not only for the reduction of PTSD symptoms, but for depression and anxiety as well (Pearlman, Wortman, Feuer, Farber, & Rando, 2014). In fact, research has shown that prolonged exposure is highly beneficial for people who have been deeply affected by the loss of a loved one, but where the loss was not necessarily sudden or traumatic (Shear, Frank, Houck, & Reynolds, 2005).

Mourning Process

Among traumatically bereaved clients, the unprocessed trauma often impedes the mourning process. We base our approach on Rando's (1993, 2014) six "Rs." The first process is to *Recognize the loss*. Exposure activities, such as writing a letter to the deceased, can facilitate recognition. The second process requires the client to *React to the separation*. This process includes identifying and mourning secondary losses, such as the loss of sexual intimacy or financial stability after the death of a spouse. It is also important for the mourner to *Recollect and re-experience the deceased*. This can be done by assisting the client in developing a realistic assessment of the deceased and their relationship. The mourner must also *Relinquish old attachments to the loved one* by giving up assumptions that were invalidated by the death. For example, a man may have to relinquish his assumption that "my brother will always be there for me." Next, the mourner must *Readjust* his own identity so that it is consistent with the new reality. For example, he may adopt qualities of the deceased, as when a son attempts to be as patient with his own children as his father was with him. In the final mourning process, the client is encouraged to *Reinvest* in a future without the deceased, such as engaging in new, life-affirming pursuits and relationships.

Therapist Issues

Therapists and counselors are likely to encounter two issues with unique manifestations in their work with traumatic bereavement clients. One such issue is *countertransference*, all of the therapist's thoughts and feelings about each client, including the client's losses, adaptations to them, and way of relating to others. While it is an inevitable aspect of psychotherapy, therapists who have experienced a sudden, traumatic loss may find their own grief activated. Even without a history of such loss, sudden or untimely death evokes empathy and can stir fears in the therapist of similar losses. *Vicarious traumatization* reflects enduring negative changes that can be incurred as a result of engaging with trauma survivors and their trauma material (Pearlman & Saakvitne, 1995). As we open our hearts to a succession of traumatic bereavement clients, we may find ourselves increasingly saddened about living in a world where some people take others' lives, whether intentionally or not, and others die prematurely, often with great suffering. In working with this population, therapists may find that their strong countertransference responses to each sudden death accumulate and lead to an increased vulnerability to vicarious traumatization. The antidotes to these potential pitfalls are (1) noticing what is most challenging about the work and how it is affecting oneself, and (2) committing to address these issues in either clinical consultation or our own personal psychotherapies.

Note

- 1 Material in this chapter is based in part on a book entitled *Traumatic Bereavement: A Practitioner's Guide* (Pearlman, Wortman, Feuer, Farber, & Rando, 2014).

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5

Finding the Evidence *Use of the CareSearch Site in Bereavement Care*

Jennifer Tieman and Sarah Hayman

Needing Evidence

Supporting those who have been bereaved through the loss of a loved one is the area of practice of an important and skilled profession, underpinned by a growing body of research. There is increasing recognition of the need for research to provide guidance for bereavement practitioners in areas such as recognizing a complicated grief reaction, identifying those who are vulnerable and minimizing adverse outcomes (Zhang, El-Jawahri, & Prigerson, 2006).

The movement towards evidence-based healthcare worldwide is based on the belief that the best outcomes for patients come from the incorporation of the best available evidence about what works into care practices. In bereavement care, as in other spheres, access to evidence can support the practitioner by presenting examples of what others in the field have found to work, providing ideas and offering guidance on trusted approaches to difficult clinical problems. Published research can add to a body of evidence and explicitly states the findings of approaches, treatments, and investigations. It can be used to support a new approach or to challenge existing beliefs. It can also be used to confirm the effectiveness of existing practices. For new clinicians, and for those who may be sole practitioners needing advice, access to reliable evidence can support good bereavement care and give confidence to those making clinical decisions. This evidence needs to be current, as new approaches to understanding and supporting the bereaved continue to be developed. The report on bereavement research by the Center for the Advancement of Health found that “Research on grief and its effects, and on the care provided to bereaved individuals and families, has increased greatly in both frequency and scope over the past 20 years” (Center for the Advancement of Health, 2004).

Finding Evidence

Finding the evidence about what works in bereavement care is challenging, as it is in all areas of healthcare. There is an increasing amount of information available, growing at

an enormous rate. In 2014, the PubMed database contained over 24 million references, with 20,000 new items being added weekly (PubMed, 2014). Finding useful information quickly is not straightforward in the field of bereavement care, where concepts and terminology can be complex and diffuse (Tieman, Hayman, & Hall, 2015). People working in the profession of caring for the bereaved will not necessarily have the time, skills, confidence, or willingness to frame sophisticated searches to make sure that they are finding the best available evidence.

Bereavement is an area of significant interest for palliative care. In 2013, CareSearch, a major palliative care resource, expanded the information about bereavement care provided on its site. CareSearch provides a collection of resources and tools for the whole field of palliative care, that is, for all those who work in the area, as well as for patients, carers, friends, and families. This service is funded by the Australian government as an open-access resource available at anytime and anywhere at www.caresearch.com.au. The philosophy underpinning the CareSearch information service is that practice should be informed by the best available evidence. All information provided on CareSearch is supported by evidence and subject to a range of measures designed to ensure that the information provided is of the highest quality available: current and relevant to practitioners, patients, and carers.

Bereavement resources can be found in the Patient Management area of the Clinical Evidence section, at <http://www.caresearch.com.au/caresearch/tabid/1345/Default.aspx>.

The enhancement of bereavement resources for CareSearch in 2013 included the creation of the Bereavement Search Filter. The search filter was developed by the CareSearch team using a validated methodology based on that employed previously to develop several topic-based filters, including the Palliative Care Search Filter, the Heart Failure Search Filter, and the Dementia Search Filter (CareSearch & Flinders University, 2014). This search filter enabled the development of topic-specific searches of importance to bereavement that are held as hyperlinks in the same section. The Bereavement Search Filter was created for OVID Medline and subsequently translated for PubMed.

The development of the search filter was a rigorous, iterative, and transparent process using a gold standard set of references and an expert advisory group to ensure clinical relevance and minimize bias. This process ensured a final search strategy that can be trusted to return database search results with high sensitivity (*finding* all or most *relevant* references) and high specificity (*not finding* a large number of *irrelevant* references). Full details of the methodology used to develop the Bereavement Search Filter are provided in the paper “Find me the evidence: connecting the practitioner with the evidence on bereavement care” (Tieman, Hayman, & Hall, 2015).

Thus, the busy practitioner working in the field of bereavement research can have confidence that using the search filter (via a convenient hyperlink and ready-made topic search) will offer a reliable connection to the evidence in recent bereavement research literature. This search has embedded the technical expertise of an effective search in a link that can be used many times over, remaining current.

Translating this search filter for use in PubMed means that the search can be held as a hyperlink and published on a web page, providing one-click easy access to the search results. As PubMed is open access, searching for citations is open to everyone. Using a PubMed function can restrict results to “free full text,” that is, only those references that are immediately available in full text without requiring subscription access to a journal.

The following illustration demonstrates how a practitioner in bereavement care might use the CareSearch resource to discover current research literature.

Case Illustration: A Search for Self-Care

Rebecca, a bereavement counselor who works in a small community-based team, is concerned about the impact of working in the bereavement field on those who provide care, and would like to learn what the research says about this. Rebecca has access to the Internet but her organization does not have a library or, as far as she is aware, any subscriptions to commercial databases. She wants to find some recent information quickly so that she can provide a summary to her team, to increase their general understanding of this topic.

Rebecca goes to the CareSearch website at www.caresearch.com.au. This website is free to use and does not require her to log on or remember any passwords. She clicks through to the Bereavement and Grief area of CareSearch.

On this page she sees general information about bereavement and grief, in the palliative care context of CareSearch. At the side is a link to Bereavement PubMed Searches. She clicks on this. The message at the top of the page informs her that “The links on this page provide an easy, reliable way to find relevant bereavement literature in English. Each link runs an immediate and up-to-date search of PubMed.” Rebecca sees that the list of topics includes *Self Care*, and below that are two links, one to *Everything* and one to *Free full text only*. Rebecca wants to see full text articles immediately rather than be taken to a reference for something she may have difficulty obtaining; therefore she clicks on *Free full text only* below *Self Care*. Immediately she is taken to the PubMed search results page for her search, through a link based on the validated Bereavement Search Filter, combined with terms

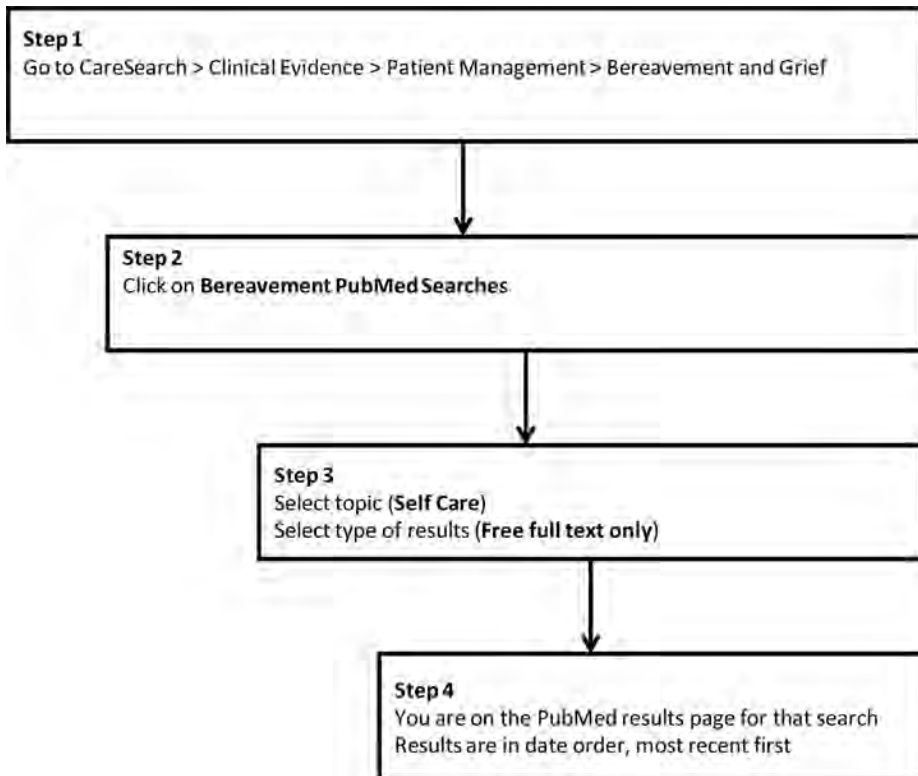


Figure 5.1 Step-by-step topic search in CareSearch for “self care in bereavement”

selected to create an expert search on the topic of “self care”. Rebecca does not herself need to test all the different possible term combinations; this work has been done already and embedded in the link. Figure 5.1 shows the steps to follow for this topic search.

At the time of writing, the results page contains 10 articles for Rebecca’s search (self care in bereavement) that are available in free full text immediately. (It is worth noting here that these numbers change as the PubMed database is updated; the CareSearch links go to the latest real time results for PubMed Searches.) Of these, Rebecca thinks the first three listed will be useful. They are recent publications from 2011 to 2014; her results come back with the most recent listed first.

As all three seem useful, she clicks on the *Free Article* or *Free PMC Article* link within each reference and is taken directly to each complete article.

Rebecca bookmarks the Bereavement PubMed Searches page at <http://www.caresearch.com.au/caresearch/tabid/2784/Default.aspx> so that she can return directly to it.

Additional Search Techniques

The bereavement topic searches provided on CareSearch were selected as topics of current interest to bereavement care practitioners, and ratified by the Expert Advisory Group (Tieman, Hayman, & Hall, 2015). It is likely, however, that individual users of the site will wish to search for other topics within bereavement. It is possible to construct any search, using the Bereavement Search Filter as a base to retrieve bereavement literature from PubMed, and then combine it with a topic of personal interest. Instructions for this are provided on the site at <http://www.caresearch.com.au/caresearch/tabid/2949/Default.aspx>. The second illustration below shows an example.

All PubMed search strategies can be saved as an alert and used to generate emails from PubMed when new resources are added that are relevant to that search. It is necessary to register for the PubMed service MyNCBI to do this. We discuss briefly below how this is done and general instructions for creating saved PubMed searches are provided at http://www.ncbi.nlm.nih.gov/books/NBK3842/#MyNCBI.Saving_and_Managing_Searches.

Case Illustration: A Search for Bereavement and Depression

Rebecca, the bereavement counselor, has used the link provided to a PubMed search on self-care within bereavement. She would also like to know about bereavement and depression. She goes to the PubMed Bereavement searches page on CareSearch, and follows the link to *Create Your Own Bereavement PubMed Search*. Here there are instructions for creating a search using her own topic combined with the Bereavement Search Filter. (Figure 5.2 shows the steps for creating your own bereavement search.) She follows the instructions to run the Bereavement Search Filter and then clicks on **Advanced**, below the search box on the PubMed results page. She enters her term Depression in the top box and clicks on *Add* next to the Bereavement Search Filter search to add that to the second box. Rebecca then clicks on the Search button to execute her search for depression AND bereavement. These two concepts have been automatically combined with AND in the PubMed Search Builder. The results page for her search appears.

Second, Rebecca would like to know when new items relevant to her search are added to the PubMed collection. To do this, she goes to the Sign in to NCBI link at the top of the PubMed search page. Here she registers for an NCBI account. When she is signed in, she follows the link to *Save search* on the screen below the search box. Clicking on this enables her to save any search strategy and request regular email updates of results.

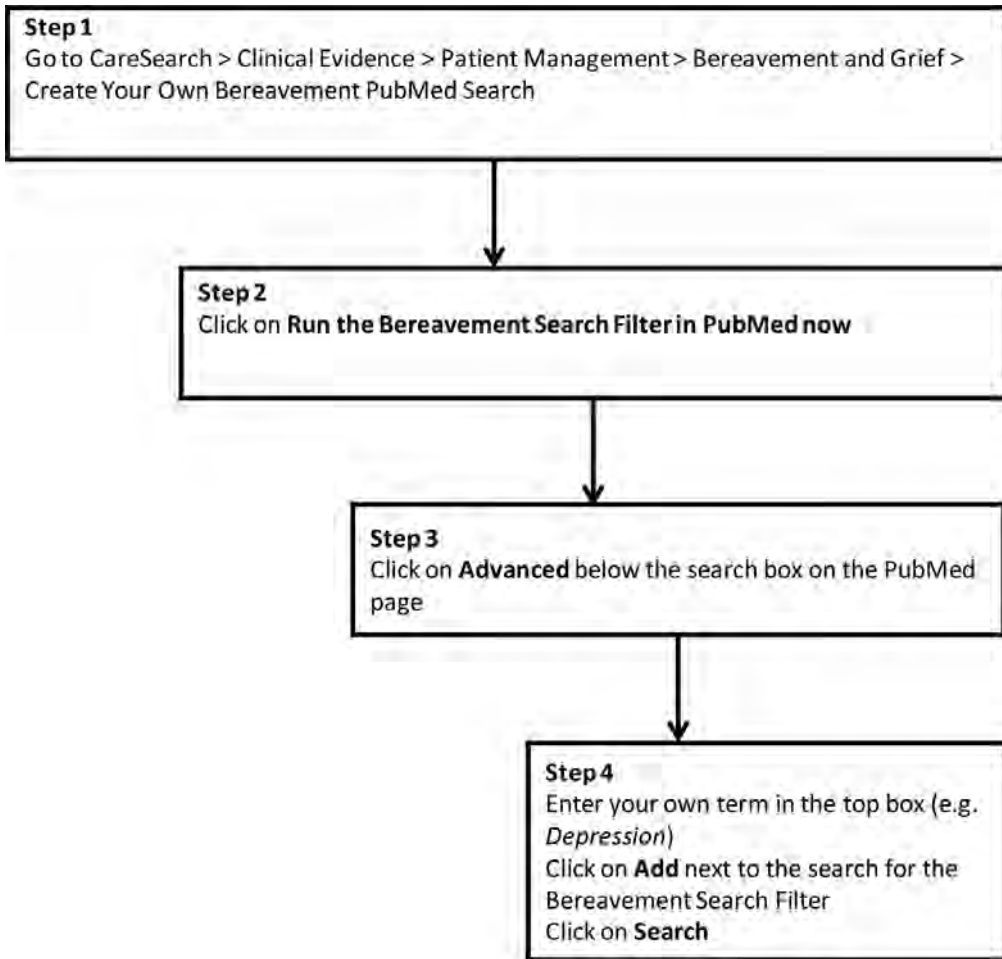


Figure 5.2 Step-by-step instructions for creating your own bereavement search

Using Evidence

While the PubMed searches make finding and retrieving articles very easy, health professionals may not always have the time to read, reflect, and synthesize all content. To further support professionals and to make the evidence easier to translate into action, CareSearch provides clinical pages that have returned the relevant literature, extracting key messages from the research. This material is written by expert practitioners under the guidance of a national advisory group and regularly reviewed to ensure quality, currency, and relevance (CareSearch, 2014).

Concluding Thoughts

Those whose expertise is the support of people suffering bereavement will not necessarily have expertise in how to construct an effective search strategy, and their time is better spent in their own clinical endeavors. One individual, even an expert searcher, will not necessarily be able to construct a high-performing search of PubMed for publications relevant to

bereavement. Indeed, the analysis of terminology and literature sources undertaken within the development of the Bereavement Search Filter demonstrated the complexity of the language and concepts in this field, which can lead to challenges in searching the literature effectively. We wrote: “The nature and structure of the bereavement knowledge base can also affect evidence retrieval. Concepts and terminology within the field are not always clearly delineated in the literature, making the evidence at times hard to identify and access” (Tieman, Hayman, & Hall, 2015).

The CareSearch resources to support bereavement care are designed to meet the needs of busy counselors, social workers, nurses, doctors, and other professionals working in this important field, who want to be able to find the best available research evidence. The guided searches using the validated strategy of the Bereavement Search Filter aim to overcome the difficulties of knowing which terms to use in an area that can be diffuse. The option to go straight to free full text aims to overcome difficulties of access to the information once it has been discovered.

The context of the bereavement resources in CareSearch, described in this chapter, is that of palliative care; that is, the expected death of a loved one. A further development of this work will be promotion of a broader, more sensitive version of the Bereavement Search Filter. This version will be located on the Flinders Filters website (CareSearch & Flinders University, 2014). It will connect the user to research across the whole scope of the topic, including literature on grief generally, not just grief resulting from the death of a loved one.

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Part II

Assessing Bereavement

6

Hogan Grief Reaction Checklist (HGRC)

Nancy S. Hogan and Lee A. Schmidt

Purpose

Bereaved individuals seeking professional help with their grieving want answers to questions about recovery and ultimately they want to know how to make meaning out of the meaninglessness of their lives (Neimeyer & Thompson, 2014). These goals mirror the hopes of adults who attend bereavement support groups. Newly bereaved adults choose to attend groups, in part, to learn from one another about the emotional, physiological, cognitive, and spiritual/existential grief reactions they are having and to talk to others about coping and adapting to life following the death of a loved one. The Hogan Grief Reaction Checklist (HGRC) (Hogan, Greenfield, & Schmidt, 2001) is a research instrument with items grounded in the personal stories of bereaved adults who felt the hopelessness and meaninglessness of early grief and yet, with time and work, were able to regain a sense of hope for a future that is filled with meaning and purpose.

Development

The HGRC items were empirically generated from verbal and written data obtained from bereaved parents whose child had died. To capture the variability associated with the cause of death, different focus groups were conducted with groups of parents who had experienced a child's death due to illness, accident, suicide, or homicide. Content analysis of data resulted in six categories (Despair, Panic behavior, Detachment, Blame and anger, Disorganization, and Personal growth). Care was given to writing items so that they mirrored words and phrases used by the bereaved in order to capture their experience in their own language. The HGRC has been used in research with bereaved parents (Feigelman, Jordan, & Gorman, 2009; Hogan, Greenfield, & Schmidt, 2001), widows (Hogan & Schmidt, 2002; Hogan, Schmidt, & Coolican, 2014), spouses (Kounonen, Tarkka, Paunonen, & Laippala, 1999), and clinical patients (Gamino, Sewell, & Easterling, 2000). A full description of the item development and confirmatory factor analysis of the measure is presented elsewhere (Hogan, Greenfield, & Schmidt, 2001) and further psychometric information is also available (Neimeyer & Hogan, 2001; Neimeyer, Hogan, & Laurie, 2008).

Format and Psychometric Properties

The HGRC consists of 61 items scored on a 5-point Likert-type scale with descriptors ranging from “Does not describe me at all” to “Describes me very well” (see Appendix 6.1). The subscales with the number of items and Cronbach’s alpha internal consistency values from Hogan et al. (2001) are:

1. *Despair* (13 items, = .89) measures emotional reactions including sadness, loneliness, hopelessness and pessimism.
2. *Panic behavior* (14 items, = .90) measures physiological reactions such as worry and panic attacks as well as psychosomatic symptoms including headaches, stomachaches, and backaches.
3. *Personal growth* (8 items, = .87) measures a sense of having become more compassionate, tolerant of self and others, and more forgiving, optimistic, and hopeful about the future.
4. *Blame and anger* (7 items, = .79) measures emotional reactions such as blame, anger, resentment, and bitterness.
5. *Detachment* (8 items, = .87) measures emotional reactions of feeling disconnected from self and from others.
6. *Disorganization* (8 items, = .87) measures cognitive reactions including difficulty in concentration, learning, and remembering information.

The internal consistency for the total instrument was .90.

The HGRC is scored by summing the items for each subscale. A total score for all items of the HGRC cannot be computed because the *Personal growth* subscale is negatively related with the other five subscales of the measure. Five of the subscales, *Despair*, *Panic behavior*, *Blame and anger*, *Detachment*, and *Disorganization*, represent the multidimensional nature of the bereavement process. The *Personal growth* subscale represents existential resilience characteristic of one of the outcomes of the grieving process (Hogan & Schmidt, 2002). Independent research (Gamino, Sewell, & Easterling, 2000) reported similar internal consistency for all of the subscales.

Test–retest reliability of the HGRC examined over a one-month timespan showed all subscales were significantly reliable at the $p < .001$ level, attesting to the temporal stability of the instrument. HGRC subscales are correlated as predicted with the Texas Revised Inventory of Grief (TRIG), Grief Experience Inventory (GEI), and the Impact of Event Scale (IES) subscales, offering evidence of convergent validity. The *Personal growth* subscale is negatively correlated to each of the other HGRC subscales and all of the GEI, TRIG, and IES subscales, offering compelling evidence that personal growth is a unique feature of the bereavement process (Hogan, Greenfield, & Schmidt, 2001).

Evidence of the HGRC’s construct validity was obtained using data from bereaved mothers to determine if the scale was sensitive to differences in groups of participants. The first analysis grouped mothers by cause of death (illness, accident, homicide, or suicide). Findings showed no difference in groups by the cause of death on four HGRC subscales (*Despair*, *Detachment*, *Disorganization*, or *Personal growth*). However, suicide and homicide survivors had significantly higher panic behavior scores than illness and accident survivors, and the homicide survivors, in addition, had significantly higher blame and anger scores than the other three groups. The time since death variable was assessed to determine if intensity of grief measured by the HGRC changed over time. For this analysis bereaved parents whose child had died less than 3 years earlier were compared with parents whose child had died more than 3 years earlier. The analysis showed a temporal effect such that parents who were closer in time to the death had significantly higher scores than parents further in time since the death on all of the *Distress* subscales, but correspondingly lower scores on *Personal growth* (Hogan, Greenfield, &

Schmidt, 2001). Construct validity was further supported in a longitudinal study showing, as predicted, that the bereaved participants measured at 6, 13, and 25 months after death had significantly lower HGRC subscale scores over time for *Despair*, *Detachment*, and *Panic behavior*. Time effects were not significant for *Disorganization* or *Blame and anger*. In contrast, HGRC scores on the *Personal growth* subscale significantly increased over time. Independent research found that significantly higher HGRC grief subscales are related to traumatic death, younger age of decedent, and perception of preventability, and two bereaved liabilities, a history of mental health treatment and greater number of other losses. Using the HGRC *Personal growth* subscale as a positive outcome, the same authors identified the following correlates of adaptive grieving: ability to see some good resulting from the death, having a chance to say goodbye, intrinsic spirituality, and spontaneous positive memories of the deceased (Gamino, Sewell, & Easterling, 2000). Others have reported a significant association between personal growth measured by the HGRC and better mental health (Feigelman, Jordan, & Gorman, 2009).

To bridge the gap between research, theory and practice we tested the Grief to Personal Growth Theory (using structural equation modeling). The grief variable was represented by the HGRC *Despair* and *Detachment* subscales. One path of the model led from grief to intrusion to avoidance (both of which were operationalized by the IES) through social support (operationalized by the Inventory of Social Support (Hogan & Schmidt, 2002; see Chapter 15) and eventuating in personal growth. A second path led from grief to personal growth, showing a negative correlation. Model testing revealed an acceptable fit of this model to the data (Hogan & Schmidt, 2002). The tested grief to personal growth theory provides a scientific explanation and provides guidance to clinicians who work with bereaved adults.

Clinical Applications

The HGRC instrument items were obtained from the words and phrases of bereaved adults as they described their grief. Thus, the items listed below can be presented to bereaved adults in therapy to help them learn how other bereaved adults have described cognitive, emotional, physiological, and existential/spiritual thoughts and feelings related to the death of a loved one. Learning that others have had similar reactions can help to normalize a client's sense of hopelessness and helplessness. Reading the items could also help clients identify specific issues they wish to discuss with the therapist. The personal growth items can encourage patients to see that, with time and support, they too may become hopeful again. For example, the *Personal growth* items "I reached a turning point where I began to let go of some of my grief," "I am having more good days than bad," and "I have hope for the future" may give a bit of hope to the bereaved: if others have gotten through the dark times and regained meaning and purpose in their lives, it is also possible for them.

Hogan Grief Reactions Checklist Factored Items

Factor 1—*Despair*

1. My hopes are shattered
3. I have little control over my sadness
6. I feel like I am in shock
11. I believe I should have died and he or she should have lived
14. I feel heaviness in my heart
17. I want to die to be with him or her
25. I don't believe I will ever be happy again
29. I agonize over his or her death

- 33. I feel like I am walking in my sleep
- 40. I have difficulty accepting the permanence of the death
- 47. I feel hopeless
- 55. I frequently cry
- 59. I ache with loneliness

Factor 2—*Panic Behavior*

- 4. I worry excessively
- 7. Sometimes my heart beats faster than it normally does for no reason
- 13. I often have headaches
- 16. I have burning in my stomach
- 18. I frequently have muscle tension
- 21. I feel shaky
- 27. I frequently feel frightened
- 31. I have panic attacks over nothing
- 34. I have shortness of breath
- 38. I am experiencing periods of dizziness
- 44. I am frequently fatigued
- 50. I feel sick more often
- 52. I often have back pain
- 56. I startle easily

Factor 3—*Personal Growth*

- 2. I have learned to cope better with life
- 10. I feel as though I am a better person
- 12. I have a better outlook on life
- 19. I have more compassion for others
- 24. I am stronger because of the grief I have experienced
- 30. I am a more forgiving person
- 36. I am more tolerant of myself
- 41. I am more tolerant of others
- 45. I have hope for the future
- 51. I reached a turning point where I began to let go of some of my grief
- 60. I am having more good days than bad
- 61. I care more deeply for others

Factor 4—*Blame and Anger*

- 5. I frequently feel bitter
- 8. I am resentful
- 15. I feel revengeful
- 37. I have hostile feelings
- 42. I blame others
- 48. I want to harm others
- 58. I get angry often

Factor 5—*Detachment*

- 9. I am preoccupied with feeling worthless
- 22. I am confused about who I am

- 23. I have lost my confidence
- 28. I feel unable to cope
- 35. I avoid tenderness
- 43. I feel like I don't know myself
- 53. I am afraid that I will lose control
- 54. I feel detached from others

Factor 6—*Disorganization*

- 20. I forget things easily, e.g., names, telephone numbers
- 26. I have difficulty remembering things from the past
- 32. I have difficulty concentrating
- 39. I have difficulty learning new things
- 46. I have difficulty with abstract thinking
- 49. I have difficulty remembering new information
- 57. Tasks seem insurmountable

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Appendix 6.1 Hogan Grief Reaction Checklist (Adult)

This questionnaire consists of a list of thoughts and feelings that you may have had *since* your loved one died. Please read each statement carefully, and choose the number that best describes the way you have been feelings during the past two *weeks, including today*. Circle the number beside the statement that best describes you. Please do not skip any items.

1. Does not describe me at all
2. Does not quite describe me
3. Describes me fairly well
4. Describes me well
5. Describes me very well

1. My hopes are shattered	1	2	3	4	5
2. I have learned to cope better with life	1	2	3	4	5
3. I have little control over my sadness	1	2	3	4	5
4. I worry excessively	1	2	3	4	5
5. I frequently feel bitter	1	2	3	4	5
6. I feel like I am in shock	1	2	3	4	5
7. Sometimes my heart beats faster than it normally does for no reason	1	2	3	4	5
8. I am resentful	1	2	3	4	5
9. I am preoccupied with feeling worthless	1	2	3	4	5
10. I feel as though I am a better person	1	2	3	4	5
11. I believe I should have died and he or she should have lived	1	2	3	4	5
12. I have a better outlook on life	1	2	3	4	5
13. I often have headaches	1	2	3	4	5
14. I feel a heaviness in my heart	1	2	3	4	5
15. I feel revengeful	1	2	3	4	5
16. I have burning in my stomach	1	2	3	4	5
17. I want to die to be with him or her	1	2	3	4	5
18. I frequently have muscle tension	1	2	3	4	5
19. I have more compassion for others	1	2	3	4	5
20. I forget things easily, e.g., names, telephone numbers	1	2	3	4	5
21. I feel shaky	1	2	3	4	5
22. I am confused about who I am	1	2	3	4	5
23. I have lost my confidence	1	2	3	4	5
24. I am stronger because of the grief I have experienced	1	2	3	4	5
25. I don't believe I will ever be happy again	1	2	3	4	5
26. I have difficulty remembering things from the past	1	2	3	4	5
27. I frequently feel frightened	1	2	3	4	5
28. I feel unable to cope	1	2	3	4	5
29. I agonize over his or her death	1	2	3	4	5

30. I am a more forgiving person	1	2	3	4	5
31. I have panic attacks over nothing	1	2	3	4	5
32. I have difficulty concentrating	1	2	3	4	5
33. I feel like the walking dead	1	2	3	4	5
34. I have shortness of breath	1	2	3	4	5
35. I avoid tenderness	1	2	3	4	5
36. I am more tolerant of myself	1	2	3	4	5
37. I have hostile feelings	1	2	3	4	5
38. I am experiencing periods of dizziness	1	2	3	4	5
39. I have difficulty learning new things	1	2	3	4	5
40. I have difficulty accepting the permanence of the death	1	2	3	4	5
41. I am more tolerant of others	1	2	3	4	5
42. I blame others	1	2	3	4	5
43. I feel like I don't know myself	1	2	3	4	5
44. I am frequently fatigued	1	2	3	4	5
45. I have hope for the future	1	2	3	4	5
46. I have difficulty with abstract thinking	1	2	3	4	5
47. I feel hopeless	1	2	3	4	5
48. I want to harm others	1	2	3	4	5
49. I have difficulty remembering new information	1	2	3	4	5
50. I feel sick more often	1	2	3	4	5
51. I reached a turning point where I began to let go of some of my grief	1	2	3	4	5
52. I often have back pain	1	2	3	4	5
53. I am afraid that I will lose control	1	2	3	4	5
54. I feel detached from others	1	2	3	4	5
55. I frequently cry	1	2	3	4	5
56. I startle easily	1	2	3	4	5
57. Tasks seem insurmountable	1	2	3	4	5
58. I get angry often	1	2	3	4	5
59. I ache with loneliness	1	2	3	4	5
60. I am having more good days than bad	1	2	3	4	5
61. I care more deeply for others	1	2	3	4	5

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Note: This scale is published in the public domain to encourage its use by interested clinicians and researchers. No formal permission is required for its duplication and use beyond citation of its source and authorship.

Integration of Stressful Life Experiences Scale (ISLES)

Jason M. Holland

Purpose

In recent years there has been increased interest in the concept of meaning-making, with researchers, clinicians, and theorists examining a range of meaning-oriented constructs, such as meaning in life, sense-making, benefit-finding, and identity reconstruction, just to name a few (Park, 2010). Despite preliminary support for the important role of meaning-making in adjustment to stressful life events like bereavement (Gillies & Neimeyer, 2006; Park, 2010), this area of study has suffered from a number of limitations, most notably the lack of empirically supported and easily administered assessment tools for gauging meaning-oriented phenomena.

The Integration of Stressful Life Experiences Scale (ISLES) was developed to address this gap (Holland, Currier, Coleman, & Neimeyer, 2010). Based on Park's (2010) Meaning-Making Model, the ISLES assesses the degree to which there is (or is not) a discrepancy between the situational meaning made of a particular life event (i.e., appraisals and reappraisals of the event and its significance or meaning) and one's sense of global meaning (i.e., overall beliefs, goals, and worldviews). For example, after the loss of a loved one by violent means, a bereaved individual may appraise the event as a highly threatening and unpredictable act of volition that challenges basic assumptions about the safety of the world, benevolence of other people, and predictability of everyday life.

The ISLES was created as a general-purpose measure of meaning made of stress and has been used successfully with military veterans (Currier, Holland, Chisty, & Allen, 2011), violence-exposed teachers in El Salvador (Currier et al., 2013), older adults with depression (Marquett et al., 2013), and college students who experienced a variety of stressors (Holland et al., 2010). It has also been shown to have great relevance for individuals who have lost a loved one in a number of studies (Burke et al., 2014; Holland, Currier, & Neimeyer, 2014; Holland et al., 2010; Lee, Feudo, & Gibbons, 2014; Lichtenthal, Burke, & Neimeyer, 2011).

Development

The ISLES is a theoretically derived measure, and candidate items were developed by considering the question, "If we wanted to assess meaning made of stress in a clinical context, what

would we ask our clients?” This pool of items was then scrutinized by the research team, and items deemed to be not representative of the construct or overly redundant were removed. This process resulted in 30 candidate items for further investigation (Holland et al., 2010).

Although some of the candidate ISLES items were positively worded, such that an affirmative response would indicate greater meaning made of a stressful loss or other life experience (e.g., “I have made sense of this event”), most items were worded negatively so that an affirmative response would indicate less meaning made of an event (e.g., “This event is incomprehensible to me”). There are several reasons for this preference for negatively worded items. In particular, it has been suggested that meaning-making often occurs outside of individuals’ conscious awareness, and that individuals are most frequently aware of these processes when some kind of discrepancy exists between the situational meaning made of a stressor and global meaning structures (Creamer, Burgess, & Pattison, 1992; Moulds & Bryant, 2004). Thus, we believed that clients and research participants would have an easier time commenting on the extent to which a discrepancy does or does not exist, rather than reporting on a felt sense of “coherence,” “integration,” or “meaning.” Furthermore, conceptually similar scales that use more positively worded items (e.g., those tapping into benefit-finding or growth) have shown inconsistent associations with relevant outcomes, perhaps due to confounding with less adaptive processes, such as self-deception, avoidance, and/or the degree to which the event plays a central role in one’s life narrative (see Zoellner & Maercker, 2006, for a review).

Following extensive psychometric analyses, the initial pool of 30 candidate items was then winnowed down to the 16 best-performing items, and it is this set of 16 items that make up the full version of the ISLES (Holland et al., 2010). More recently a 6-item short form of the ISLES was created for screening purposes in research protocols and clinical settings where brevity is essential (Holland, Currier, & Neimeyer, 2014).

Format and Psychometric Properties

Multiple studies have identified the presence of two related ISLES factors, for both the full and short versions of the scale (Currier et al., 2013; Holland et al., 2010; Holland, Currier, & Neimeyer, 2014). The first factor is labeled *Comprehensibility*, which assesses the extent to which someone has been able to make sense of a loss or other stressor and adaptively integrate it into some larger framework for understanding themselves, others, and the world around them. This subscale includes items such as “I have made sense of this event” and “I have difficulty integrating this event into my understanding about the world,” and taps into more assimilative aspects of meaning made of stress (i.e., meaning made by appraising the stressor in a way that does not require significant alteration of one’s global meaning structures). The ISLES also gauges *Footing in the world*, which may be conceptualized as an assessment of the extent to which the world in general does or does not make sense in the aftermath of a significant life event like bereavement. *Footing in the world* includes items such as “Since this event, the world seems like a confusing and scary place” and “My beliefs and values are less clear since this event,” and taps into more accommodative aspects of meaning made of stress (i.e., the extent to which one’s sense of global meaning has or has not been altered to accommodate a stressful life event).

The ISLES can be scored by simply summing items together (after reverse-coding item 2 in the full version of the scale), and depending on the purpose of the assessment, a total score or two separate subscale scores (for *Comprehensibility* or *Footing in the world*) may be derived. All items are scored so that higher scores indicate more adaptive meaning made of a stressful life event. Though clear cutoffs for the ISLES have yet to be established, unpublished data indicate that a total ISLES score of 52 or below (for the full 16-item version of the measure) can correctly classify bereaved young adults as having elevated complicated grief symptoms

with 90% sensitivity and 74% specificity. Likewise, a total score of 20 or below on the 6-item short form of the ISLES may be used as a rough cutoff for indicating problems with meaning made of loss.

In its initial validation study, the ISLES was shown to have strong internal reliability ($\alpha = .80$ to $.92$), moderate test–retest reliability over 2–3 months ($r = .48$ to $.59$), and concurrent validity with other meaning-oriented measures (Holland et al., 2010). A factor analytic study has also demonstrated the distinctiveness of ISLES scores from posttraumatic stress symptoms and general psychiatric distress (Currier et al., 2011). Subsequent psychometric studies of the ISLES have largely focused on examining its unique predictive abilities, even after statistically controlling for other known risk and protective factors. These studies have unanimously supported the ISLES as unique correlate of outcomes, such as posttraumatic stress symptoms and mental healthcare referrals (Currier et al., 2011), workplace burnout (Currier et al., 2013), salivary cortisol (Holland, Rengifo et al., 2014), as well as suicidality and life-threatening behavior (Holland, Malott, & Currier, 2014). From a bereavement standpoint, more adaptive meaning made of a loss has been shown to be associated with greater physical and mental health, over and above complicated grief symptoms, circumstances of the loss, and demographic factors (Holland, Currier, & Neimeyer, 2014). In sum, these studies demonstrate that the ISLES provides unique information about a person’s world of meaning, beyond what is typically captured by other measures.

Preliminary findings also support the use of the ISLES as an assessment tool for tracking changes over time in meaning made of loss or other stressful life events. For example, in one study, improvements in meaning made of loss (as assessed by changes in ISLES scores) over a 2- to 3-month period were found to be strongly associated with reductions in complicated grief symptoms (Holland et al., 2010). The ISLES has also been used in a recent clinical trial, and in this study it was able to successfully detect treatment-induced changes in meaning made of a variety of stressors (Holland, Chong, Currier, O’Hara, & Gallagher-Thompson, 2015).

Clinical Application

The clinical applicability of the ISLES with bereaved individuals is illustrated in the case of Cindy, a 37-year-old Chinese-American woman who presented to treatment with a variety of problems following the loss of her father due to complications after a series of strokes. Most notably, Cindy reported intense feelings of guilt about moving forward in her life, believing that she had somehow let her father down as a caregiver and that it was her “duty” to make it up to him. Beyond her present feelings of guilt, she also experienced an altered sense of past and future. As she was largely estranged from the rest of her family (due in part to disagreements over how to best care for her ailing father), Cindy was left with the feeling that many of her memories and past experiences, which had served as a foundation for her personal identity, also died with her father. Likewise, she had the sense of having lost a future “audience” for her life narrative—a role that her father had always played—witnessing and affirming her accomplishments and struggles in life. Given these difficulties envisioning and making sense of her past, present, and future, Cindy scored a 39 on the ISLES at the outset of treatment. Most notably, she “strongly agreed” with the statement, “when I talk about this event, I believe people see me differently” and “agreed” that she no longer felt “part of something larger” than herself.

Considering Cindy’s situation through the lens of the Dual Process Model of Coping with Bereavement (Stroebe & Schut, 1999), her therapist noticed that she was primarily managing the loss of her father by relying on “restoration-oriented” coping strategies (e.g., working long hours and distracting herself), to the exclusion of more “loss-oriented” strategies (e.g., considering her current thoughts/feelings). Thus, treatment initially focused on normalizing

the experience of not immediately knowing how to proceed with one's life after loss and encouraging Cindy to allow herself space to not have everything "figured out." As she gradually confronted the painful and private internal experiences that she had been avoiding, Cindy expressed that something still felt "unfinished" with her father, as though she had not properly said goodbye or honored his final wishes. Through a process of imaginal conversations with her father, she articulated a need to undertake a final ritual, making amends with her estranged brother and spreading her father's ashes as a family in his birthplace of Shanghai. Following this ritual, Cindy recounted that she imagined her father smiling down upon her and being proud of what she and her brother had done. At the end of treatment, Cindy reported reduced feelings of guilt and scored substantially higher on the ISLES, with a score of 60, indicating greater meaning made of her loss.

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Appendix 7.1 The Integration of Stressful Life Experiences Scale (ISLES)

Please indicate the extent to which you agree or disagree with the following statements with regard to your recent loss. Read each statement carefully and be aware that a response of agreement or disagreement may not have the same meaning across all items.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
1. Since this loss, the world seems like a confusing and scary place	1	2	3	4	5
2. I have made sense of this loss	1	2	3	4	5
3. If or when I talk about this loss, I believe people see me differently	1	2	3	4	5
4. I have difficulty integrating this loss into my understanding about the world	1	2	3	4	5
5. Since this loss, I feel like I'm in a crisis of faith	1	2	3	4	5
6. This loss is incomprehensible to me	1	2	3	4	5
7. My previous goals and hopes for the future don't make sense anymore since this loss	1	2	3	4	5
8. I am perplexed by what happened	1	2	3	4	5
9. Since this loss happened, I don't know where to go next in my life	1	2	3	4	5
10. I would have an easier time talking about my life if I left this loss out	1	2	3	4	5
11. My beliefs and values are less clear since this loss	1	2	3	4	5
12. I don't understand myself anymore since this loss	1	2	3	4	5
13. Since this loss, I have a harder time feeling like I'm part of something larger than myself	1	2	3	4	5
14. This loss has made me feel less purposeful	1	2	3	4	5
15. I haven't been able to put the pieces of my life back together since this loss	1	2	3	4	5
16. After this loss, life seems more random	1	2	3	4	5

Note: This adapted version of the ISLES is reproduced with permission from Holland et al. (2010). The scale has been slightly modified from its original form to make it more relevant for bereaved individuals (i.e., the word "loss" is substituted for the word "event"). With the exception of item 2 (which should be reverse scored), all items should be scored using the 1 (Strongly agree) to 5 (Strongly disagree) format presented above. A sum of all items can be taken to compute a total ISLES score. Likewise, items 1, 3, 5, 7, 9, 11, 12, 13, 14, 15, and 16 can be summed to compute the *Footing in the world* subscale, and items 2, 4, 6, 8, and 10 can be summed to compute the *Comprehensibility* subscale.

Meaning of Loss Codebook (MLC)

Evgenia Milman, Robert A. Neimeyer, and James Gillies

Purpose

There has been an increasing emphasis in the field of grief on the role that meaninglessness and the corresponding search for meaning play in bereavement. Indeed, scholars adopting narrative constructivist (Neimeyer & Sands, 2011), cognitive behavioral (Malkinson, 2007), psychodynamic (Horowitz, Bonanno, & Holen, 1993), stress-and-coping (Park, 2010), and systemic perspectives (Hooghe & Neimeyer, 2012) have all described the struggle to reconstruct meaning as a key component of the grief experience. This theoretical connection between grief and meaning has also been supported by empirical research, which has found that those who report having made meaning following death-related loss tend to also report improved grief outcomes (Park, 2010). Accordingly, meaning reconstruction has been proposed as a frame for grief therapy with individuals (Neimeyer & Sands, 2011), families (Hooghe & Neimeyer, 2012), and groups (MacKinnon et al., 2014). Crucially, the awareness of meaning reconstruction as a paradigm for clinical work with the bereft is also increasing. For example, next to Kubler-Ross's stage model and Worden's Task Model, licensed professional counselors in the US were found to be most familiar with the meaning-making theory of grief (Ober, Granello, & Wheaton, 2012).

Despite the growing recognition of the significant role that the quest for meaning plays in the grief experience, there were no observer-rated tools in existence for identifying what meaning an individual has made following death-related loss (Gillies, Neimeyer, & Milman, 2014). The Meaning of Loss Codebook (MLC) was developed to address this limitation.

Development

A primary focus in the development of the MLC was ensuring that it reflected diverse experiences of grief (Gillies et al., 2014). Thus, three open-ended prompts were utilized in order to elicit written reflections regarding the role that meaning played in the grief experiences of a purposive sample of 162 bereaved adults who varied considerably in terms of ethnicity, relationship with the deceased, age of deceased, cause of death, and level of grief distress. These

prompts probed how the participants have made sense of, found unsought benefit in, and felt their identities changed as a result of their losses. Participants' responses to these prompts were then content-analyzed via open coding. First, responses were divided into individual meaning units, which are words or phrases that express a complete and distinguishable meaning. Through a process of constant comparison, each such unit was then assigned to a meaning category. The emerging category system was either kept as is or altered to reflect each new meaning unit. Once coding was complete, interrater reliability was examined between three independent raters.

Format and Psychometric Properties

The MLC comprises 30 meaning categories that are described in Appendix 8.1 along with sample meanings. MLC meaning categories represent the themes that emerge when an individual has made meaning in the context of grief. In cases in which more than one category appears to apply, the MLC offers exclusion criteria as well as appropriate alternative categories to consider. The MLC can be applied to transcripts of psychotherapy sessions, written accounts of grief (e.g., client journaling), and published memoirs of loss, including online grief blogs. Interrater reliability between pairs of MLC raters ranged between Kappa coefficients of .82 and .83 ($p < .05$), which is considered excellent agreement.

Lending support to the convergent validity of the MLC is the overlap between MLC meaning categories and (a) items in self-report meaning measures as well as (b) meaning themes identified by previous grief studies. Beyond this convergence the MLC has the advantage of offering more than twice the number of distinct categories compared to previous systems for measuring meaning in grief. Such differentiation of content allows for nuanced assessments of meaning while still permitting aggregation of categories when more general assessments are of interest. Crucially, the MLC includes both negatively and positively valenced meaning categories. For example, *regrets* or *lost identity* clearly signal that the bereaved has made negative meaning of the loss, whereas *personal growth* or *valuing life* clearly signal that the bereaved has made positive meaning of the loss. Alternatively, other meaning categories, such as *lost innocence*, could reflect either negative or positive meaning; in the former case one might report disillusionment by what feels like an unpredictable and unfair world, in the latter case one might report developing a more mature or evolved understanding of the world. Accordingly, the MLC allows researchers and clinicians to attend not only to what meaning the bereft has made, but also to whether that meaning is connotatively positive or negative in nature.

Clinical Applications

The MLC can serve as a guide for assessing whether and what meaning a client has made, thereby offering a means of documenting therapeutic progress and aiding in the clinical choices that contribute to this progress. The MLC clinically can be applied either via analysis of session recordings or by noting the emergence of MLC categories in the course of a session.

Figure 8.1 contrasts the initial and the final sessions of a six-session psychotherapy with Cara, a 30-year-old woman who experienced the stillbirth of her daughter two months prior, whose complete therapy is commercially available for the training of psychotherapists in a constructivist or meaning-making model (Neimeyer, 2007; see also Alves, Mendes, Gonçalves, & Neimeyer, 2012). As can be seen in this figure, the overall amount of meaning made by Cara nearly doubled from the first session to the last. Crucially, the number of positive-meaning

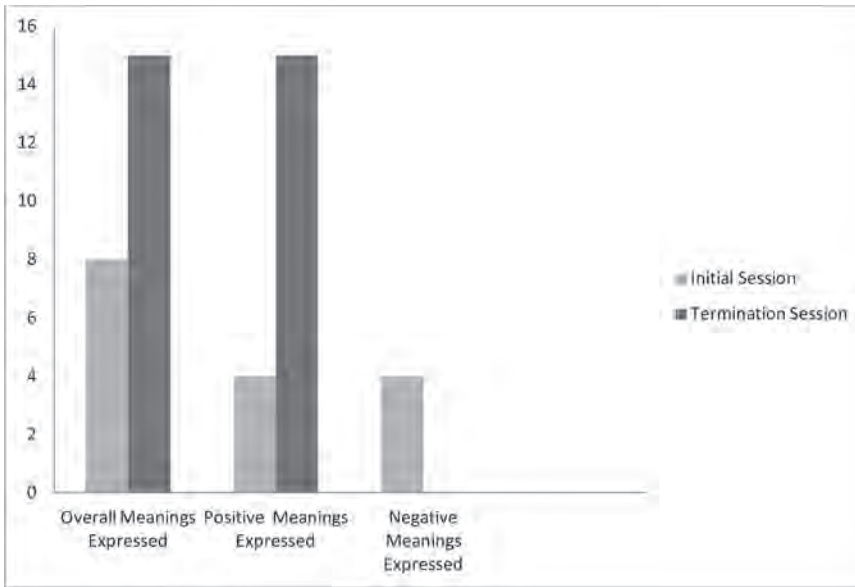


Figure 8.1 Comparison of MLC meaning category expression in the first session versus the termination session

themes nearly quadrupled over the course of the sessions while the negative-meaning themes, which had comprised half of the meaning expressed by Cara in the first session, were entirely absent in the final session. Accordingly, this figure exemplifies how the MLC can be employed as means of documenting therapeutic progress in terms of how much and what kind of meaning a client has made.

Figures 8.2 and 8.3 offer a detailed account of the meanings expressed in Cara's first and final sessions respectively. Noting the meaning themes present in the initial session, the therapist might choose to draw on and elaborate the positive meanings Cara has made as a way of addressing her negative meaning-making. For example, Cara's sense that the world is no longer predictable and safe (*lost innocence*) might be reframed in the context of her finding positive meaning in relation to her bond with her family (*family bond*), her bond with her stillborn daughter (*time together*), and her increased sense of *valuing life*. Accordingly, through the use chair work and an exploration of Cara's vivid dreams, the therapist focused on Cara's relationship with her family and her continuing bond with her stillborn child. Subsequently, Cara was able to shift from her negative sense of an unpredictable world to a positive sense of the compassionate role she intends to play in her family and professionally given life's unpredictability. This change is reflected in the emergence of meaning categories such as *personal growth*, *compassion*, and *valuing relationships*, in the continued expression of the *family bonds* meaning category, and in the absence of the previously expressed *lost innocence* meaning category. In addition, the therapist's emphasis on the fluid nature of Cara's life narrative (via directed journaling and exploration of previous losses) aided in addressing Cara's negative meaning surrounding *regret*, leading to her re-engagement in life and the consequent emergence of the *moving on* and *coping* meaning categories. Thus, Figures 8.2 and 8.3 illustrate how noting the MLC meaning categories expressed by a client might emphasize the areas that warrant clinical attention and inform the approach the therapist takes to encouraging meaning-making.

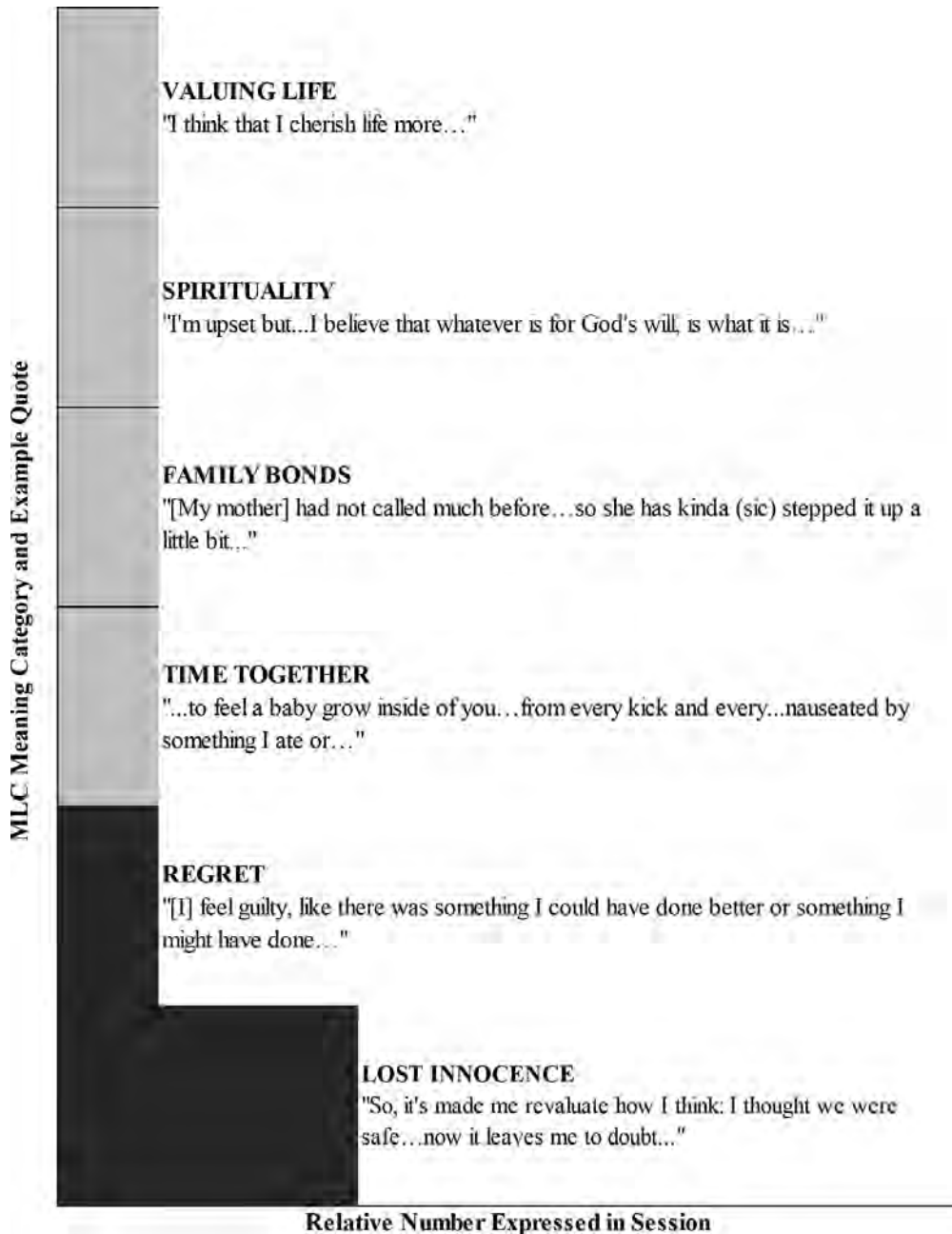


Figure 8.2 MLC meaning category expression in the initial session: Category name, illustrative client quotation, valence, and relative frequency

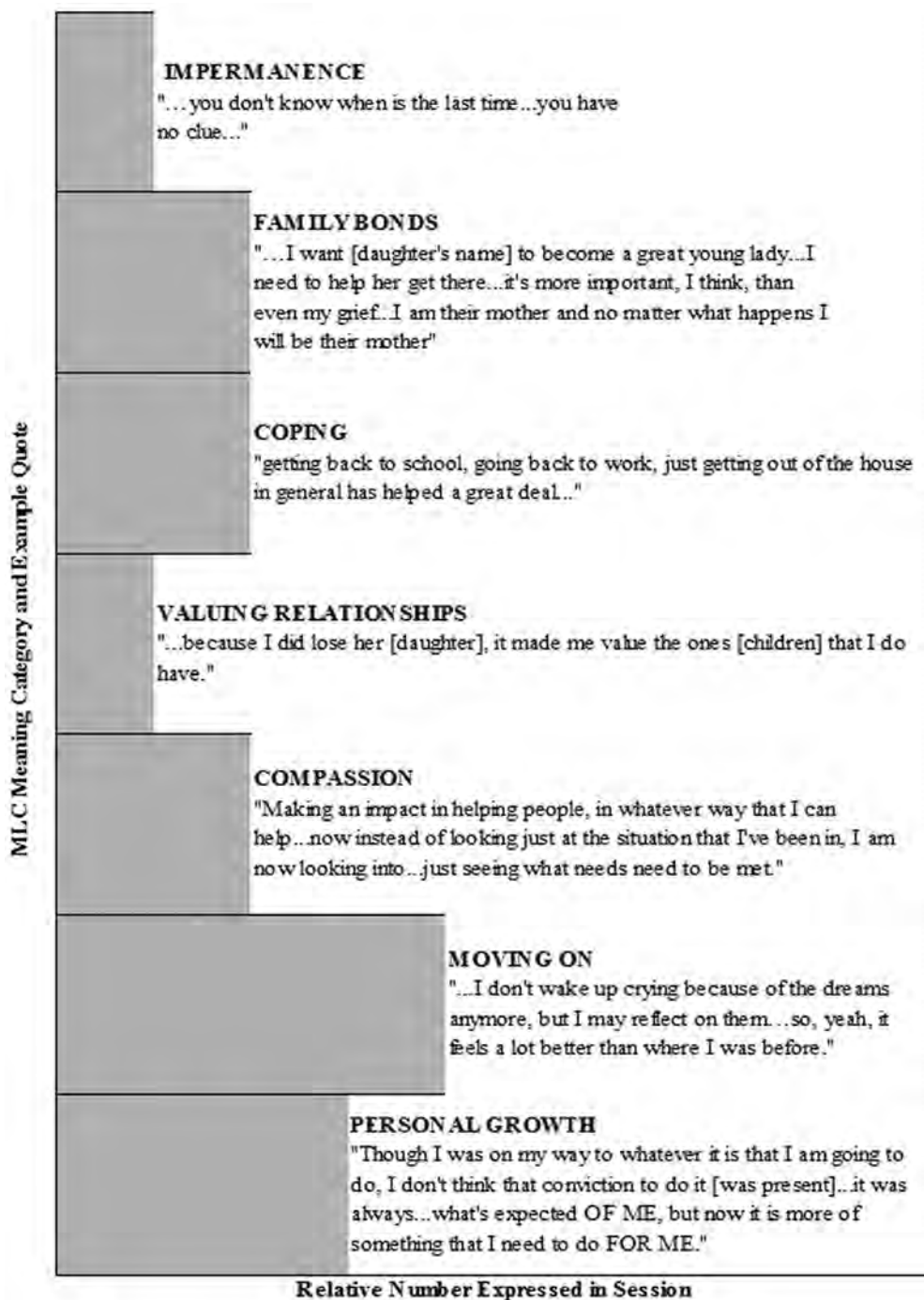


Figure 8.3 MLC meaning category expression in the termination session: Category name, illustrative client quotation, valence, and relative frequency

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Appendix 8.1 Meaning of Loss Codebook

Meaning of Loss Categories

1. *Valuing life*: Reflects the mourner's respect for the value of life. Phrases common to this category include: "cherish," "respect," "life is precious," and "don't take life for granted."
2. *Live to the fullest*: References the sentiment of living to the fullest or taking advantage of time.
3. *Impermanence*: Reflects the theme that "life is short," that "everyone dies," and that "it's a matter of time" for each of us. Also reflected is the notion that there are "no guarantees in life," but rather a certain randomness in when and how we die.
4. *Personal growth*: Refers to internal character improvement or personal development in the respondent, resulting in greater strength, maturity, changed priorities, responsibility, etc. Exclusions: External behavioral changes are coded in Category 5.
5. *Lifestyle changes*: Specific external behavioral or general lifestyle changes (e.g., "drinking less," "pursuing an education," "taking better care of my health"). Exclusions: Increased helping behaviors coded in Category 8. Internal growth in character is coded in Category 4.
6. *Family bonds*: Includes references to a change in outlook and/or behavior towards family members (e.g., "family means more to me now," "spend more time with my children").
7. *Valuing relationships*: Refers to appreciating social support, valuing friendships and relationships to people in general, and efforts to become emotionally closer to others. Exclusions: Family-related valuation coded in Category 6.
8. *Compassion*: Reflects the idea that experiencing loss has made the bereaved individual more altruistic, sensitive, empathic, and willing or able to help others.
9. *Coping*: Includes various means of adaptively responding to the loss (e.g., "I'm coping" or "I'm dealing with it"). Exclusions: Coping by "moving on" coded in Category 10. Coping via "acceptance" coded in Category 12.
10. *Moving on*: Limited to the phrase "moved on," a colloquial expression implying that the loss is a thing of the past and the bereaved person is making progress in her or his life.
11. *Greater perspective*: Focuses on the notion of not being upset by "small stuff" or "little things."
12. *Acceptance*: The term "accept" is required for coding into this category.
13. *Decedent preparation for death*: Refers to the idea that the decedent was prepared for loss (e.g., "he was ready to go," "we were prepared for her death").
14. *Memories*: References general or specific memories of the deceased (e.g., "she lives in our memory," "I will never forget him").
15. *Time together*: Refers to the sentiment of valuing the time one had with the deceased loved one.
16. *Affirmation of deceased*: Reflects the notion that "she lived a good life" or "he was a good person" (e.g., "he was a person of character," "she was so loving").
17. *Release from suffering*: Captures the sentiment that the death ended sickness or suffering and brought peace to the decedent and/or the bereaved.
18. *Spirituality*: Includes any mention of God, religion, spiritual faith, the afterlife, and more ambiguous notions, such as "they're in a better place" or "they're watching over me." Exclusions: More general statements regarding appreciation of life are coded into Category 1 and those regarding a change in perspective are coded into Category 4.
19. *Identity as bereaved person*: Refers to new bereavement-related identities that one takes on as a result of loss (e.g., orphan, widow, single mother). Exclusions: "Survivor" identity coded in Category 21. Loss of identity coded in Category 27. Unspecified change to identity coded in Category 29.

20. *Survivor identity*: Refers to a particular identity in which the bereaved individual views or defines her/himself specifically as a “survivor.”
21. *Emotionality*: Covers a range of references to emotion or emotional expression that are not necessarily depressive or negative in nature, such as “I’m more emotional now,” “my emotions are different,” and “deep emotion is a gift.” Exclusions: References to specifically depressive or negative emotion are coded in Category 22.
22. *Negative affect*: Covers a wide range of negative affective responses to loss that resemble complicated grief, guilt, depression, emptiness, or other psychological distress.
23. *Regret*: Reflects expressions of regret about something done or left undone, with statements such as “I wish I’d done this . . .” or “I could have done that . . .”
24. *Missing the deceased*: Reference to missing, longing, or yearning for the deceased.
25. *Lack of understanding*: Captures the sentiment that one is trying to make sense or meaning but hasn’t found it or has given up on trying to do so. Meanings in this category refer to confusion, frustration, resignation, or a process of continually asking why the loved one had to die.
26. *Lost identity*: Refers to loss of specific roles or sense of self, usually described as a devastating loss, such as “I lost my existence” or “my whole identity.”
27. *Lost innocence*: Refers to lost innocence or naiveté or trust in the goodness of the world or people in it.
28. *Identity change, nonspecific*: Refers to the presence of change but without specification of the nature of the change (e.g., “I’m a new person”).
29. *Meaning made, nonspecific*: Refers to having found meaning or sense in the loss, but with no specification of how or what kind of sense. Statements in this category included “there was a reason, but I don’t know it yet” and “not much, but some sense.”
30. *No meaning*: Reflects that there was no benefit or no sense to be made.

Grief and Meaning Reconstruction Inventory (GMRI)

Robert A. Neimeyer, James M. Gillies, and Evgenia Milman

Purpose

As many practicing clinicians can attest, grieving clients often struggle with complex issues of meaning in the wake of loss, grappling with such questions as “How do I make sense of my loved one’s death?” and “What is the meaning of my life now in its wake?” At other times, they seek answers to questions such as “How do I recover or reconstruct a significant connection to my loved one that survives her or his physical death?” (Neimeyer & Thompson, 2014). Accordingly, recent scholarship in the field of bereavement has converged on the conclusion that grieving entails an attempt to reaffirm or reconstruct a world of meaning that has been challenged by loss (Neimeyer & Sands, 2011). Specifically, whether theorists formulate grief in terms of shifts in the mourner’s *assumptive world* (Janoff-Bulman, 1989), *global meanings* (Park, 2010), *self-narratives* (Neimeyer, 2001), *autobiographical schemas* (Boelen, van den Hout, & van den Bout, 2006), or *role relationship models* (Horowitz, Bonanno, & Holen, 1993), each views the grieving individual as negotiating the challenge that a death event poses to his or her manner of understanding and functioning in the world (Gillies, Neimeyer, & Milman, 2014).

Supporting this proposition, a burgeoning body of research documents that bereaved young people (Currier, Holland, & Neimeyer, 2006; Holland & Neimeyer, 2010), parents (Keesee, Currier, & Neimeyer, 2008), adults (Davis, Wohl, & Verberg, 2007), and older adults (Coleman & Neimeyer, 2010) who are unable to make sense of the death of a loved one are at risk of complicated and protracted grief symptomatology, whereas those who succeed in finding meaning in the experience show greater adaptation and resilience. Until recently, however, no convenient measure has existed to assess the degree and type of meanings made in the wake of loss for use in research and clinical settings. The Grief and Meaning Reconstruction Inventory (GMRI) was constructed to fill this void.

Development

The content for the GMRI was derived from a purposive sample of 162 bereaved adults who were selected to ensure considerable diversity in ethnicity, relationship between bereaved and decedent, age of deceased, cause of death, and level of grief distress. Each responded to a series

of probes about the sense they had made of the loss, any benefit or life lessons that they had winnowed from it, and significant changes in their sense of personal identity that had resulted. Their narrative responses were then carefully analyzed into discrete meaning themes which were then categorized (Gillies et al., 2014), and 65 representative Likert scale items were constructed to capture the range of meanings made across these categories. A second sample of 332 adults bereaved in the last 2 years then completed this preliminary version of the GMRI, which was factor analyzed to identify different coherent subscales in the measure, and the resulting scale was tested for its validity, internal consistency, test–retest reliability, and relation to several different measures of bereavement adaptation and behaviors reflecting meaning-making in the wake of loss (Gillies, Neimeyer, & Milman, 2015).

Format and Psychometric Properties

In its factor analyzed and validated form, the GMRI consists of 29 items (e.g., “I value and appreciate life more”; “Since this loss, I’m more self reflective”) that are rated on 5-point Likert scales, ranging from *Strongly disagree* to *Strongly agree*; see Appendix 9.1). The items factor into the following subscales, each of which displays good internal consistency:

1. *Continuing bonds* (7 items, $\alpha = .85$), reflecting an ongoing attachment or sense of connection to the deceased.
2. *Personal growth* (7 items, $\alpha = .83$), bearing on the respondent’s sense of becoming a stronger, more responsible, and more thoughtful person.
3. *Sense of peace* (5 items, $\alpha = .79$), referring to a feeling that both the deceased and loved one were prepared for the death, and that the loss made sense to the survivor.
4. *Emptiness and meaninglessness* (6 items, $\alpha = .76$), a negative factor, assessing the extent to which the death left the survivor feeling lost, alone, without a sense of understanding or benefit.
5. *Valuing life* (4 items, $\alpha = .76$), signaling the survivor’s investment in living life fully despite its brevity.

The total score on the GMRI ($\alpha = .84$) simply represents the sum of the ratings of all items for Factors 1, 2, 3, and 5, with those for Factor 4 being reverse scored so that higher values on all factors represent better adjustment.

The validity of the GMRI is supported by its significant negative correlation ($-.39$) with the Inventory of Complicated Grief-Revised (ICG-R), with the exception of Factor 4, *Emptiness and meaninglessness*, which showed the predicted positive correlation (.68) with this widely used index of protracted and intense grieving. Similarly, significant negative correlations were observed between the GMRI and Hogan Grief Reaction Checklist factors measuring grief-related *Despair* ($r = -.29$), *Blame and anger* ($r = -.26$), *Detachment* ($r = -.32$), and *Disorganization* ($r = -.25$). Also as expected, significant positive correlations were found between the HGRC’s *Personal growth* factor and both the GMRI total ($r = .35$), and GMRI Factor 2, *Personal growth* ($r = .54$). The GMRI displayed more modest negative correlations ($-.24$ to $-.25$) with general measures of psychiatric distress. As a final reflection of its validity, respondents scoring high on the GMRI also reported significantly more engagement in behaviors reflective of making meaning of the loss, such as volunteering to help other bereaved persons; contributing to grief support groups; enjoying new hobbies and activities; donating to charitable causes; talking about spiritual, existential, and philosophical issues; and taking time to enjoy the little things in life. Test–retest reliability for the total GMRI was good (.71) across a 4–6 week period (see Gillies et al., 2014, for details).

Clinical Applications

In addition to its use in research on the process and outcome of meaning-making in bereavement and the efficacy of grief therapy, the GMRI can prove useful in both documenting therapeutic progress through its periodic administration across treatment and in targeting areas deserving of closer clinical assessment and intervention. In the latter case, it can be useful to simply compute the mean score for each of the items on a given factor and plot these in a simple line graph to enhance their comparison by both client and therapist.

To illustrate this straightforward technique, Figure 9.1 displays the GMRI profile for Cheryl, a 32-year-old woman who had lost her husband to suicide two months before. As her peak score on *Emptiness and meaninglessness* (EM) indicates, Cheryl struggled greatly with the meaning of her husband's depressive choice, leading him to place a handgun to his head and pull the trigger in their living room just 30 minutes after she left for work. As her low scores on both *Sense of peace* (SP) and *Continuing bond* (CB) reflect, Cheryl remained greatly distressed about the traumatic circumstances of the dying and struggled with a troubled ongoing attachment to her husband, which was characterized by a great deal of "unfinished business." Accordingly, therapy concentrated on attempting to make sense of the death through addressing the myriad questions it raised for her, ranging from concerns about whether her husband had suffered in dying (which was resolved sufficiently for her through an in-session review of the medical examiner's autopsy report with the emotional and interpretive support of the therapist) through questions about his motives (addressed through therapist-prompted imaginal dialogues with her husband about his despair and fatal decision). These and other interventions (e.g., a photographic review of the relationship in better times) also contributed incrementally to a partial re-establishment of a less trauma-saturated ongoing bond with her husband, as she drew on relatively intact sources of meaning in her present and future. Among these were her evident commitment to *Valuing life* (VL) and *Personal growth* (PG), given clear expression in relation to a caring network of friends and family, and most particularly in her powerful investment in raising her 16-month-old daughter to live fully, despite the shared tragedy that

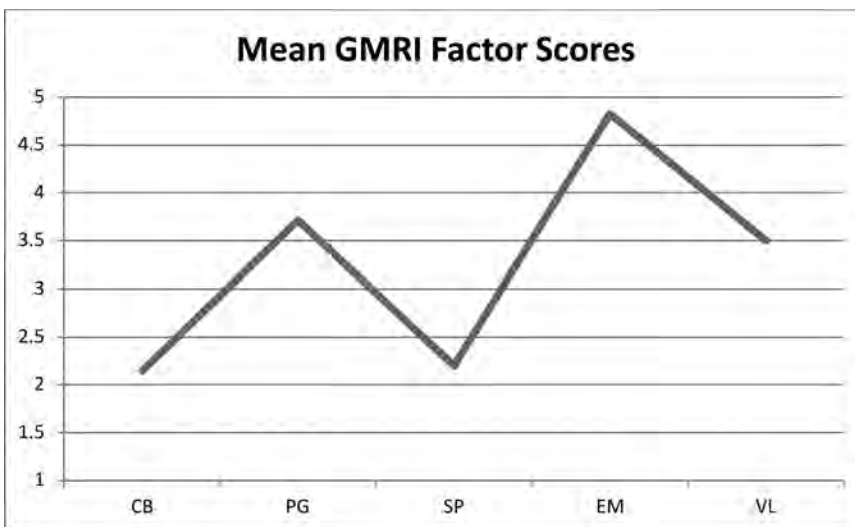


Figure 9.1 Cheryl's GMRI profile three months following her husband's death by suicide. CB, continuing bonds; PG, personal growth; SP, sense of peace; EM, emptiness and meaninglessness; and VL, valuing life

had touched their lives. Re-administration of the GMRI documented conservation of these core values and gradual progress in other areas over the five months of the therapy.

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Appendix 9.1 Grief and Meaning Reconstruction Inventory

Name: _____

Date: _____

The following statements refer to thoughts, beliefs, feelings, and meanings some bereaved people experience following their loss. Please circle the number that rates the degree to which each of these experiences has been true for you in the past week, on a scale from 1 to 5:

- 1 = Strongly disagree
 2 = Disagree
 3 = Neither agree nor disagree
 4 = Agree
 5 = Strongly agree

1. The time I spent with my loved one was a blessing	1	2	3	4	5
2. I do not see any good that has come from this loss	1	2	3	4	5
3. Since this loss, I'm more self-reflective	1	2	3	4	5
4. I value family more	1	2	3	4	5
5. I will see my loved one again	1	2	3	4	5
6. Since this loss, I find myself more alone and isolated	1	2	3	4	5
7. I've been able to make sense of this loss	1	2	3	4	5
8. Since this loss, I'm a stronger person	1	2	3	4	5
9. I can't understand this loss	1	2	3	4	5
10. I was prepared for my loved one to die	1	2	3	4	5
11. My loved one was a good person; he/she lived a good life	1	2	3	4	5
12. I value and appreciate life more	1	2	3	4	5
13. Since this loss, I've changed my lifestyle for the better	1	2	3	4	5
14. Memories of my loved one bring me a sense of peace and solace	1	2	3	4	5
15. This death brought my loved one peace	1	2	3	4	5
16. I've lost my innocence	1	2	3	4	5
17. This death ended my loved one's suffering	1	2	3	4	5
18. I miss my loved one	1	2	3	4	5
19. Since this loss, I make more effort to help others	1	2	3	4	5
20. I feel empty and lost	1	2	3	4	5
21. I cherish the memories of my loved one	1	2	3	4	5

22. Since this loss, I value friendship and social support more	1	2	3	4	5
23. My loved one was prepared to die	1	2	3	4	5
24. Whenever I can, I seize the day. I live life to the fullest	1	2	3	4	5
25. Since this loss, I'm a more responsible person	1	2	3	4	5
26. I believe my loved one is in a better place	1	2	3	4	5
27. I feel pain from regrets I have in regard to this loss	1	2	3	4	5
28. I've come to understand that life is short and it gives us no guarantees	1	2	3	4	5
29. Since this loss, I've pursued new avenues of knowledge and learning	1	2	3	4	5

Factor	Item numbers
1. Continuing bonds	1, 5, 11, 14, 18, 21, 26
2. Personal growth	3, 8, 13, 19, 22, 25, 29
3. Sense of peace	7, 10, 15, 17, 23
4. Emptiness & meaninglessness*	2, 6, 9, 16, 20, 27
5. Valuing life	4, 12, 24, 28

*These items are reverse scored.

Note: This scale is published in the public domain to encourage its use by interested clinicians and researchers. No formal permission is required for its duplication and use beyond citation of its source and authorship.

Inventory of Daily Widowed Life (IDWL)

Michael Caserta, Dale Lund, and Rebecca Utz

Purpose

It is generally agreed that the coping processes bereaved spouses/partners pursue become the underlying mechanisms that largely determine how well they adapt to their losses (Hansson & Stroebe, 2007), which has understandably been the focus of researchers and clinicians alike (Stroebe, Folkman, Hansson, & Schut, 2006). One framework that has attracted growing attention since its emergence in the late 1990s is Stroebe and Schut's (1999, 2010) Dual Process Model of Coping with Bereavement (DPM). This model holds that as bereaved individuals adapt to the loss they engage in two forms of coping. *Loss orientation* (LO) addresses the effects of the loss itself, typically involving grief-work, rumination, reminiscences, and reframing the nature of the continuing bonds one has with the deceased. Alternatively, *restoration orientation* (RO) is that form of coping focused on the life changes consequential to the loss, including adjusting to a new role identity as a single person and taking on additional responsibilities and tasks, sometimes requiring new skills to be learned. The DPM also takes into account the need to periodically take time away from grief to engage in diversionary respite from the stress and the negative emotions associated with the loss or to address other matters needing attention. A distinguishing feature of this model is *oscillation* through which the bereaved will consciously and deliberately alternate between the two forms of coping. Although LO is generally emphasized more recently after the loss with greater attention to RO later, oscillation will occur throughout the course of bereavement.

The amount of attention given to LO versus RO at any given time will vary with each individual and no optimal oscillation pattern has yet been determined (Caserta & Lund, 2007; Stroebe & Schut, 2010). Adverse outcomes could potentially occur, however, if individuals fail to oscillate adequately, being too enmeshed in one form of coping at the expense of the other (Stroebe & Schut, 2010). It is important, therefore, for researchers to examine factors associated with ineffective oscillation as well as for clinicians to identify those experiencing difficulty engaging in both LO and RO processes in a way that fosters adaptation. The Inventory of Daily Widowed Life (IDWL) was designed to measure the amount of engagement in LO and RO processes as well as the extent of oscillation between them. We also briefly present in this chapter a set of companion indicators that we constructed since the IDWL was initially developed. Although not part of the IDWL itself, these items are meant to accompany the scale to provide information specifically about oscillation.

Development

We initially generated 20 Likert-format items (10 LO and 10 RO) using face validity criteria derived from Stroebe and Schut's (1999) theoretical description of potential features associated with both processes. These items were then scrutinized by an assembled panel of judges including a licensed grief counselor, two widows and two widowers bereaved approximately 5 years who had adapted effectively, and members of our research team who did not have roles in the development of the 20 items. The panel was familiarized with the LO and RO features of the DPM and then instructed to inspect the items for readability, ease of comprehension, and if deletions or additional items were needed. The panel suggested some wording changes to improve clarity as well as the addition of an LO and RO item to the scale, resulting in a final 22-item version consisting of two 11-item subscales, one measuring LO and one RO. The IDWL was validated as part of a self-administered questionnaire containing selected outcome measures completed by 163 bereaved spouses, ages 45–94, 84 of whom were recently widowed (2–5 months) and 79 being bereaved 12–15 months (Caserta & Lund, 2007).

Format and Psychometric Properties

The IDWL instructs the respondent to report how much time in the past week he or she spent on the LO and RO activities depicted by each item, using a 4-point response format ranging from *Rarely or not at all* to *Almost always* (see Appendix 10.1). Each subscale score ranges from 11 to 44, with higher numbers representing higher levels of LO- or RO-related coping. From these scores, an oscillation balance score is calculated by subtracting the LO score from the RO score, yielding a potential range of –33 (exclusively LO-focused) to +33 (exclusively RO-focused). A score equal to 0 indicates perfect balance; however, a score ranging from –4 to +4 represents relative balance between the LO and RO processes. Oscillation scores exceeding an absolute value of 10 indicate a primary focus in one process over the other with greater values, especially those exceeding +20, representing a movement toward almost exclusive emphasis on LO or RO coping (Caserta & Lund, 2007).

Reliability estimates based on the 163 respondents mentioned earlier indicate good internal consistency. The LO subscale yielded $\alpha = .91$ for the recently bereaved (2–5 months) and $.88$ for those bereaved 12–15 months; the RO subscale generated $\alpha = .78$ for both subsamples. Reliability was further confirmed in a recently completed intervention study based on the DPM in which a sample consisting of 328 spouses/partners bereaved 2–6 months at baseline generated $\alpha = .91$ for the LO subscale and $\alpha = .73$ for the RO subscale (Caserta, Utz, Lund, Swenson, & de Vries, 2014).

Construct validity of the IDWL was determined by examining relationships between the LO and RO subscales and selected outcomes, controlling for time since death. As expected, both subscales produced statistically significant relationships with common bereavement outcomes such as grief, depression, and loneliness but perceived self-care and daily living skills only generated statistically significant relationships with the RO subscale (see Caserta & Lund, 2007, for more detail). This is consistent with the DPM in that RO specifically pertains to addressing challenges associated with life changes due to the loss (Stroebe & Schut, 1999, 2010). Validity was also supported by differences in balance scores between the early ($M = 1.2$) and later ($M = 4.7$) bereavement groups, illustrating a greater emphasis in RO coping later in the course of bereavement versus early on (Stroebe & Schut, 1999, 2010). This was confirmed longitudinally in the aforementioned intervention study in which hierarchical linear modeling revealed incrementally greater emphasis in RO coping over a period of time spanning up to 18 months post loss (Caserta et al., 2014).

Companion Items

When we completed the 2007 validation study for the IDWL scale we recognized that oscillation is a complex concept with multiple dimensions in addition to balance. Such dimensions include awareness, control, and intent. Three separate *Awareness* items measure whether a bereaved person perceives his or her focus to be more directed at LO, RO, or a combination of LO and RO. *Control* captures the extent to which one makes a deliberate effort to engage in one process versus the other as needs warrant. *Intent* measures the reason one moves from one focus to the other. The awareness and control items use numerical or Likert (1–5) response formats where a higher number indicates greater levels of those attributes. The intent item is open-ended to allow clinicians or researchers to content-analyze the potentially diverse reasons bereaved individuals have for alternating between LO or RO coping at any given time. These companion items appear in Appendix 10.1 following the IDWL.

Clinical Applications

The IDWL subscale *Oscillation balance scores* and the information obtained from the companion items can be used by researchers and clinicians to track the extent of engagement in both coping processes as well as if one process is favored over the other by the bereaved and by how much. Because oscillation is a dynamic concept, measurement should be taken on multiple occasions; a one-time assessment that indicates a very high (unbalanced) engagement in LO or RO may not be sufficient to determine whether it is problematic, as individual life situations may influence the apparent imbalance temporarily, after which there would be a “swing” to a greater emphasis in the other form of coping. Persistent imbalance, however, could signal risk for adverse outcomes such as complicated grief (Stroebe & Schut, 1999, 2010) and in such cases, professional intervention could be warranted. At that time, a clinician could use the companion items related to *Awareness* to help the client recognize to what extent he or she is self-aware of his or her own coping strategies. In time, once the client is guided to recognize where he or she is directing an effort, the individual could exercise control over when this happens. Eventually, the *Control* item could be used to help the clinician determine if the client is beginning to make deliberate efforts to direct his or her coping in a direction that fosters adaptation. Information gathered from the *Oscillation intent* item could bring to the forefront conscious motivations for why and how often the bereaved client alternates focus between LO and RO coping.

We offer the following illustration. A widow bereaved for 18 months is still experiencing inordinate difficulty and decides she needs professional help. At the initial assessment she has a balance score skewed in the direction of almost exclusive attention to LO coping and is unable to address new responsibilities important to daily function, for example managing the household finances—something her deceased spouse used to handle. At the same time, her awareness scores confirm she is quite aware of this imbalance but is unable to escape the persistent rumination over her loss. The clinician initiates a treatment plan for complicated grief. As the treatment begins to obtain positive results, the IDWL balance and oscillation awareness scores also start to moderate. At this point the clinician can determine the level of control the woman has over when she deals with her loss and when she addresses RO-related issues. With the clinician’s help, she no longer will be chronically enmeshed in the loss and will begin to purposely (intent) engage in addressing the daily RO-related challenges (e.g., managing the household budget) she had been avoiding when she first sought treatment. This is affirmed by an oscillation balance score now showing more attention to RO-focused coping tempered with a healthier level of engagement in LO processes consistent with effective adaptation.

Because the IDWL scale was initially developed to assess coping strategies unique to the DPM among persons participating in intervention research, it is important to gain more knowledge about the scale's usefulness in clinical practice. We encourage clinicians to explore a wide range of creative options for using the IDWL and to share suggestions with us and other bereavement practitioners, researchers, and scholars.

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Appendix 10.1 Inventory of Daily Widowed Life (IDWL)

Below is a list of activities, tasks, or issues that those who have lost a spouse or partner sometimes need to confront or do in their daily lives. For each item, please indicate how frequently you have done it *during the past week*.

	Rarely or not at all	Once in a while	Fairly often	Almost always
1. Thinking about how much I miss my spouse/partner	1	2	3	4
2. Thinking about the circumstances or events associated with my spouse/partner's death	1	2	3	4
3. Yearning for my spouse/partner	1	2	3	4
4. Looking at old photographs and other reminders of my spouse/partner	1	2	3	4
5. Imagining how my spouse/partner would react to my behavior	1	2	3	4
6. Imagining how my spouse/partner would react to the way I handled tasks or problems I faced	1	2	3	4
7. Crying or feeling sad about the death of my spouse/partner	1	2	3	4
8. Being preoccupied with my situation	1	2	3	4
9. Engaging in fond or happy memories about my spouse/partner	1	2	3	4
10. Feeling a bond with my spouse/partner	1	2	3	4
11. Dealing with feeling lonely	1	2	3	4
12. Visiting or doing things with others	1	2	3	4
13. Finding ways to keep busy or occupied	1	2	3	4
14. Dealing with financial matters	1	2	3	4
15. Engaging in leisure activities (hobbies, recreation, physical activity, etc.)	1	2	3	4
16. Attending to my own health-related needs	1	2	3	4
17. Engaging in employment or volunteer work	1	2	3	4
18. Watching TV, listening to music, listening to the radio, reading	1	2	3	4
19. Attending to legal, insurance or property matters	1	2	3	4
20. Attending to the maintenance of my household or automobile	1	2	3	4
21. Focusing on other things besides grieving	1	2	3	4
22. Learning to do new things	1	2	3	4

Scoring Instructions:

- LO Subscale Score = Sum of items 1–11
- RO Subscale Score = Sum of items 12–22
- Oscillation balance = RO score minus LO score

IDWL Companion Items

Sometimes when people adjust to the loss of their spouse or partner they focus their attention on dealing with two different types of issues. One issue is dealing with their grief, emotions, and feelings and the other issue is dealing with new responsibilities and activities and/or having time away from grieving. Please answer the following questions related to how you have focused your attention on these two issues *during the past week*.

1. During the past week, to what extent have you focused your attention on dealing with your grief, emotions and feelings? (Circle a number below) [*Awareness*]

1	2	3	4	5
Very little				A great deal

2. During the past week, to what extent have you focused your attention on dealing with new responsibilities and activities and/or having time away from grieving? (Circle a number below) [*Awareness*]

1	2	3	4	5
Very little				A great deal

3. During the past week, to what extent have you gone back and forth in focusing your attention on dealing with both of these issues? (Check the response below that is most accurate for you) [*Awareness*]

- (1) I have not gone back and forth because I have focused on only one issue.
(If you checked this answer, please skip the next two questions)
- (2) Gone back and forth once or twice this past week.
- (3) Gone back and forth several times this week.
- (4) Gone back and forth a few times each day.
- (5) I have gone back and forth several times each day.

4. If you have given attention to dealing with both of these issues at least once this past week, were you able to go back and forth as you wanted to do so? (Circle a number below) [*Control*]

1	2	3	4	5
I have no control				Yes, I have full control over this

5. When I go back and forth between dealing with these two issues, I usually do it because I _____ [*Intent*]

Perceived Life Significance Scale (PLSS)

Rachel Hibberd

Purpose

Much research in recent years has identified the importance of meaning as an element of recovery from significant loss. The majority of models and measures of meaning have focused on meaning as “sense-making”; in other words, as an effort to integrate the loss with coherent and positive narratives about world and self (e.g., Davis, Nolen-Hoeksema, & Larson, 1998; Gillies & Neimeyer, 2006; Janoff-Bulman, 1992; Park & Folkman, 1997). In contrast, a recent literature review identified a distinct conceptualization of meaning as *life significance*: the perception of value associated with a goal, relationship, or aspect of life experience that exists or is pursued in the present and future (Hibberd, 2013). Life significance is what is meant when we speak of something that “means a lot” to us; it is intrinsically, transcendentally, existentially valued. For example, experiences such as watching one’s young children play soccer, working hard on a political or activism project, writing a book, or watching the sunset may produce feelings of life significance.

Qualitative research and theoretical models suggest that life significance may be an important and by no means guaranteed outcome in grief recovery, as individuals strive to identify what “matters” when an important relationship is fundamentally altered (Armour, 2003; Tedeschi & Calhoun, 1996; Wheeler, 2001). Bereavement may strip a mourner of important life roles (e.g., parent, wife), and significant moments may seem empty in the absence of someone with whom to share them (Hershberger & Walsh, 1990). Confrontation with death also brings issues of significance to the forefront; individuals may question the point of living at all, or a renewed awareness of life’s scarcity may produce a sense of appreciation (Tedeschi & Calhoun, 1996). The Perceived Life Significance Scale, a new measure of life significance, seeks to quantify the perceived intrinsic value of one’s activities, relationships, and everyday experiences (Hibberd & Vandenberg, in press). In clinical practice, the PLSS can be useful as a measure of change in life significance across a course of therapy, as well as to stimulate discussion of life meaning with grieving clients.

Development

Item content for an initial large pool of potential PLSS items was developed using qualitative data from four focus groups ($N = 31$), specifically focusing on the construct of life significance as described above (Hibberd & Vandenberg, in press). Focus group participants were asked a

number of questions about their experiences of finding “what matters” following bereavement, with particular attention to (a) specific language used by participants to describe meaning, and (b) any distinctions articulated between different sources of meaning (i.e., as relevant to hypothesized subdimensions of life significance).

Item selection, as well as evaluation of the reliability and validity of the final 19-item Perceived Life Significance Scale, was conducted in two phases with two different samples. Selection of items for the final 19-item PLSS scale (from the initial large item pool generated by focus groups, described above), as well as exploratory factor analyses to identify potential subscales, involved an ethnically diverse group of bereaved undergraduate students at a large Midwestern university ($N = 353$). Analyses confirming the factor structure of the scale, as well as examining its validity with respect to other measures, was conducted with a separate sample of community bereaved adults ($N = 483$). See Table 11.1 for a summary of sample demographics and PLSS mean scores.

Format and Psychometric Properties

The PLSS consists of 19 items, each rated on a 7-point Likert scale, assessing individuals’ perceptions of current life significance. There are three subscales: *Active life significance* (Cronbach’s

Table 11.1 Demographic characteristics and mean PLSS scores of community and student samples

Demographic characteristic	Community sample		Student sample	
	N	%	n	%
Marital status				
Married or partnered	184	52	93	14
Widowed	74	21	0	0
Single	57	16	365	76
Divorced or separated	37	11	17	3.5
Ethnicity^a				
Caucasian	322	91	318	66
Hispanic or Latino/a	8	3	14	3
African-American	6	2	134	28
Asian	8	2	17	3
Other	14	4	11	3
Religious affiliation^a				
Protestant Christian	92	26	156	32
Catholic	90	26	110	23
Nondenominational Christian	73	21	85	18
Atheist or agnostic	73	22	71	15
Other	20	9	32	7
Gender				
Male	15	4	121	25
Female	330	96	359	75
	Mean	SD	Mean	SD
Age (years)	45.00	12.30	25.30	7.63
Closeness to deceased ^b	6.70	0.83	5.69	1.32
Time since loss (months)	38.57	34.00	46.62	36.72
PLSS total score	87.33	22.22	109.26	16.88

^aTotal percentage is greater than 100 due to some participants endorsing multiple categories.

^bAssessed using a Likert scale with endpoints 1 (not close at all) and 7 (very close).

SD, standard deviation.

$\alpha = .95$), *Receptive life significance* ($\alpha = .70$), and *Negative life significance* ($\alpha = .93$). Specifically, *Active life significance* is derived from intentional pursuit of and engagement with valued activities and goals; this is life significance as the “performative dimension” of meaning (Armour, 2003). Individuals find active life significance in the things they *do*. In contrast, *Receptive life significance* involves a more passive appreciation of beautiful or special life experiences, as described by individuals who report a greater awareness of the value of everyday life after becoming aware of life’s finitude (Wheeler, 2001). Individuals find receptive life significance in the things they *experience*. The *Negative life significance* subscale is composed entirely of negatively worded items (e.g., “My life is empty;” “I feel disconnected from the world”); thus, this subscale likely reflects a painful awareness of the absence of valued activities and relationships. Total score on the PLSS is calculated by simply adding the sum of all items, after reverse-scoring *Negative life significance* items. Higher PLSS total scores indicate stronger perceived life significance.

Quantitative analyses of the PLSS support the measure’s reliability ($\alpha = .95$ for the full scale), factor stability, and convergent and discriminant validity. The three-factor structure was found to be stable across both the community and student samples, and two of the three subscales correspond closely with hypothesized subdimensions of life significance (Hibberd, 2013). Additionally, the PLSS was found to correlate in expected directions with similar constructs (i.e., strongly and positively with general measures of meaning, and more moderately in a negative direction with constructs unrelated to meaning—grief intensity, depression, negative affect). A joint factor analysis of PLSS items and a commonly used measure of post-loss beliefs (the World Assumptions Scale; Janoff-Bulman, 1989) found better fit for a two-factor model, supporting the proposed distinction between life significance and sense-making. Finally, individuals who report stronger life significance also report greater fulfillment across a variety of domains, as well as more involvement with activities and roles likely to generate meaning (e.g., parenting, volunteering, caregiving).

Clinical Applications

In clinical practice, the PLSS can be used to assess for changes in life significance over the course of therapy by comparing scores across time points. It can be particularly useful when therapist and client share an explicit goal of identifying and pursuing valued experiences or behaviors (e.g., as compared with a shared goal of symptom reduction). Because of its face validity, the measure can also be used as a tool to stimulate discussion with clients about what the intended outcomes of therapy should be, what kinds of significance clients are currently experiencing, and how “what matters” has changed since a shattering loss.

Acceptance and Commitment Therapy (ACT), to provide an example, is a contextual behavioral style of therapy in which life significance (referred to as either “values” or “committed action” within the model) is of primary importance as an outcome of treatment (Hayes, Strosahl, & Wilson, 2011). In an 8-week ACT group for individuals who had experienced a morally injurious loss, the PLSS was used to assess life significance at the beginning and end point of therapy. One group member, Carol, demonstrated a particularly strong treatment response, corresponding with her report at follow-up assessment of a life that felt significantly more vital and engaged. Carol had witnessed the deaths of several civilian children during military service in Bosnia and was haunted by a sense of injustice and horror about these senseless deaths.

During a group exercise in which individuals were prompted to identify the link between the pain of loss and a cherished value, Carol discussed the particular gut response she has to violence perpetrated against children and linked it with a value of care and kindness toward innocent lives. She began to work on putting this value into practice more often during her work as a teacher, actively practicing compassion and perspective-taking when she felt irritated by her students. As she began to see students blossom under this treatment, Carol

described a sense of purpose and satisfaction consistent with the *Active life significance* subscale of the PLSS. She also became more connected with the intimacy and meaning available in her present-moment experience, consistent with the *Receptive life significance* subscale. Carol's total PLSS score at the end of the group was 102, close to the average found in our sample of bereaved undergraduates (see Table 11.1) and significantly higher than her score at the beginning of treatment. Discussing this gain with Carol in a follow-up call after the final group session afforded her an opportunity to discuss ways that she can continue to remain connected with the things that matter most in her life.

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Appendix 11.1 Perceived Life Significance Scale

Name: _____

Date: _____

Please respond to each of the following statements by indicating how often, or how completely, each statement is true for you. Use the following scale:

1 = Never/Completely disagree to 7 = Always/Completely agree

1. I feel satisfied and fulfilled by the things I do	1	2	3	4	5	6	7
2. There's nothing in my life that really matters*	1	2	3	4	5	6	7
3. I try to live my life to the fullest	1	2	3	4	5	6	7
4. There are moments when I'm powerfully aware of how valuable life is	1	2	3	4	5	6	7
5. I feel alive and full of vitality	1	2	3	4	5	6	7
6. I'm involved in activities that feel rewarding	1	2	3	4	5	6	7
7. My life feels like a waste of time*	1	2	3	4	5	6	7
8. I really care about the things I am doing with my life	1	2	3	4	5	6	7
9. Sometimes something so special or meaningful happens that I get choked up	1	2	3	4	5	6	7
10. I feel I have nothing to live for*	1	2	3	4	5	6	7
11. My life is empty*	1	2	3	4	5	6	7
12. The pain and suffering I've experienced connects me to other people who have also suffered	1	2	3	4	5	6	7
13. Life is too short to waste time on petty things	1	2	3	4	5	6	7
14. My life feels pointless at times*	1	2	3	4	5	6	7
15. If you look closely, the world is a beautiful place	1	2	3	4	5	6	7
16. I am energized by the things I want to do in my life	1	2	3	4	5	6	7
17. I am deeply engaged in my life	1	2	3	4	5	6	7
18. I feel disconnected from the world*	1	2	3	4	5	6	7
19. I am an active participant in my own life	1	2	3	4	5	6	7

*Reverse-scored.

Subscale	Item numbers
1. Active life significance	1, 3, 5, 6, 8, 16, 17, 19
2. Negative life significance	2, 7, 10, 11, 14, 18
3. Receptive life significance	4, 9, 12, 13, 15

Note: This scale is published in the public domain to encourage its use by interested clinicians and researchers. No formal permission is required for its duplication and use beyond citation of its source and authorship.

Inventory of Complicated Spiritual Grief (ICSG)

Laurie A. Burke and Robert A. Neimeyer

Purpose

Grieving precipitates a variety of reactions to the loss of a cherished loved one, including, in some cases, complicated grief (CG) (Prigerson et al., 1995)—a protracted, debilitating, and sometimes life-threatening response to loss. However, for a subset of spiritually inclined mourners, bereavement also assaults their long-held religious beliefs or spiritual ways of experiencing and understanding the world. A crisis of faith in the context of bereavement that includes the collapse or erosion of the griever's sense of relationship to God and/or the faith community has been termed "complicated spiritual grief" (CSG) (Burke, Neimeyer, McDevitt-Murphy, Ippolito, & Roberts, 2011; Shear et al., 2006), and consistently has been linked with CG (Burke & Neimeyer, 2014; Burke et al., 2011; Burke, Neimeyer, Young, Piazza Bonin, & Davis, 2014; Lichtenthal, Burke, & Neimeyer, 2011; Neimeyer & Burke, 2011).

Thus, understanding the association between CG and CSG is important for clinicians, spiritual leaders, and researchers who seek to develop, implement, and evaluate psychospiritual interventions to help grievers who are suffering spiritually following loss. Unfortunately, until recently, few grief-specific measurement tools existed to assess spiritual crisis in bereavement, leaving professionals forced to use generic measures of spiritual struggle instead. To bridge this critical gap, we developed, tested, and validated the Inventory of Complicated Spiritual Grief (ICSG). To our knowledge, the ICSG is the only validated scale available to assess a client's level of spiritual distress specifically in the wake of the death of a loved one.

The ICSG is an easy-to-use, multidimensional measure of spiritual struggle following loss that can be used in a variety of clinical settings and with a range of research samples. In responding to indicators of spiritual crisis, the ICSG instructs participants to consider their index loss as they select from four response options that best describe their experience in relation to both God and fellow believers.

Development

The development of the ICSG arose from efforts by Shear and her research team (2006) to assist Protestant pastors at a Pittsburgh church who requested help in piloting a simple-to-use, faith-based intervention for congregants grieving the death of a loved one. Shear's team first studied the bereavement path of 31 African American church attendees in an effort to ascertain how or if their faith was affected by the loss. Self-reports revealed that grievers' reactions spanned the

full range of responses from “faith stronger than ever” to “faith seriously shaken.” The researchers found that 19% of respondents reported that their faith took a turn for the worse during bereavement—a phenomenon that Shear and her colleagues referred to as “spiritual grief” (p. 7)—a grief-stricken spiritual reaction to an ostensibly premature or unfair loss, believed by the survivor to have occurred as a result of God’s doing or not-doing, undermining the griever’s previous spiritual ability to make sense of life and death. Shear’s team argued that experiencing grief in spiritual terms is similar to experiencing grief psychologically, where reactions to loss are viewed on a continuum of *highly resilient* to *severely complicated* responses, with the most problematic spiritual response being termed “complicated spiritual grief.” Accordingly, the original 28 items on the ICSG were derived from the results of Shear et al.’s (2006) study, focus group research participants (Burke, Neimeyer, Young, et al., 2014), and ongoing collaboration with other church pastors who routinely work with bereaved parishioners. Representative ICSG items include: “I sense the absence of God more than I do the presence of God,” and “I have withdrawn from my fellowship with other believers.” Importantly, because the content of the items originated with Christian congregants, both African American and Caucasian, it remains to be established whether the scale can be used meaningfully with mourners in other religious traditions. For example, although its focus on a personal relationship with God may be shared by practitioners of other monotheistic, Abrahamic traditions (i.e., variations of Judaism and Islam), it could be inappropriate for use with those who espouse different spiritual frameworks (e.g., Buddhism, Hinduism, or less theistic spiritual or secular world views). In such cases, other measures might be developed to better assess unique spiritual struggles expressed in these terms.

Format and Psychometric Properties

To test the ICSG, Burke, Neimeyer, Holland, et al. (2014) collected data from two samples. The first sample consisted of 152 grieving adults, referred to as the “community sample,” and the second consisted of 152 bereaved undergraduate psychology students at a large, mid-South, state university, referred to as the “college student sample.” The ICSG’s psychometric properties were established and an 18-item scale, including two subscales—*Insecurity with God* and *Disruption in religious practice*—emerged. This two-factor model was supported using exploratory factor analysis with the community sample. Confirmatory factor analysis with the student sample further revealed this model’s generalizability. Additionally, internal consistency and high test–retest reliability of both subscales as well as the total ICSG confirmed our expectations in terms of the scale’s satisfactory performance in measuring spiritual distress following loss.

Specifically, using item content, Burke, Neimeyer, Holland, et al. (2014) found that the first seven-item factor structure—*Insecurity with God*—assessed the extent to which the mourner experienced anger toward God in the wake of the loss or struggled with feeling confused or unprotected by God. The second factor structure—*Disruption in religious practice*—consisted of 11 items and appeared to measure the extent to which the loss interfered with one’s fellowship with the faith community, worship, or other religious practices. The total score for the ICSG represents the sum of all items, including the two subscales.

In terms of convergent and discriminant validity, total scores as well as subscale scores were correlated with representative scales in expected directions. For instance, in relation to convergent validity, ICSG total scores were statistically significantly correlated with the following measures in both the community and college student samples, respectively: Inventory of Complicated Grief-Revised (ICG-R) (Prigerson & Jacobs, 2001; $r = .34$, $r = .49$), the *Negative religious coping* subscale of the Brief RCOPE (Pargament, Smith, Koenig, & Perez, 1998; $r = .43$, $r = .50$), and subscales of the Religious Coping Activities Scale (RCA) (Pargament, Ensing, Falgout, & Olsen, 1990), including *Discontent* ($r = .53$, $r = .57$), and *Plead* ($r = .31$, $r = .23$). In terms of discriminant validity, ICSG total scores were found to have a statistically significant negative association with the following measures

in both samples, respectively: *Positive religious coping* subscale of the Brief RCOPE ($r = -.36$, $r = -.50$), subscales of the RCA, including *Spiritual-based coping* ($r = -.49$, $r = -.63$), *Good deeds* ($r = -.32$, $r = -.45$), *Interpersonal religious support* ($r = -.15$ n.s., $r = -.31$), *Religious avoidance* ($r = -.27$, $r = -.42$), and meaning-making as assessed using the Integration of Stressful Life Experiences Scale (ISLES) (Holland, Currier, Coleman, & Neimeyer, 2010; $r = -.28$, $r = -.48$). Thus, higher levels of complicated grief, negative religious coping, religious discontent, and religious pleading were correlated with higher ICSG total scores. Conversely, lower levels of positive religious coping, spiritually based coping, religious good deeds, interpersonal religious support, religious avoidance, and meaning made of loss were correlated with higher ICSG scores.

Tests of incremental validity also revealed that severe levels of complicated grief were related to higher ICSG total scores, even when scores on the negative religious coping subscale of the Brief RCOPE (a non-grief-specific measure of spiritual struggle) were held constant, as was true in both the community ($\beta = .22$, $p = .009$) and college student samples ($\beta = .36$, $p < .001$).

Additionally, in the community and college student samples, respectively, the seven items included in the *Insecurity with God* subscale were found to have good internal consistency ($\alpha = .89$ and $.87$), as did the 11 items included in the *Disruption in religious practice* subscale ($\alpha = .93$ and $.96$), and the 18 items included in the ICSG as a whole ($\alpha = .92$ and $.95$).

Finally, using a subset of grievors in the college student sample who provided follow-up data 3–4 weeks after the initial assessment ($n = 31$), results revealed high test–retest correlations for the *Insecurity with God* subscale ($r = .96$, $p < .001$), *Disruption in religious practice* subscale ($r = .95$, $p < .001$), and total ICSG ($r = .97$, $p < .001$), indicating the stability of the ICSG over time.

Clinical Applications

Spiritually distressed clients and clinicians alike often struggle to find the “right” opening in the therapeutic setting to broach the topic of a faith that has been compromised after the death of a loved one. Whether it be a sense of shame and self-disappointment on the part of the griever, or a sense of uncertainty and caution on the part of the therapist, initiating discussions that include sentiments such as disappointment with God, anger toward fellow believers, confusion about how to make spiritual sense of the death, or other complex emotions, thoughts, and responses is difficult for many mourners. Thus, the ICSG can be clinically useful not only as a means of assessing the trajectory of the survivor’s spiritual path throughout bereavement, but also in ascertaining exactly which spiritual/religious issues might surface for a particular believer in the confines of therapy.

To illustrate this, we highlight below how items on the ICSG helped to identify the spiritual struggle of one severely distraught mother in her spiritual quest for meaning and purpose. Elaine is a 65-year-old, married, African American woman whose 24-year-old son had been murdered in the process of a carjacking 6 years prior to our assessment. Her ICG-R scores indicated exceptionally high levels of CG symptoms, and yet existing scales of non-grief-specific spiritual crisis failed to capture the depth of her spiritual struggle that was apparent to both her and the clinical team. Prior to its empirical validation, Elaine agreed to participate in a focus group designed to refine the ICSG’s content to better reflect the experience of spiritually inclined mourners. The responses of focus group participants revealed an overarching narrative of resentment and doubt toward God, dissatisfaction with the spiritual support received, and substantial changes in their spiritual beliefs and behaviors following the death.

For instance, in regard to withdrawing from fellowship and worship, participant narratives spoke volumes about the source of clinically significant distress in relation to would-be spiritual supporters:

Most church members don’t know how to deal with grief. It makes them uncomfortable. And so it becomes more about their comfort than your pain. So, you choose who you open up to and confide in, and the rest of the people you avoid. You really

can't give them the chance to invalidate you or make you feel [worse]—you just keep them at bay.

As a whole, the group agreed with Elaine's sentiments in relation to both God and the spiritual community:

We don't like to admit that we get angry at God . . . because people would condemn us if we say that, so we don't. We're already hurt and we don't want to be hurt more by them condemning us for revealing our true feelings.

Thus, clinically, the ICSG can be useful as a therapeutic conversational springboard, perhaps by simply asking clients to complete the measure between or before sessions, and then encouraging them to "Start anywhere . . . which of these items that you marked would you like to tell me more about—which are salient for you today?" Discussing these then allows the griever to put into words the unspeakable, as the clinician invites deeper exploration of the client's pain in order to craft and use intervention techniques specifically appropriate for the situation. For instance, often the spiritually distressed griever feels at a loss as to where to direct the overwhelming amount and type of disappointment, discontent, and resentment welling up inside, sensing that to directly target God or a fellow believer is somehow inappropriate. However, the savvy clinician can assist by guiding a chairing experience, for example, where the griever holds an imaginal conversation with God (or a fellow congregant), allowing for full expression of anger, anguish, and sorrow in a safe, supportive setting.

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Appendix 12.1 Inventory of Complicated Spiritual Grief (ICSG)

Please think about your loss of _____, and then read each statement carefully. Choose the answer that best describes how you have been feeling during *the past two weeks including today*. Please answer these based on how you *actually* feel, rather than what you *believe* you should feel.

Items	Not at all true	A little true	Some what true	Mostly true	Very definitely true
1) I don't understand why God has made it so hard for me	0	1	2	3	4
2) I have withdrawn from my fellowship with other believers	0	1	2	3	4
3) I go out of my way to avoid spiritual/religious activities (e.g., prayer, worship, Bible reading)	0	1	2	3	4
4) I no longer feel safe and protected by God	0	1	2	3	4
5) I find that spiritual/religious activities are not very fulfilling (e.g., prayer, worship, Bible reading)	0	1	2	3	4
6) I find it impossible to pray	0	1	2	3	4
7) I struggle with accepting how a good God allows bad things to happen	0	1	2	3	4
8) I find it difficult to surrender my life to God	0	1	2	3	4
9) I don't feel as comforted by church fellowship as I used to	0	1	2	3	4
10) I can't help feeling angry with God	0	1	2	3	4
11) I don't feel very much like joining in fellowship to praise God or to glorify Him	0	1	2	3	4
12) The strong guiding light of my faith has grown dim and I feel lost	0	1	2	3	4
13) I'm confused as to why God would let this happen	0	1	2	3	4
14) I have lost my desire to worship	0	1	2	3	4
15) I find it impossible to worship	0	1	2	3	4
16) I feel my loss is unfair	0	1	2	3	4
17) I sense the absence of God more than I do the presence of God	0	1	2	3	4
18) I am a faithful believer, so I don't understand why God did not protect me	0	1	2	3	4

Notes: A sum of all items can be taken to compute a total ICSG score. Likewise, items 1, 4, 7, 10, 13, 16, and 18 can be summed to compute the *Insecurity with God* subscale, and items 2, 3, 5, 6, 8, 9, 11, 12, 14, 15 and 17 can be summed to compute the *Disruption in religious practice* subscale.

This scale is published in the public domain to encourage its use by interested clinicians and researchers. No formal permission is required for its duplication and use beyond citation of its source and authorship.

Moral Injury Questionnaire—Military Version (MIQ-M)

Joseph M. Currier

Purpose

Clinicians and researchers historically have emphasized the consequences of life-threatening events in the etiology of posttraumatic stress disorder (PTSD) and related problems. However, military service often entails exposure to a far more diverse set of potential traumas and high-magnitude stressors. For example, the emergence of guerrilla warfare and terrorism in the modern military era has engendered an increased probability of severe moral and/or ethical challenges for service men and women (e.g., fighting in densely populated areas, unmarked combatants, ambiguous civilian threats, constant threat of improvised explosive devices). So as to capture this alternate category of military traumas, Litz et al. (2009) define morally injurious experiences (MIEs) as “perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations” (p. 700). Shay (2014) also offers a complementary, three-dimensional definition of MIEs that focuses more strongly on the role of leadership malpractice: “(a) a betrayal of ‘what’s right’; (b) by someone who holds legitimate authority; (c) in a high stakes situation.”

In accordance with Criterion A for PTSD, these definitions highlight that MIEs can occur via direct experiences as a victim or agent of trauma as well as indirect forms of exposure (i.e., witnessing or hearing about MIEs). In addition, MIEs might occur without a salient possibility of physical injury/death (e.g., betrayal by a leader or trusted civilian) and/or in the context of life-threatening experiences that have traditionally provided the basis for a diagnosis of PTSD in military populations (e.g., treating civilians more harshly than necessary to obtain information that could minimize additional suffering/death to comrades and civilians). Given an amassing base of evidence for the possible mental health consequences of MIEs (for review, see Litz et al., 2009), the Moral Injury Questionnaire—Military Version (MIQ-M) was developed to provide a screening instrument for gauging levels of exposure to possible MIEs among veterans and other military personnel (see Appendix 13.1 for list of items).

Development and Format

Drawing on clinical evidence and available research findings at the time (e.g., Drescher et al., 2011), 20 items were theoretically derived to cover six general domains of MIEs: acts

of betrayal (i.e., by peers, leadership, civilians, or self; 3 items), acts of disproportionate violence inflicted on others (5 items), incidents involving death or harm to civilians (4 items), violence within military ranks (2 items), inability to prevent death or suffering (2 items), and ethical dilemmas and/or moral conflicts (4 items). Respondents are instructed to endorse the frequency they experienced each of the MIEs in the context of their military service. Items are rated on a 4-point scale in which 1 = *Never*, 2 = *Seldom*, 3 = *Sometimes*, and 4 = *Often*, and a total score is computed to provide an estimation of the respondent's overall exposure to possible MIEs in their military service (i.e., not only limited to war-zone deployments). Following a psychometric evaluation of these initial items (Currier, Holland, Drescher, & Foy, 2015), one item assessing sexual trauma (i.e., "I was sexually assaulted") was omitted to winnow the instrument down to a final set of 19 items.

Along with two colleagues, Kent Drescher and Dave Foy, we needed to address several substantial issues in developing the MIQ-M items. For example, we opted to combine direct involvement and witnessing MIEs for several of the items. While clinicians should be mindful about the unique psychological and spiritual/existent issues that may emerge from being an agent of trauma, we were concerned that grave shame and possible fears of legal ramifications would decrease the likelihood of obtaining accurate information from respondents who were directly responsible for committing acts of abusive violence during their military service. In addition, we worded the items in manner that could be considered causes of a moral injury (6 items); (e.g., "I saw/was involved in the death(s) of an innocent in the war") or effects (13 items, e.g., "I feel guilt for surviving when others didn't") of MIEs. Although this instrument is primarily intended to assess "exposure" to MIEs rather than the "symptoms" of a moral injury per se, we needed to blur these lines for capturing several key stressors that might lead to a moral injury.

Psychometric Properties

Although there are reports of increasing utilization of the MIQ-M among clinicians and researchers working with military populations, psychometric evidence for the instrument is currently based on a single study conducted by Currier et al. (2015). We recruited two samples of veterans for this study, including (1) a group 131 Iraq/Afghanistan veterans from a large community college in southern California (data collected between 2011 and 2013) and (2) a clinical sample of 82 veterans of the Iraq/Afghanistan wars who were in the first week or two of a residential treatment program for PTSD with a not-for-profit organization also located on the West Coast (data collected between 2008 and 2012). Participants in the community sample completed the MIQ-M along with self-report assessments of their military background and common forms of mental health symptomatology in this population. In contrast, participants in the clinical sample exclusively completed the MIQ-M.

Four key psychometric findings emerged from Currier et al.'s study. First, as one may anticipate, veterans in the clinical sample endorsed significantly higher scores across all of the MIQ-M items. Second, in keeping with trauma exposure measures in general, factor analytic results supported a one-factor solution for the MIQ-M (i.e., a unidimensional factor structure). Third, convergent validity analyses revealed that higher scores (indicative of greater exposure to MIEs) were correlated with greater exposure to general combat-related activities/circumstances ($r = .63$), impairments in work/social functioning ($r = .42$), PTSD symptomatology ($r = .65$), and depression ($r = .39$) in the community sample. Fourth, when controlling for demographic risk factors, deployment-related factors, and exposure to possible life-threatening traumas, tests of incremental validity indicated that MIQ-M scores were also uniquely linked with suicide risk and the other mental health outcomes assessed in the study. These findings provide evidence for the validity of the MIQ-M and support the applicability of

this measure for further research and clinical practice with individuals who are struggling to regain their psychological and (possibly) spiritual footing in the aftermath of MIEs.

Clinical Applications

The clinical utility of the MIQ-M is illustrated in the case of Mr. C, a 39-year-old, married Caucasian man with three young children. Mr. C was responsible for supervising security details for the Army National Guard during his second deployment to Iraq. Despite exposure to heavy fighting and unexpectedly performing several combat operational duties (e.g., sniper) across his two deployments, Mr. C maintained a steady psychological equilibrium and functioned quite well in the war-zone. However, while securing a checkpoint late one night in an isolated area, Mr. C and three of his men were confronted with an ambiguous but highly threatening situation. Despite their best attempts to force an oncoming vehicle to change course, a driver approached the checkpoint at a high speed and Mr. C needed to give orders for his men to fire upon the vehicle with their heavy artillery. Upon inspecting the vehicle, Mr. C did not discover an apparent group of insurgents or enemy combatants. Rather, he found the remains of an Iraqi family, including a husband, wife, and four young children.

Mr. C was psychiatrically discharged from the military shortly after this incident due to having a “mental breakdown,” and subsequently completed a lengthy psychiatric hospitalization in a military facility. At the time of a referral for psychotherapy 4 years later, Mr. C was still displaying severe PTSD symptoms along with a complex array of other emotional, interpersonal, and spiritual/existential problems related to the incident with the Iraqi family as well as a range of other MIEs. Along with being responsible for the deaths of several children, the following MIEs occurred “Sometimes” or “Often” during his military service (i.e., item score of 3 or 4 on the MIQ-M): betrayal of personal values, struggling with the humanity of the enemy, guilt about not saving someone’s life, negotiating ethical/moral dilemmas, feeling guilt about surviving, chaotic and out of control events, destroying civilians’ property unnecessarily, and making mistakes that led to death/suffering.

There are no currently established clinical thresholds or norms for the MIQ-M. However, we have applied the instrument in research with several independent samples of Iraq/Afghanistan veterans. On average, participants who were sampled in community contexts obtained total scores of 30 or below on the MIQ-M. As one may predict by Mr. C’s case, veterans sampled from clinical settings obtained higher overall scores on the instrument (approximate average range = 45–55). In general, these preliminary descriptive results indicate that persons who are seeking treatment for PTSD and other trauma-related problems will have confronted worse exposure to MIEs than nonclinical samples. As such, the MIQ-M may serve as an effective screening tool for assessing exposure to possible MIEs in the context of both psychological assessment as well as treatment planning.

Depending on the case, clinicians might administer the MIQ-M in a self-report manner or incorporate the items as part of their clinical interviews. However, prior to inquiring about MIEs and other potential traumas, clinicians need to specify their intentions and establish a context about why they are inquiring about different aspects of the patient’s military background. For example, a clinician may state in a respectful and caring manner: “As I’m figuring out how I might be of help to you, I really need to understand the full range of your military experiences. However, please know that we’re only going to scratch the surface today and I’m only going to ask you about the frequency these events occurred.” In so doing, clinicians should also start by inquiring about more benign aspects of the patient’s background and other types of difficult experiences that may have occurred for him or her in the context of military service (e.g., life-threatening stressors, physical injury, loss of close personal friends). Hence, when it comes time to provide information about MIEs, the patient should feel more

comfortable in the interview and may be less likely to feel shamed or stigmatized by disclosing these types of potential traumas.

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Appendix 13.1 Moral Injury Questionnaire—Military Version (MIQ-M)

Directions: Serving in the military can entail exposure to many stressful life events. Considering your possible war-zone deployment(s) and military service in general, please indicate how often you experienced the following types of events. Please read each statement carefully and note that for these statements, a response of 1 indicates that you “never” experienced the item and a response of 4 indicates that the item occurred “often” for you.

	Never	Seldom	Sometimes	Often
1. Things I saw/experienced in the war left me feeling betrayed or let down by military/political leaders				
2. I did things in the war that betrayed my personal values				
3. There were times in the war that I saw/engaged in revenge/retribution for things that happened				
4. I had an encounter(s) with the enemy that made him or her seem more “human” and made my job more difficult				
5. I saw/was involved in violations of rules of engagement				
6. I saw/was involved in the death(s) of an innocent in the war				
7. I feel guilt over failing to save the life of someone in the war				
8. I had to make decisions in the war at times when I didn’t know the right thing to do				
9. I feel guilt for surviving when others didn’t				
10. I saw/was involved in violence that was out of proportion to the event				
11. I saw/was involved in the death(s) of children				
12. I experienced tragic war-zone events that were chaotic and beyond my control				
13. I sometimes treated civilians more harshly than was necessary				
14. I felt betrayed or let down by trusted civilians during the war				
15. I saw/was involved in a “friendly fire” incident				

	Never	Seldom	Sometimes	Often
16. I destroyed civilian property unnecessarily during the war				
17. Seeing so much death has changed me				
18. I made mistakes in the war-zone that led to injury or death				
19. I came to realize during the war that I enjoyed violence				

Note. A sum of all items can be taken to compute a total score for the Moral Injury Questionnaire—Military Version (MIQ-M). This score will provide an estimated degree of “exposure” to potentially morally injurious stressors rather than gauging “symptoms” of a moral injury. At present, there are no established clinical thresholds for the MIQ-M or corresponding norms. The above instructions may be altered to make the measure applicable to different groups of interest and this numbering of items corresponds to the numbering used in the initial psychometric evaluation (Currier et al., 2015). In addition, an item assessing sexual trauma (i.e., “I was sexually assaulted”) was omitted from this version based on Currier et al.’s (2015) findings. This lack of evidence was likely due to problems with the wording of the item and characteristics of the study samples (i.e., over-representation of male veterans). Interested persons might consider revising the wording of this item to capture possible exposure to military sexual trauma.

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The Two-Track Bereavement Questionnaire for Complicated Grief (TTBQ-CG31)

Simon Shimshon Rubin and Ofri Bar-Nadav

Purpose

Bereavement is a powerful and life-changing event for many people. Despite the pain, the yearning, and the imagery related to the deceased or the death scene, the response to loss commonly is adaptive, and does not typically require intervention by mental health professionals. Adjustment to loss, however, can be facilitated in numerous ways by the community, family, and mental health professionals (Bar-Nadav & Rubin, in press). The clinician, the researcher, and indeed the bereaved themselves and their families share an interest in having measures to assist them in the quantification and classification of grief and loss as well as in specifying where they might benefit from professional assistance. Identifying someone's response to bereavement as requiring professional intervention, and even adding that the response fits the category of "complicated bereavement" or the DSM-5's "persistent complex bereavement disorder" can be useful when reasonable criteria are in place (American Psychiatric Association, 2013; Prigerson et al., 2011).

In the controversy regarding designating some forms of bereavement as diagnosable, we advocate a balanced position of specifying what in the bereavement response would benefit from intervention (Rubin, Malkinson, & Witztum, 2008; Shear et al., 2011). In keeping with the Two-Track Model of Bereavement (Rubin, 1999; Rubin, Malkinson, & Witztum, 2012), the nature, extent, and distress/dysfunction involved is organized along the twin domains of the model. Track I, *Biopsychosocial functioning*, focuses on the degree to which the bereaved is managing biological, social, and self-homeostasis. Track II focuses on the *Relationship to the deceased and the death story*, and assesses the degree and areas in which the continuing bond to the deceased and/or the death story are a source of difficulty (Rubin, 2012).

Development

Accordingly, we sought to create a measure that would utilize the perspective of the Two-Track Model of Bereavement that would be suitable for research and clinical use. The result was the Two-Track Bereavement Questionnaire (TTBQ), which we standardized on a sample of 356

persons. This 70-item self-report measure yields a total score as well as scores on individual variables associated with Track I (*Biopsychosocial functioning*) and Track II (*Relationship to the deceased*). Elsewhere we reported on the measure and its uses (Rubin et al., 2009) and recommend it for research in the field.

The next stage of our work sought to create a short form that would be both easy to use and that could identify complications of grief. We chose 31 items for inclusion on the basis of their loadings on the original factor structure as well as perceived clinical utility. This measure, the TTbQ2-CG31 follows in Appendix 14.1 (Rubin, Bar-Nadav, & Malkinson, 2013).

Format and Psychometric Properties

The TTbQ2-CG31 consists of 31 self-report items that are rated on 5-point Likert scales. A total of 412 adults completed the questionnaire, 86 of whom had lost parents, 96 had lost spouses, and 230 had lost children. The mean time since loss was 75 months. The questionnaire yields a total score indicating the degree of current difficulties in the grief process, with an internal reliability of $\alpha = .91$. Next, we conducted both exploratory and confirmatory factor analyses, finding and confirming a four-factor structure that focus on particular areas of difficulties in the grief process. Above the recommended cut-off points to be specified in the next section, individual factor scores as well as the total score can be taken as indications of complications in grief.

The four scales of the measure were grouped such that one factor is associated with Track I—*Biopsychosocial dysfunction* and three factors are related to Track II—*Relationship to the deceased and death story*. The factors are distributed as follows:

1. *Relational active grief and trauma* (RAGT-15 items, $\alpha = .94$), reflecting an ongoing hardship adjusting to life without the deceased, including features associated with difficulty in separation, “I think of _____ all the time”; distress, “Now I understand people who think about putting an end to their own life after losing a close person”; and experience of trauma, “I see images or pictures from the death scene that enter my thoughts.”
2. *Conflicted relationship with the deceased* (RC-5 items, $\alpha = .66$), reflecting the negative and conflicted aspects of the relationship with the deceased, prior to and post death, “My relationship with _____ had many and strong ups and downs.”
3. *Close and positive relationship with the deceased* (CPR-2 items, $\alpha = .68$), reflecting positive aspects of the relationship to the deceased, along the pathways of closeness and trust, “_____ was the person closest to me.”
4. *Dysfunction* (D-9 items, $\alpha = .79$), reflecting problems in coping with the loss and maintaining functioning in areas involving emotion regulation, “My mood is very depressed”; cognitive appraisal, “The direction of the changes in the meaning of my life has been for the worse only”; and in a variety of areas such as “I find it difficult to function socially.”

Clinical Applications

For many persons, there is considerable variation in the response to loss, which will be reflected in changing scores as a function of time, grief work, and changing life circumstances (Rubin et al., 2012). By administering the TTbQ2-CG31 relatively soon after the death, the response to loss baseline would be established. However, whenever administered, the measure yields a meaningful and clinically significant assessment on either or both Track I *Biopsychosocial functioning* and Track II ongoing *Relationship to the deceased and the death story*.

We recommend use of the TTbQ2-CG31 in a number of ways. For those looking to identify areas of particular concern based on quantitative parameters, we offer guidelines for

identifying persons along a continuum of acute grief to complications of bereavement. We generally identify individuals as presumptively exhibiting acute grief early in their response to loss in the first months post loss. Due to ongoing controversies regarding the trajectories of grief, we strongly advocate continued monitoring of individuals with scores above our cut-offs even when no intervention is instituted (Bryant, 2014; Simon, 2013). Usage of the term “complicated bereavement” will vary depending on the individual clinician, but we use the presumption of complications of bereavement after 13 months pending individual assessment.

We arrived at our suggested figures by analyzing our bereaved sample who were an average of 6 years post loss, and chose cut-offs that classify approximately 5% of adult children bereaved of parents, 10% of bereaved partners, and 25% of parents bereaved of adult children who are continuing at these levels of problematic response to loss. Thus, our cut-offs are as follows: (a) a total score on the TTbQ2-CG31 of 3.4 or more; or (b) a score of 4.1 or greater on RAGT (*Relational active grief and trauma*); or (c) a score of 3.1 or above on D (*Dysfunction*). From our experience, since RAGT includes items related to aspects as recurrent imagery of the death scene, strong connection to the deceased, disbelief that the death took place, potential life threat, etc., we recommend attention to individuals exhibiting scores above 3.6 for potential complications in RAGT.

The remaining two scales related to close and positive relationship and conflicts in the relationship are particularly sensitive to types of kinship. Taken together they reflect important aspects of the interpersonal relationship, with conflict being a particular focus of attention for clinician assessment. In Appendix 14.1, the distributions and cut-offs of the RAGT and D scales, as well as of the total score for our participants, are shown.

In addition to the evaluation of response to loss at any point in the bereavement period, there are several other important ways to use the measure. These include:

1. *Repeated use:* Having a baseline measure, one can determine improvement or worsening over time by administration at a later date. As the measure is self-report and easily adapted to computer administration, it would be quite simple to conduct a comparison between time periods.
2. *Treatment effectiveness:* Grief-specific assessment of intervention is feasible through administration of the measure at the assessment phase, at the start of intervention, during the course of treatment, at its conclusion, and at follow-up. Designing valid studies of any intervention requires careful planning, but even for individual clinicians, having available a standardized measure for use with clinically meaningful items is a welcome addition to the consulting room.
3. *Clinical screening:* In addition to the use of the factor and total scores for their quantitative information, all of the TTbQ2-CG31 items were chosen to warrant review by clinicians. Items such as “Now I understand people who think about putting an end to their own life after losing a close person”; “I am in great need of help”; “I believe and trust in my abilities to cope on my own with the tasks of life”; etc. serve to pinpoint areas worthy of further clinical evaluation.

As a clinical illustration, Sarah (a pseudonym), aged 67, lost her husband Baruch unexpectedly to a massive heart attack. She witnessed the efforts made to save his life by emergency personnel, and he died in her arms at their home. She was referred for treatment by her daughter to the second author (OBN) three months later. Referral reflected the daughter’s concerns, particularly by her mother’s strong reluctance to return home since the day of the death. Sarah stayed over at her children’s homes, and she found even the task of returning to the house to pick up clothes extremely difficult and upsetting. Following the initial consultation session, which identified great distress and the experience of traumatic bereavement, Sarah accepted

the recommendation for treatment and completed the TTbQ2-CG31. She scored 3.74 on the total TTbQ2-CG31, 4.25 on RAGT, and 2.75 on D. Her close and positive relationship was 4.5, but significantly, her score on the conflict scale was also elevated at 3.4. Her rating of individual items worthy of note included 3 on the degree to which she needed help, and 3 on understanding people who wished to put an end to their lives following loss.

In the initial sessions of treatment, she described her experience of trauma at the death scene and the impossibility of returning to their house where he had died. A retiree from her previous employment, Sarah was a full-time volunteer who went to great pains to make sure she was busy and without time to rest and experience painful thoughts and emotions related to Baruch and his death. As she described it, being busy helped her maintain a sense of coherence, built up her self-esteem, and kept her from “drowning in her sorrow.” As can be seen by her unusually high score of negative aspects of the relationship to her dead husband, she was very ambivalent with respect to his memory.

The treatment plan focused on her difficulties in emotion regulation and functioning (Track I), as well as upon her continuing bond with her deceased husband and the manner in which he had died (Track II). With regard to the former, improvement in her functioning followed the work Sarah did as OBN encouraged her to attend to her feelings and to approach her fluctuating level of discomfort in small and manageable units. At the same time, building on her success in her volunteer work, her positive relationships with her children and grandchildren, and her many areas of competence strengthened Sarah’s experience of resilience. She reconnected with her secure base and felt grounded in her strong sense of meaning and value (Neimeyer, 2001).

Parallel to this work, OBN also focused on Track II’s ongoing relationship to Baruch. Sarah was encouraged to approach thinking about her husband with openness to her complex feelings. She was encouraged to share small and manageable portions of the traumatic memories of the death scene, which allowed her significant relief. The ongoing relationship to Baruch was colored by ambivalence in the pre-loss relationship. She missed him deeply and sincerely, but at the same time felt and exhibited great anger towards him. She was angry at the way he had treated her desires and personal ambitions. A charismatic figure who had distinguished himself in both work and social contexts, Baruch had insisted that she be a supportive wife while he made himself the center of attention. Strongly encouraged to take the role of the moon reflecting the sun’s light, she found herself feeling generally invisible and insignificant in these social situations—and quite resentful. Voicing her anger and frustration in therapy was an important aspect of the treatment and allowed her to rework her experience of their relationship.

Treatment continued intensively for 15 months before moving to occasional meetings and ongoing follow-up. By this time, Sarah was much more confident in herself, her social interactions, and her abilities. Sarah continues to volunteer and still works very hard, but the driven quality of her involvement has lessened greatly. She has rented out her home, and relocated to live near her daughter. She has also become involved in a romantic relationship. Her scores at the conclusion of treatment reflected many of the improvements. Her total score was now 2.43, her RAGT score had declined to 2.75, and her dysfunction score was 2.13. In the realm of conflict vis-à-vis her husband, this score too had declined to 2.6.

Concluding Thoughts

The TTbQ2-CG31 is a significant addition to therapists’ and counselors’ blueprints and tool-boxes rooted in the Two-Track Model of Bereavement (Rubin et al., 2012). The questionnaire is designed to give meaningful information to aid clinicians in recognizing areas of particular difficulties and to assist them in the specification of targeted intervention domains. On the basis of the information provided by the measure, both clinicians and researchers are better

positioned to conceptualize, assess, and study the grief and mourning processes. In addition to the overall score on the measure, each of the factor scales provides important information on the unfolding of the bereavement process over time.

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Appendix 14.1 The Two-Track Bereavement Questionnaire—CG31 on Life Following Loss

Please complete the following questionnaire, which addresses a variety of questions concerning your life after the loss of a person important to you. Please read the questions and mark the answer that seems most appropriate to you.

At the end of the questionnaire is a section where you may add your comments. Thank you.

<p><i>Information about you</i></p> <p>Today's date: ____/____/____</p> <p>Your sex: (please circle) Male/Female</p> <p>Your age: _____</p> <p>Your country of birth: _____</p> <p>Country you live in now: _____</p> <p>Years in this country: _____</p> <p>Religion: (please specify): _____</p> <p>Degree of religious observance/belief: Please circle the number that applies best to you.</p> <table border="1" style="margin-left: 20px; border-collapse: collapse; text-align: center;"> <tr> <td style="padding: 5px;">1</td> <td style="padding: 5px;">2</td> <td style="padding: 5px;">3</td> <td style="padding: 5px;">4</td> <td style="padding: 5px;">5</td> </tr> <tr> <td style="padding: 5px;">Very little</td> <td style="padding: 5px;">Little</td> <td style="padding: 5px;">So-so</td> <td style="padding: 5px;">Much</td> <td style="padding: 5px;">Very much</td> </tr> </table>	1	2	3	4	5	Very little	Little	So-so	Much	Very much	<p><i>Details about the deceased</i></p> <p>First Name of the deceased: _____</p> <p>Date of death*: ____/____/____</p> <p>Age at death: _____</p> <p>Circumstances of the death: _____</p> <p>Your relation to the deceased: (please specify how you were related to or involved with the deceased). _____ _____</p> <p>*(date of death allows for computation of time since loss.)</p>
1	2	3	4	5							
Very little	Little	So-so	Much	Very much							
<p>Languages spoken at home: _____ _____ _____</p>											
<p>In all parts of the questionnaire, unless stated otherwise: 1—true, 2—mostly true, 3—so-so, 4—mostly not true, 5—not true.</p>											
<p>Part I. All questions refer to the past week unless stated otherwise</p>											
	True		So-so		Not true	For office use only					
1. My mood is very depressed:	1	2	3	4	5	A2 rI-DF					
2. I feel very anxious:	1	2	3	4	5	A3 rI-DF					

3.	The direction of the changes in the meaning of my life has been for the worse only:	1	2	3	4	5	A6 rI-DF
		Several times a day	Almost daily	Almost every week	Almost every month	Almost never	
4.	Thoughts and feelings flood and confuse me:	1	2	3	4	5	A7 rII-RAGT
		True	So-so	Not true			
5.	I function very well at work / school (Circle the X on the right if not applicable):	1	2	3	4	5	A9 I-DF X
6.	My self-perception this week has been almost totally positive:	1	2	3	4	5	A11 I-DF
7.	I find it difficult to function socially:	1	2	3	4	5	A12-r I-DF
8.	I believe and trust in my abilities to cope on my own with the tasks of life:	1	2	3	4	5	A19 I-DF
9.	Following the loss, it is fair to describe my current situation as in great need of help:	1	2	3	4	5	A20 rII-RAGT

Part II. Please read the instructions for the next section and proceed

In the following questions, wherever a line (_____) appears, please answer as if the name of the deceased was written there. The questions refer to the past week, unless stated otherwise.

	True		So-so		Not true	For office use only
1. Our relationship was such that when I think of _____, I usually remember our disagreements:	1	2	3	4	5	B2*-r II-RC
	Almost never	Almost every month	Almost every week	Almost daily	Several times a day	
2. Occasionally, I behave or act emotionally, as if I don't believe that _____ is gone. This happens to me:	1	2	3	4	5	B4 II-RAGT
	True		So-so		Not true	
3. I think of _____ all the time:	1	2	3	4	5	B6-r II-RAGT
4. I've reached a degree of acceptance of the loss of _____:	1	2	3	4	5	B7 II-RAGT
5. Thoughts about _____ bring up positive feelings in me:	1	2	3	4	5	B9 II RC
	Almost never	Almost every month	Almost every week	Almost daily	Several times a day	
6. I remember _____:	1	2	3	4	5	B10 II-RAGT
	True		So-so		Not true	
7. I avoid things that remind me of _____:	1	2	3	4	5	B11-r II-RC
8. Life without _____ is too hard to bear:	1	2	3	4	5	B13-r II-RAGT

3. My relationship with _____ was characterized by sharp changes between being close to being angry and/or wishing to be distant

C7-r
II-RC

4. _____ was the person closest to me:

C8-r
II-CPR

Part IV. Please proceed

The next questions ask about your thoughts and feelings today.

	True		So-so		Not true	For office use only
1. Because of the loss I feel very angry:	1	2	3	4	5	D4-r II-RAGT

Whom are you angry with and why?

(A) _____

(B) _____

	True		So-so		Not true	
2. I keep on experiencing the loss as a shocking and traumatic event in my life:	1	2	3	4	5	D7-r II-RAGT

Please explain why:

	Almost never	Almost every month	Almost every week	Almost daily	Several times a day	
3. I see images or pictures from the death scene that enter my thoughts:	1	2	3	4	5	D10 II-RAGT
4. I see images or pictures of _____ in my head:						D11 II-RAGT
5. I am flooded by thoughts and feelings about the death of _____:						D14 II-RAGT

	True	So-so	Not true
6. I am able to talk and share my feelings with other people and to receive their help and support:			D18* I-DF

If you wish to add information about how you have coped with your loss or to make additional comments, please add them here.

Thank you for your participation.

For office use only:

The numbers in the right hand column give the item number on the full scale TTbQ2-70. Persons interested in comparing the differences between the TTbQ2-70 to the original TTbQ will find that information on the TTbQ2-70.

Score by adding numbers of relevant scale, and dividing by number of items completed for each score except for X (*r* = reversal where 1 = 5, 2 = 4, 4 = 2, 5 = 1).

- Track I—Dysfunction = I-DF
- Track II—Relational Active Grief and Trauma = II-RAGT
- Track II—Conflict in the Relationship = II-RC
- Track II—Close Positive Relationship = II-CPR
- Total = raw scores of DF + RAGT + RC + CPR divided by number of items completed

Updates and other information regarding the TTbQ can be found at the website: etc.

TTbQ2-CG31 Clinician score sheet

Track II	Relational Active Grief and Trauma (RAGT)	A4R ¹ +A9R +B2 +B3R +B4 +B6 +B8R + B9 +B10R +B12R +B13R +D1R + D2R + D3 +D4 +D5	This should be calculated as a mean score (Total score divided by number of items completed).
Track II	Conflict in the Relationship (RC)	B1R +B5 +B7R +C2R +C3R	
Track II	Close and Positive Relationship (CPR)	C1R +C4R	
Track I	Dysfunction (D)	A1R +A2R +A3R +A5 +A6 +A7R +A8 +D6	
Total Score of TTbQ2-CG31		RAGT raw score ² + CR raw score + CPR raw score + D raw score divided by total number of items completed.	

¹R means to reverse the score so that 1 = 5, 2 = 4, 3 stays the same, 4 = 2, and 5 = 1.

²Raw score is the score computed after reversing the items labeled R but before division by number of items per factor.

Inventory of Social Support (ISS)

Nancy S. Hogan and Lee A. Schmidt

Purpose

Perceived lack of social support by a bereaved person has been identified as a risk factor for difficulty recovering from the death of a loved one (Doka, 1989; Rando, 1993; Stroebe & Schut, 2001; Worden, 1991). However, measuring social support and its effects on bereaved individuals' outcomes has posed difficulties for researchers (Gamino, Sewell, & Easterling, 1998). The ability of healthcare professionals and others to give appropriate and effective support to bereaved populations is dependent upon the support person's understanding of how bereaved individuals define things that help or hinder their coping with grief (Hogan & DeSantis, 1994; Hogan & Schmidt, 2002). The purpose of developing the Inventory of Social Support (ISS) was twofold: to operationalize social support as experienced by bereaved individuals and to better understand the role social support plays in adaptation to loss.

Development

The ISS items were initially developed from qualitative data obtained from 157 bereaved adolescents who provided written responses to the questions "What helped you cope with your grief?" and "What made it harder for you to cope with your grief?" The qualitative responses to these open-ended questions were analyzed using content-analysis procedures, with the units of analysis being phrases and sentences written by the participants addressing things that helped (e.g., "Just being there for me. If I ever needed someone to talk to day or night, there was always someone I could talk to"), and things that hindered their adapting to their loss (e.g., "The way people talked to me. The way they said, 'You should be over it by now'"). Participants referred to family members and friends as being helpful to them but there was a total absence of reference to school personnel or healthcare professionals supporting the bereaved adolescents (Hogan & DeSantis, 1994). Most participants in a study of 138 school personnel agreed that grieving students were overlooked (Dyregrov, Dyregrov, & Idsoe, 2013). Data were also obtained from 207 bereaved parents responding to the same "helped and hindered" questions. The data analysis resulted in findings similar to those derived from the adolescent study (Hogan, Greenfield, & Schmidt, 2001). Items for the ISS were developed from these two data sources to measure how bereaved adolescents and adults perceive social support that helps them to cope with the bereavement process.

Format and Psychometric Properties

The ISS is a brief, convenient, and unidimensional measure, which captures social support for grieving as experienced by the bereaved individual. The measure consists of five items that tap the attributes of this support. These include content related to (a) others taking the time to listen to the bereft, (b) the opportunity to express feelings openly and honestly, (c) a nonjudgmental stance of others, (d) the availability of at least one person to the bereft, and (e) getting help for grieving (see Appendix 15.1). Items are scored using a 5-point Likert-type scale, and respondents are asked to use the prior two weeks as a time dimension in rating the items. The measure is scored by adding the response values for each item, and dividing this value by the number of items in the scale.

Conceptually the ISS items represent the degree to which the bereft perceives that there is at least *one person* who will take the *time* to listen *nonjudgmentally* to them while they *openly and honestly* express their thoughts and feelings about grief. Cronbach's alpha internal consistency for this scale was .76 in a sample of 209 bereaved parents (Hogan & Schmidt, 2002). The correlation between responses over a 14-day period was .86. Criterion validity was assessed using data from 170 bereaved parents. We predicted negative relationships between ISS scores and both the *Avoidance* subscale of the Impact of Event Scale (IES) (Horowitz, Field, & Classen, 1993) and depressive symptoms as operationalized through the Beck Depression Inventory II scale (Beck, Steer, & Brown, 1996). As predicted, both correlations were significant and negative (avoidance, $r = -0.38$ and depressive, $r = -0.27$). These findings indicate that depression and avoiding grief work were negatively associated with a perception of being supported in their grieving. An exploratory factor analysis of the ISS using principal axis factoring revealed one factor explaining 51.9% of the variance. Factor loadings ranged from .47 to .74 (Hogan & Schmidt, 2002).

Further psychometric evidence for the ISS was obtained in a sample of family members who experienced the loss of a loved one and subsequently made a decision to donate tissues (Hogan, Schmidt, & Coolican, 2014). Data were collected at 6 months ($n = 107$), 13 months ($n = 82$), and 25 months ($n = 96$) post loss. Measures included the Hogan Grief Reaction Checklist (HGRC), the IES, the On-going Attachment Scale, and the ISS. Cronbach's alpha for the ISS was consistent over time, at .82, .88, and .87 at 6, 13, and 25 months, respectively. Social support was significantly and negatively related to avoidance at 13 months ($r = -.298$, $p = .008$) and 25 months ($r = -.28$, $p = .008$), but not at 6 months ($r = -.11$, $p = .28$). The strongest association between social support and personal growth was noted at the 13-month time point ($r = .53$, $p < .001$) followed by 6 months ($r = .43$, $p = .001$) and 25 months ($r = .30$, $p = .006$). Social support was negatively related, as expected, to the core grief variables of despair and detachment at all time points (despair: $r = -.24$, $r = -.33$, and $r = -.32$; detachment: $r = -.35$, $r = -.29$, and $r = -.36$, all $p < .05$, at 6, 13, and 25 months, respectively). Data for all variables over the three time points were available for a sample of 20 participants. The mean values from the ISS did not change significantly over time $F(2, 38) = 2.00$, $p = .154$ (Hogan et al., 2014).

Theoretical Contributions

In addition to its general usefulness in research on bereavement, social support, as measured by the ISS, has been shown to be an important variable in developing a theory of grief to personal growth. A path model was hypothesized, based on prior work with bereaved adults and adolescents. Using structural equation modeling, research with bereaved adults showed that despair pathways led to social support, which in turn led to the outcome personal growth (Hogan & Schmidt, 2002).

Specifically, we tested two possible pathways through the grief to personal growth process using structural equation modeling. Findings showed that the HGRC *Despair* and *Detachment* subscales (Hogan & Schmidt, 2002) path led to the IES *Intrusion* subscale, which led to the

IES *Avoidance* subscale, which in turn led to the ISS scale pathway, which terminated at the HGRC *Personal growth* variable. The second model tested the pathway directly from *Despair* to *Personal growth*. Findings from this study showed a negative direct path between *Despair* and *Personal growth*, suggesting that personal growth is distinct from grief (*Despair* and *Detachment*). The analysis was conducted with cross-sectional data, which requires caution in interpreting the temporal sequencing of events in the model. However, one of the key findings, the relation between social support and personal growth, speaks to the importance of social support as bereaved individuals work through their grief. In other words, social support seems to bridge the anguish of grief with the possibility of personal development in its aftermath. The grief to personal growth theory provides a scientific explanation of the important role social support plays in the bereavement process and provides guidance to clinicians who work with bereaved adults (Hogan & Schmidt, 2002).

Clinical/Support Application

The question I find most helpful in assessing the social support of bereaved adolescents and adults is simply, “Is there at least one person you can talk to about your grief?” This question often results in the bereaved telling stories about how they were helped or hindered by others’ words. If they identify that there is no one available to them I help them to find a health professional with expertise in bereavement care.

The content of the social support items suggests that bereaved individuals judge the ability of others to be helpful by the degree to which would-be helpers listen without judgment, which then provides a safe environment for the bereaved to talk openly and honestly about their grief. By extension, for bereaved persons, effective therapeutic interactions by clinicians might better be called “being-listened-to therapy” rather than the classical “talk therapy.” In short, *healing*, in the case of grief, involves *hearing*.

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Appendix 15.1 Inventory of Social Support (Hogan & Schmidt, 2002)

Directions: Read each item carefully. Using the scale shown below, please select the number that best describes the way you have been feeling during the *past two weeks, including today*. Please select the number that best describes YOU and put that number in the blank provided.

- 1 = Does not describe me at all
- 2 = Does not quite describe me
- 3 = Describes me fairly well
- 4 = Describes me well
- 5 = Describes me very well

- ____ 1. People take the time to listen to how I feel.
- ____ 2. I can express my feelings about my grief openly and honestly.
- ____ 3. It helps me to talk with someone who is nonjudgmental about how I grieve.
- ____ 4. There is at least one person I can talk to about my grief.
- ____ 5. I can get help for my grieving when I need it.

Note

This scale is published in the public domain to encourage its use by interested clinicians and researchers. No formal permission is required for its duplication and use beyond citation of its source and authorship.

Part III

Coping with Grief

16

The Grief River

Thom Dennis

Clients for Whom this Technique is Appropriate

This approach has been used with adults and teenagers from a variety of ethnic, racial, and socioeconomic backgrounds. Some experience with recreational water activities such as canoeing, kayaking, or rafting is helpful but not required to grasp the principal imagery used in this technique. It may be less appropriate for clients who have a difficulty grasping analogical language, or whose personal metaphors for loss are rich and provide ample orientation to the experience.

Description

Models are necessary, then, for they give us something to think about when we do not know what to think, a way of talking when we do not know how to talk. But they are also dangerous, for they exclude other ways of thinking and talking, and in so doing they can easily become literalized, that is, identified as *the* one and only way of understanding the subject.

(McFague, 1982)

In recent years, much has been written about the limitations of “stage” models, in particular Elizabeth Kübler-Ross’s “five stages of dying/grieving” (Doka & Tucci, 2011). Despite years of research and the proposal of many alternative models, her model continues to dominate the popular imagination. Although the stage metaphor is no longer in vogue, clinicians continue to talk about the grief “process,” another scientific term that often implies predictability and universality. Although we must insist upon the use of scientific method in thanatology research, perhaps part of the problem lies in our continued preference to employ scientific and technical language when we work with clients.

Neimeyer’s (2001) emphasis on meaning reconstruction invites us to explore the client’s own metaphors as we work together to find ways to cope with and integrate loss. As important

as the client's metaphors are to the individual therapeutic encounter, a need persists for clinicians and clients to find ways to talk together to each other about loss, in essence to select accessible metaphors and develop them into new models, capable of captivating the popular imagination.

In 2009 I introduced the *grief river model*, which builds upon the commonly used "wave" metaphor that describes the emotional reactivity of grief (Dennis, 2009). Arguably, these waves of grief more closely resemble whitewater rapids than the rhythmic action of ocean waves on a beach or the relatively rare tsunami. The various phases of a river (headwaters, rapids, run, delta) are utilized to acknowledge and account for the impact of loss and grief over the course of the entire lifespan.

By introducing the concept of the *headwaters*, the clinician can address preexisting issues shaping the current loss, including religious and cultural values, the nature of the relationship with the deceased, previous losses, personality and temperament, and mental health concerns.

The *rapids* describe the acute phase of grief that not only includes emotional reactivity, but also all the physical sensations and cognitive processes that clients face as they attempt to adjust to an environment without the deceased. Negotiating the rapids involves acknowledging concurrent stressors and requires the gathering of companions, resources, and skills necessary to cope with the current loss.

Typically, the bereaved acknowledge that at some point a shift takes place. Gradual or abrupt, these shifts indicate a transition into the next phase of the grief river called the *run*. The run is characterized by relatively smooth waters when the bereaved can return their attention to the scenery and events of everyday life. However, grief may persist just below the surface. Events such as holidays, anniversaries, family events, and life crises may trigger additional sets of rapids.

The *delta* phase corresponds to Erikson's eighth stage of psychosocial development, Integrity versus Despair. Delta "moments" include anytime we engage in meaning-making activity or acknowledge our own mortality. These are the times of our lives when we engage in life review and develop a point of view about our own death.

Finally, by including a final phase called *rejoining the sea*, the grief river model provides an opportunity for clinicians to explore with clients their existential questions and beliefs about the end of life, including the possibility of an afterlife.

By emphasizing the continuity of life and the ongoing integration of loss, this model allows clients to shift their focus from trying to achieve "resolution" or "closure" to gathering the appropriate resources and support necessary to cope with the current crisis.

The technique involved in applying this model to therapeutic interactions requires thoughtful and timely interjections of the river and water metaphors into the conversation. The overall goal is to normalize the client's experience of loss by comparing it to this nature-inspired metaphor. The hope is that by understanding the experience better, we render it more manageable.

The intentional use of metaphorical language rather than technical or clinical language guards against the danger of literalizing the chosen metaphor. Intuitively, the client understands that when we say, "grief is a river," we are employing a figure of speech that compares something that is new, hard to explain, and unique to the individual with something else that is more familiar. Using picture language engages the client's imagination to find creative ways to cope with the loss. The clinician's use of metaphorical language gives permission to the client to introduce his or her own metaphors.

Case Illustration

During their first session, after clarifying the context of the counseling relationship and establishing rapport, the therapist invited Margaret, a 70-year-old widow, to talk about her current loss in the context of her life story. Margaret shared that her second husband, Henry, to whom she was married for 26 years, had recently died. She also mentioned other significant losses, including the death of the grandmother who raised her, a divorce from her first husband, and feeling estranged from the belief system of her youth. She expressed fear for her future given some personal health concerns, diminished financial resources, and a limited support network. She said that her life felt “chaotic” and that she could not tell “which way was up or down.”

Reviewing Margaret’s life story allowed for an assessment of preexisting coping skills and external supports, as well as the opportunity to make note of significant life experiences that functioned as historical antecedents (headwaters) impacting the current loss. Margaret’s own metaphors provided the opportunity to introduce the grief river metaphor by comparing her reference of the chaos to whitewater rafting (the rapids). The therapist normalized her experience by describing these “waves of grief” as intermittent and episodic, interspersed across the lifespan with periods of relative calm (the run). Based on his initial assessment, the therapist projected that, given time and the proper resources and support, the client would “become more buoyant” or demonstrate resilience. In future sessions they explored the “new territory” she faced without her husband as her “rowing partner.” Together they strategized some new ways of negotiating her way through these “troubled waters.”

Over the course of the counseling relationship, the therapist would occasionally return to the use of river metaphor as they addressed Margaret’s concerns about growing old alone (the delta) and as she struggled to re-interpret the idea of an afterlife in light of her evolving belief system (rejoining the sea). Their conversation involved finding ways to manage emotional “flooding,” strategies to “keep her head above water,” and identifying the companions, supplies, and sandbars she would need as she continued her life journey. Margaret was quick to adopt this kind of metaphorical thinking and talking. It offered an easy and creative way to normalize her experience. She expressed that she found it helpful because it allowed her to draw upon her own experience of learning how to swim and to access memories of coping strategies she acquired from her grandmother while growing up.

Concluding Thoughts

This model’s use of metaphorical language offers a useful framework for clinicians and clients to talk about an individual’s unique grief journey without the danger of the metaphor becoming literalized. It acknowledges the continuity of life experiences and the ongoing challenge of integrating the current loss in light of concurrent stressors and future mile-markers such as birthdays, holidays, anniversaries, life crises, developmental plateaus, and other losses. Although the model provides a way of talking about grief and loss over the course of the lifespan, its major contribution is shifting the focus from believing in the need to resolve one’s grief or achieving closure, to encouraging clients to focus on developing the skills and resources necessary to negotiate their way through this particular loss and future life stressors.

Although this model has yet to be validated by quantitative or qualitative research, anecdotal feedback from clients, clinicians, chaplains, and social workers suggests the metaphorical approach to be very promising. The model has been used in a variety of settings including hospice, private practice, adolescent day-treatment, hospital, and faith community settings. One grief counselor in England collected photographs of different phases of rivers and invited clients to use them to identify where they were on their grief journey. Another used the model with a group of bereaved teenagers on a whitewater rafting trip in the state of Washington. For more information about the model visit: www.griefriver.com.

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Self-Assessment of Tasks of Mourning

J. Shep Jeffreys

Clients for Whom the Technique is Appropriate

Adults who need support in verbalizing the status of their mourning can benefit from this brief procedure for conceptualizing and locating their estimate of the extent of grief feelings, thoughts, and behaviors. Clients whose work life is primarily scientific, technological, and data-oriented find that this personal assessment exercise fits with their style of looking at life. Additionally, for individuals who experience grief as a stunning, articulation-freezing condition, this exercise provides a useful structuring and normalizing activity. However, it may be inappropriate for some clients who find the quantification of elusive feelings offensive or reductionistic, and who prefer a more metaphoric or poetic way of describing them.

Description

Although there have been a number of stage and phase theories presented to describe the course of the human grief reaction, Worden's (2009) Four Tasks of Mourning offers a template for assessing a client's activity or movement associated with: (1) balancing denial and reality; (2) externalizing emotional pain; (3) adapting life assumptions and meanings; and (4) continuing bonds with their deceased loved ones or other loss object. In order to separate thoughts from feeling responses, some clients desire to perform a rating for *intellectual* responses and another for *emotional* responses under each of the four task categories.

This exercise is not a clinical diagnostic instrument but rather a conversation stimulator. It provides an uncomplicated structure for understanding and communicating the client's own view of his or her grieving. In some cases this has included the client's critique of the exercise and suggestions for improving it. Intellectualized conversation about the grief process can be gently moved into associated feelings where appropriate. All comments are desirable as they lead to conversation about the client's grief.

Directions to Client

1. Clients are directed to recall and reflect on their grief in terms of the four task categories of behavior.

2. Clients are directed to place an (X) on the line between 0 and 100 to reflect their current best estimate of their activity or movement in relation to a particular task (see Appendix 17.1).
 - *Task 1* asks clients to rate the extent to which they have incorporated the irreversibility of the loss into conscious awareness.
 - *Task 2* asks clients to rate the extent to which they have expressed their emotional pain.
 - *Task 3* asks clients to consider and rank the extent to which they have adapted cognitively and behaviorally to the post-loss world.
 - *Task 4* asks clients to consider and rank the extent to which they have created and integrated a new inner image of the deceased or other loss object into their post-loss world.
3. Clients are then encouraged to discuss their ratings on each of the four tasks with the object of affirming or resetting goals for their grief therapy. Focus on one or more of the tasks can provide needed cognitive structure where it is required or simply open the conversation about the client's grief.

Case Illustration

John is a 49-year-old divorced man whose college-age son was killed in an auto crash while on vacation. His stated reasons for seeking grief therapy were his obsessive thoughts about his son's death and the debilitating guilt associated with these thoughts. He also noted some unfinished business associated with his divorce. He presented as a man of few words who prided himself on control of his feelings. He is a research scientist whose work-life is more about data than people, and who is more nonverbal than verbal, and more solo than social. At five months since the death of his son he felt a loss in motivation at work, was weary of his ruminations, and expressed feeling overwhelmed with a sense of inner pain and diminished self-control.

After explaining the basics of the four tasks, and noting the individual mediating factors of grieving, I offered him the opportunity to organize his sense of grief at this point using the self-assessment exercise. He agreed, looked it over and after asking for some definitions and examples, he responded. His X mark for Task 2 was very near the 0 point of the scale. The area of his greatest initial interest was his need to control emotional release. He was able to describe the childhood messages he received about not expressing sadness, anger, or fear and how he automatically switched to intellectualizing to avoid emotional pain. He was not able to allow himself to cry, sob, moan, or emit any sounds that reflected an affective mourning expression.

On Tasks 1 and 4 he marked the X close to the middle of the rating line and his Task 3 X was between the midpoint and 100. He expressed a desire to focus on these latter three in more detail "down the line."

The benefit of this structured exercise for John was the opening of a conversation about his grief and setting some goals for additional therapeutic work.

Concluding Thoughts

When losses are overwhelming, clients who have difficulty conceiving and expressing their thoughts and/or feelings can benefit from a template to reflect on and frame a sense of their own grief. This is organized with the clusters of thoughts, feelings, and behaviors associated with the four tasks described above. The structure of the assessment and resulting conversation

with the therapist can reduce the overpowering effect of loss and provide a sense of normalization, conveyed by comments such as “Now I know I am not crazy” and “I don’t feel so alone.”

Each of the four tasks provides a dimension of human grief response associated with client healing. Each is supported by clinical experience and research: *Task 1*—the balance between denial and reality (Jeffreys, 2011; Worden, 2009); *Task 2*—the externalization of emotional pain (Jeffreys, 2011; Pennebaker, 1990; Worden, 2009); *Task 3*—cognitive and behavioral adaptation (Jeffreys, 2011; Neimeyer & Sands, 2011; Worden, 2009); *Task 4*—a new internalized bond (Jeffreys, 2011; Root & Exline, 2014; Worden, 2009).

When implementing the self-assessment with the client, it helps to emphasize that: (1) there is no one right way to grieve and adapt to life losses (a variety of mediating factors impact on individual grief responses); (2) there is no exact timetable for adaptation and healing; (3) people need not respond to the four tasks in the same way and to the same extent; and (4) this assessment exercise represents only a specific slice of time and may be responded to differently at the next therapy session. When used as part of a thorough intake evaluation and mental health history, and creating a safe context for the client to review and reflect on his or her own grief, the Self-Assessment of the Tasks of Mourning can help the client articulate the impact of a loss, consider his or her adaptation in several relevant domains, and establish clear goals for the therapy to follow.

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Appendix 17.1 Client Self-Assessment Exercise

How would you assess your degree of activity/movement for each of the *Four Tasks of Mourning* with regard to your most painful loss? Please place an **X** in the appropriate location between (0) = “little or no activity/movement” and (100) = “much activity/movement.”

Task 1	
Still mostly unreal, can't believe it	Very real, no doubt that it happened
0	100
<hr/>	
Task 2	
Little or no feelings have been expressed	Many feelings have been expressed
0	100
<hr/>	
Task 3	
Not used to life without deceased (or other loss)	Pretty used to life without deceased (or other loss)
0	100
<hr/>	
Task 4	
Still can't let go of him/her or other loss as it used to be—unable to have new interests in my life	My connection continued with deceased as a new inner image (spiritual bond) and this fits in with my new life
0	100
<hr/>	

Mapping the Influence of Loss

Daisuke Kawashima

Clients for Whom the Technique is Appropriate

Adults who have lost loved ones are appropriate clients for this mapping technique. However, it may be difficult to use the technique with young children or people who were bereaved recently because the clients are required to abstract and account for their experience of the loss. In such cases, therapists should hear the client's narrative and map the influence of loss instead of asking the client to do so, and show the map to their client.

Description

When we lose someone close to us, the loss can shatter the meaning of our life and erode our lifestyle, daily activities, and view of world. However, we can also become more involved in our life and retrieve our agency, even when we have lost loved ones. Through mapping the influence of loss, we can identify various domains of meaning reconstruction such as daily activities and priorities, self-perceptions, interpersonal relationships, view of future, view of world, and faith and spirituality (Gillies & Neimeyer, 2006).

During the mapping session, the therapist tells the client, "Using this tool, I would like you to think about how the loss of your loved one influences your life, and how you would like this influence to be changed." After this instruction, the bereaved is asked to fill the blank in the center of the map (see Figure 18.1) by writing the deceased's name or initials. The bereaved is then asked to consider the influence of the loss and write down narratives or responses in the meaning construction domains (e.g., Daily Activities, Priorities, My Emotion) arrayed around this central box. The therapist should tell the client that he or she can write anything and should not encourage their client to map the influence of their loss through all of the domains—only those that seem relevant to him or her. If the client senses unique emotions or thoughts that do not fit existing domains, then he or she is encouraged by the therapist to use the blank domain. After mapping the influences, the client is asked to narrate the contents and relationships of each domain in response to questions such as: "Which domain is most influenced by your loss?" "Is there any domain that was influenced by your loss that you were not aware of previously?" "Is there any domain which was not influenced by your loss?" "Are there any relationships between the domains?" Finally, the client is invited to make a new

map that considers any possible future influences of their loss. If possible, the therapist should continue to listen to the client's retellings of their account of their life. This leads the client to advance the counterplots of their stories about the influence of their loss, and contributes to their development of new stories.

Case Illustration

When she was 46 years old, Yukie lost her husband, Takeshi, to suicide. She has managed to raise her children and support them financially for the 10 years since his death. As illustrated in Figure 18.1, her current priorities are still dominated by those issues. However, she notes that these priorities are changing because her children have grown up, and now they offer emotional and monetary support to her. This situation affects her daily activities. Until now, she has been concentrating on her household affairs, but now she is engaging in other activities such as suicide-prevention efforts. Through volunteer work, she has come to notice how many people are suffering in this world, and she wants to do something to improve the situation. Meanwhile, she still feels sudden surges of sadness and loneliness, and feels abandoned by the deceased. She wants to ask him why he chose to end his life and why he did not ask her for help. When we had a conversation about the domain of faith and spirituality, she told me that she used to wonder, "Why is this happening to me?" every day, but this has recently changed. She has now come to think that there is something beyond human understanding at work in our lives.

After Yukie had completed and explained her mapping, we had a conversation about the following topics: (1) the domain most influenced by her loss; (2) the influential domains that she had been unaware of until Takeshi's death; (3) the domains that were not influenced by her loss; and (4) the relationships among the domains. During the session, she came to notice that her priorities and daily activities were now changing, and she drew a double line to cross out the phrase "Gaining an income, Child-raising" and added a new one, "Eating and sleeping well." At the same time, she recognized her implicit feelings and emotions toward the deceased, about which she had never told her children. And then she traced and thickened the arrows from the center to "My emotion"

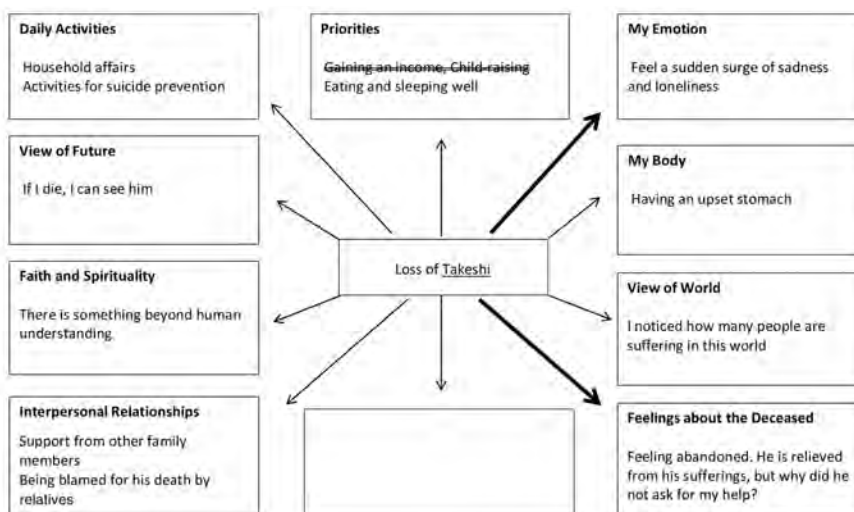


Figure 18.1 Yukie's current map of the influence of her loss

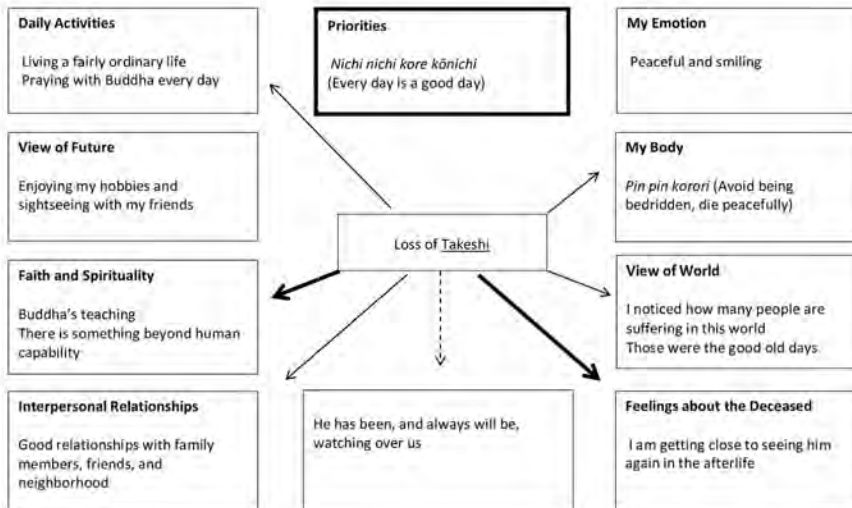


Figure 18.2 Yukie's future map of the influence of her loss

and "Feelings about the deceased." In her map, there were no influential domains that were unaffected by the loss.

After reviewing and reconsidering her current influence map, we moved to the step of writing her future or possible map (Figure 18.2). She wished to live a peaceful and ordinary life, to enjoy her hobbies, and go sightseeing with her friends. At the same time, she also wrote, "*Pin pin korori* (Avoid being bedridden, die peacefully)" in the domain of "My body," which shows her desire to live with dignity. She also wrote the Buddhist saying, "*Nichi nichi kore kōnichi* (Every day is a good day)" in the domain of "Priority," and it was circled with a thick marker. These phrases show the heart of her possible life and are related to her future daily activities (i.e., Buddhist praying every day).

In mapping the influence of her husband's suicide, Yukie realized that her devotion to Buddhism was a result of her loss. Furthermore, she recalled a feeling that her husband has been, and always will be, watching over her and her family. By means of the sacred story, she wanted to draw close to her husband and see him again in the afterlife. She incorporated these ideas into her future influence map so that it was composed of past, present, and future influences. This shows that the stories of loss are not static constructions, but are ongoing, back-and-forth processes of meaning reconstruction.

Concluding Thoughts

This technique was originally developed as a simplified tool for narrative practices during suicide prevention consultation (Kawano, Kawashima, & Shojima, 2008), and was revised for suicide survivors as a tool for self-help (Kawashima, 2014). As in Yukie's experience, clients' telling and retelling of their life stories before an audience advances their stories, and is essential to the mapping technique. In Yukie's case, her stories were well organized, but other clients do not always write and tell their stories coherently. Clients who have experienced multiple losses may need to be guided carefully in the construction of an influence map of their losses. These clients probably find it difficult to describe the influences of the loss on their future, and should concentrate on disentangling the strings of their present loss first (Neimeyer, 2015,

Chapter 25). The maps constructed by this technique may represent hidden and suppressed feelings and thoughts, and in such a case, therapists should tell their clients to feel these feelings and thoughts as they are. Furthermore, the technique of mapping the influence of loss comprises an externalizing exercise (White, 1995) that provides a scaffold for unique outcomes and the description of significant, alternative life stories. So therapists encourage their clients to tell and retell the stories of their lives by evaluating the influence of their loss and considering the unique outcomes that have occurred despite it. In addition, the therapist may find it useful to invite carefully chosen witnesses (e.g., other family members) and request that the client tell and retell their stories before this audience. This constitutes a definitional ceremony (White, 1995), and contributes to the clients' recovery of autonomy as an author or actor in their lives.

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19

Strategies for Coping with Grief

Donald Meichenbaum and Julie Myers

Clients for Whom the Technique is Appropriate

Presenting clients with a history of trauma and loss with a list of coping strategies can help mobilize resilient and adaptive responses for a broad range of survivors. However, it is not intended as a stand-alone intervention for complex loss or trauma, and is restricted in its written form to adults with at least a 6th-grade reading level.

Description

In the aftermath of experiencing traumatic events and personal losses, 5–20% of survivors evidence prolonged and complicated grief and traumatic bereavement, often with accompanying adjustment difficulties (Pearlman, Wortman, Feuer, Farber, & Rando, 2014). Although the other survivors are affected, they evidence more robust resilience and are able to continue functioning (Meichenbaum, 2013).

One factor that distinguishes these two groups is the nature of the coping strategies that they employ. We have identified a list of coping strategies, taken from the treatment literature, clinical experience, and focus groups with survivors and their mental health providers, and incorporated them into a self-report list of strategies (see Neimeyer, 2012; Rando, 1993; Shear & Gorscak, 2013). This list (see Appendix 19.1) can be used with all classes of survivors, including individuals experiencing prolonged and complicated grief reactions due to the loss of loved ones some time ago, as well as with individuals experiencing recent traumatic bereavement, as described in the case below.

First, survivors complete the list, indicating which coping strategies they have employed. This can be done either alone or with their healthcare provider. Then, they discuss with their provider the items they used and examine how, when, and in what ways they have proven helpful. A key aspect is to have survivors identify other list items that they might wish to try, and more importantly, what barriers might get in the way of using them.

This format may also be used when facilitating a group of survivors, by having each member review the list before the group meets, and then discuss which coping strategies they chose and how they used them. In this way, survivors can learn from their peers how coping strategies might be helpful and worth trying.

In this approach, assessment and suggestive interventions are interwoven. Filling out the list per se is not the most helpful feature, but rather it is the subsequent discussion and implementation that are critical to the recovery process. The list acts as a catalyst and a self-selected guide to negotiate the mourning process and to bolster resilience. The list helps the bereaved begin a healing journey whereby they can develop a new identity and narrative including examples of a number of “RE” verbs, such as re-framing, re-claiming, re-connecting, re-solving, and re-building their lives (Meichenbaum, 2013).

Case Illustration

Tom, a 44-year-old mechanic, had always thought of himself as a happy person. He enjoyed his work and was dedicated to his wife Susan and their children. Susan had difficulty controlling her diabetes, which required that Tom be a caretaker of both his children and his wife, a role he took on willingly. One day, with no sign to her husband, Susan slit her wrists in the bathtub. When Tom found her hours later, the blood-filled bathwater was still warm.

Tom’s traumatic bereavement was such that he was unable to care for his children or return to work. After a month, he sought professional help and was diagnosed with post-traumatic stress disorder. Tom had a particularly overwhelming sense of helplessness, so key to his recovery was instilling a sense of self-efficacy, which made him an ideal candidate for the Strategies for Coping with Grief.

After stabilization, Tom was introduced to the list of strategies. He felt “safer” completing the list with someone, so he and his provider reviewed it together over the course of several sessions. Tom reported that some of the items he had tried were helpful, and he was encouraged to continue those activities. In particular, he found most useful the comfort and help from others such as his siblings.

He identified several new items he would like to try and possible ways to modify items that he thought might be helpful. The provider also suggested modifications that Tom might try. For example, as Tom’s faith was shaken, he suggested new ways that he could reconnect with his spirituality, such as through poetry and meditation.

As Tom went through the list, what emerged was evidence of resilience and fortitude, despite his traumatic loss. He had a “toolbox” of things he could use by himself, which empowered him, decreasing his sense of helplessness. He found that he turned to the list around anniversary dates and particularly troubling events, even years later. In essence, the list served as relapse prevention tool.

Although Tom required professional trauma treatment, the list of strategies allowed him to take charge of his own recovery, bolstering his resilience.

Concluding Thoughts

The list of strategies provides individuals who are at different phases of their mourning process an opportunity to “take stock” of their present coping strategies and to consider other potentially useful strategies. A discussion about the list with their provider can encourage individuals to ask themselves, “What can help with my grief *now*?” It can also help individuals identify coping strategies that can be employed “down the road,” when emotional upsurges or sliding into negative self-talk with its accompanying dysfunctional emotions occur, or when preparing for high-risk situations such as anniversary events, thus minimizing being “blind-sided” by unexpected thoughts and emotions.

Research can be conducted to determine the potential usefulness of Strategies for Coping with Grief as a supplemental tool to varied interventions. We welcome feedback on the content and use of this tool.

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Appendix 19. 1 Strategies for Coping with Grief

The process of grieving is like going on a “journey.” There are multiple routes and people progress at different rates. There is no right way to grieve, no one path to take, no best coping approach. These grief coping strategies list some of the pathways that others have taken in their journey of grieving. It is *not* meant to be a measure of how well you have coped or how you should cope, since there is no one way to manage the pain following the aftermath of the loss of a loved one, no matter what the cause of his or her death. Rather, the strategies listed are suggestions of things you might consider doing to help you on your journey.

We suggest that you look through this list and put a mark by the coping strategies that you’ve tried. Hopefully, these strategies have helped you. But if you feel that you could use a little extra help, we suggest that you look through the list and then choose some new items that you would like to try. You may find them helpful, and you can add them to the strategies that you’ve already tried. This list is intended to help you discover new ways that you can move forward on your journey through the process of grief. If there are things you have done that you have found helpful that are not on this list of coping strategies, please add them at the end so we can share these with others.

Sought Comfort and Help from Others

1. I examined the thoughts that kept me from seeking help from others, such as the beliefs that “I am a burden to others,” “No one can help me, no one understands,” “I have to do this on my own,” “I should be stronger,” “Listening to the grieving stories of others will make me feel worse,” or “People are tired of hearing about my loss.”
2. I reached out to family, friends, elders, or colleagues for comfort and companionship, but gave myself permission to back off when I needed time alone.
3. I took the initiative to reach out to folks from whom I might not normally seek help. I looked for new friends in church groups, social groups, work, school, or I went on the internet to find others who experienced a similar loss. I made a list of these supports to turn to when I was struggling or experiencing pain.
4. I forced myself to be with people and to do things, even when I didn’t feel like it. I put something on my calendar almost every day, with back-up plans.
5. I allowed myself to tell people how much I loved, admired, and cared for them.
6. I hugged and held others, but felt free to tell people when I did not want to be touched.
7. I learned to grieve and mourn in public.
8. I shared my story with others who I thought would appreciate and benefit from it. I told anyone who would listen to the story of the deceased, even if they had nothing to say back.
9. I gave and received random acts of kindness.
10. I connected with animals and nature, for example, the deceased’s pet, a beautiful sunset, hike, or garden.
11. I cared for or nurtured others. For example I spent time caring for my loved ones or children.
12. I found my faith or religion comforting. I participated in religious, cultural, or ethnic mourning practices, such as attending church services, sitting Shiva, participating in a wake, celebrating the Day of the Dead, visiting a memorial shrine, etc.
13. I sought help from organized *supportive* bereavement groups, hospices, religious groups, grief retreats, talking circles, or groups specific to the way the deceased died, such as cancer support groups or survivors of violent loss groups, such as suicide or homicide.
14. I sought help from mental health professionals. For instance, attended counseling sessions or took medications as advised by my providers.

15. I read books written by others who have coped with the loss of a loved one. I read about the grieving process, loss, and advice books about other issues that arose.
16. I made a list of all the professional resources that I could use in a crisis, such as suicide hotlines, mental health crisis lines, mentors, clergy or imam, or mental health providers.
17. I decided not to walk through the grieving process alone, so I visited websites that focus on the grieving process. (*Refer to the list of websites at the end of this list.*)

Took Care of Myself Physically and Emotionally

18. I examined the thoughts and feelings that kept me from taking care of myself physically and emotionally, such as guilt, shame, sense of lost self, and loss of the will to live.
19. I established routines of daily living. Although things were different, I made new routines and did not berate myself when I was not “perfect.” I maintained personal hygiene, medical care, healthy nutrition, and regular sleep.
20. I reconnected with my body through exercise, yoga, tai chi, or expressive arts, allowing myself time to get stronger.
21. I recognized that my brain needed time to heal and for things to improve, so I forgave myself when I made mistakes, became distracted, couldn’t remember or understand.
22. I avoided the excessive use of alcohol, tobacco, recreational drugs, and caffeine as a coping mechanism.
23. I relinquished avoidance and learned to face my fears by engaging in life. I participated in activities that had meaning and kept me occupied, such as work, hobbies, crafts, singing, or dancing.
24. I allowed myself to pursue and feel positive emotions, such as compassion toward myself and others, expressions of gratitude, and emotions of love, joy, awe, and hopefulness.
25. I recognized and labeled my feelings, viewing them as a “message” rather than something to avoid. I accepted and dealt with these emotions, understanding that the less I fought them, the more I was able to handle them.
26. I regulated my strong negative emotions using slow smooth breathing, coping self-statements, prayer, or other mood-regulating techniques.
27. I allowed myself time to cry at times and gave words to my emotional pain. I distinguished feelings of grief from other feelings such as fear, uncertainty, guilt, shame, and anger.
28. I expressed difficult feelings through writing and talking to supportive others. I used journaling, reflective writing, letter or poetry writing, or other expressive arts of scrapbooking, dance, or music.
29. I engaged in gratitude activities, such as telling others how much I appreciate their love and support, reminding myself of the things that I am thankful for, and being grateful that I knew the deceased.
30. I established a safe and comforting space for myself, either physically or through imagery.

Stayed Connected to the Deceased and Created a New Relationship, while Recognizing the Reality of the Loss

31. I examined the feelings and thoughts that kept me from forming an enduring connection with the deceased, such as the fear of what others would think of me, guilt, shame, humiliation, disgust, or thoughts of anger, revenge, or being preoccupied with my grief.
32. I participated in practices, such as visiting the grave or memorial site, celebrating special occasions, prayer and candlelight vigils, public memorials, or commemorative services.
33. I commemorated the deceased’s life with words, pictures, things, or created a small place of honor for the deceased, which I could visit any time I chose.

34. I thought about what I received from the deceased and the legacy and mission to be fulfilled. I became involved in a cause or social action that was important to the deceased or myself.
35. I created a legacy such as planted a tree, started a scholarship or charity in the deceased's name, started an Internet blog, or launched new family or community practices.
36. I allowed myself to talk to the deceased and allowed myself to listen. I wrote a letter to my loved one and asked for advice.
37. I asked for forgiveness, shared joys and sorrows, and constructed a farewell message.
38. I accepted that sadness was normal and learned how to be with my grief. I learned how to contain my grief to a time and place of my choosing. However, I understood that intense upsurges of grief may arise unexpectedly and without warning, and I developed coping strategies to handle such events.
39. I used imagery techniques, shared stories and photos of my loved one, or purposefully used reminders such as music or special routines to recall positive memories. I cherished and hung onto specific, meaningful possessions (objects, pets, etc.). I actively reminisced, holding onto our relationship in my heart and mind.
40. I reached out to help and support others who are grieving for their loved ones. Helping others is a way to reengage in life and combat loneliness and tendencies to withdraw and avoid social contacts.

Created Safety and Fostered Self-Empowerment

41. I examined the thoughts that fuel my fears, avoidance, and the belief that I cannot or should not feel happy and that things would never get better.
42. I took a breather and gave myself permission to rest knowing that grieving takes time and patience, with no quick fixes.
43. I identified memories that trigger or overwhelm me and disengaged and/or established boundaries by limiting people, places, or things that cause me stress or overwhelm me so that I could address them one by one, in my own time. I learned to say "no" to unreasonable requests.
44. I identified important activities, places, or things that I was avoiding due to fear of my grief reactions. I slowly reintroduced them or allowed myself to choose those I never wanted to encounter again.
45. I began to think of myself as a "survivor," if not a "thrifer" of my own story, rather than as a "victim." I reminded myself of my strengths and of all the hard times that I have gotten through in the past.
46. I wrote out reminders of how to cope and put them on my fridge, cell phone, or computer. I looked at them when I was struggling and reminded myself of ways to be resilient.
47. I created a plan about how to cope with difficult times. I learned to anticipate and recognize potential "hot spots" of when things are most difficult. I rated each day on a 1- to 10-point scale on how well I was doing. I asked myself what I can do to make things better and increase my rating. I worked on increasing the number of good days compared to the number of bad days.
48. I avoided thinking "This is just how it is," realizing that I have choices no matter how hard life is. I came to recognize that emotional pain can be a way to stay connected with my loved one.
49. When I was overwhelmed by negative memories of the past, I avoided "time-sliding" into the past. (a) I "grounded" myself to the present by refocusing my attention on the environment around me, (b) I changed my self-talk by telling myself "I am safe and this will pass," (c) I controlled my bodily reactions by slowing down my breathing, and (d) I oriented to people's faces, voices, or touch or called for help from a friend.

Moved toward a Future Outlook and a Stronger Sense of Self

50. I examined the thoughts and feelings that kept me from moving forward, such as “I am dishonoring the deceased by getting better,” or “I am leaving him/her behind,” or “Feeling happier means that he/she is no longer important to me,” or that “My love for him/her is fading.”
51. I regained my sense of hope for the future. I worked to reestablish a sense of purpose, with meaningful short-, mid-, and long-term goals. I am creating a life worth living, taking control of my future.
52. I worked on regaining my sense of self-identity, knowing that my life had changed, but that I am still *me*. I focused on what is most important. I developed new goals and action plans, consistent with what I value.
53. I created purpose by keeping the memory of the deceased alive in others. I kept others aware of the circumstances of the death, so that some good could come from the loss. I transformed my grief and emotional pain into meaning-making activities that created something “good and helpful,” for example Mothers Against Drunk Driving and the Melissa Institute for Violence Prevention.
54. I use my faith-based and religious and spiritual beliefs to comfort me and move on. People hold different beliefs, such as “My loved one can continue to influence the lives of others in the world,” or “My loved one is no longer suffering and is in a safe place,” or “We will be reunited in the future.”
55. I examined the reasons why some of the activities that have been helpful to others in the grief process were not helpful for me, and what I can do to help myself further in the journey through grief.

Other Coping Activities or Strategies I have used to Cope with my Loss

Please feel free to let us know if you have any comments about this list, so we can be of assistance to others like yourself. You can reach the authors by e-mail at dhmeich@aol.com or at Julie.Myers100@gmail.com

Helpful Websites

www.griefnet.org
www.compassionatefriends.org
www.dougy.org
www.taps.org
www.missfoundation.org
www.afsp.org/coping-with-suicide
www.opentohope.com

Contextual Behavior Activation

Anthony Papa

Clients for Whom the Technique is Appropriate

Preliminary evidence suggests that this treatment may be appropriate for adults for whom loss-related avoidance, disengagement, and repetitive thinking are contributing to prolonged grief disorder (PGD), major depressive disorder (MDD), and/or posttraumatic stress disorder (PTSD). However, it may need to be supplemented by more exposure-based and meaning-oriented procedures when clients are preoccupied with imagery and issues surrounding a traumatic loss need to be explored.

Description

A cascade of life events ensuing from the death often magnifies difficulty adjusting to the death of a significant other. Grief typically involves the experience of emotions such as sadness, loneliness, and anger as a result of the loss of a primary source of reinforcement, but often also involves profound changes in life situations (e.g., financial status, responsibilities at home) requiring people both to make long-term changes (e.g., socializing as a widower) and to navigate short-term challenges such as deciding about funeral arrangements and disposition of the deceased's possessions. These changes in people's life situations can have a profound impact on their ability to meet the day-to-day challenges of their new lives. Thus, grief resolution typically requires making changes to accommodate these demands. Research suggests that the degree to which individuals engage in chronic avoidance and disengagement, which inhibits making the requisite changes to adapt to new life situations, has a strong effect on the course of grief.

Contextual behavior activation (CBA) for MDD is based on the hypothesis that depression arises when active, goal-directed behavioral repertoires have been either unreinforced or punished and are extinguished. These aversive consequences narrow and reinforce repertoires focused on escape and avoidance behavior, such as rumination, fostering pathology. To counter this, CBA uses operant conditioning principles to address the antecedents eliciting maladaptive behaviors or to change the form and/or function of responses to facilitate adaptive engagement so that active, goal-directed responding is again reinforced. In the context of loss, disengagement and avoidance magnifies functional difficulties by leaving changes unmade and problems unresolved, undermining people's sense of agency and promoting further

withdrawal from post-loss difficulties—a pattern we describe as a “grief loop.” As in CBA for MDD, CBA for pathological grieving seeks to alter situationally predisposed ruminative and avoidant responses that result in post-loss functional problems by decreasing the frequency of responses that serve to disconnect individuals from psychosocial resources, sources of positive reinforcement, and meaning in their lives (Papa, Rummel, Garrison-Deihn, & Sewell, 2013).

In this, therapists work with clients to identify goals and values related to who they want to be in their new post-loss life, identify roadblocks to being that person, and then generate alternative ways of responding to difficult life situations that are consistent with these goals or values, are more functionally adaptive, *and* are reinforced by their environment. Activity monitoring sheets are used to develop detailed, constantly evolving functional behavior assessments that delineate the links between the enactment of pathogenic behavior, changes in symptom severity, and the contexts or situations in which this commonly occurs. The therapist and client work collaboratively during this process to identify the contingencies (e.g., reinforcements and punishments inherent in certain situations or escape behavior used to avoid aversive consequences) maintaining symptom-related, passive coping. The goal is to target the most functionally impairing situation–response links by altering situational determinants and/or responses to create contexts in which functionally adaptive, goal-congruent actions are elicited. This entails problem solving on how to implement these changes given the existing contingencies maintaining current responses, as well as consideration of potential punishments and other practical roadblocks that might deter enactment of adaptive responses. In this, the therapist considers the number of potential reinforcements available to the individual (i.e., the range of things they value), the availability and quality of opportunities to engage in alternative, nonpathological ways (e.g., quality of relationships), and whether or not the individual has the skill to enact the identified alternatives (e.g., cook a meal). Detailed protocols for CBA are outlined in Martell, Addis, and Jacobson’s (2001) book, *Depression in Context: Strategies for Guided Action*, and *Overcoming Depression One Step at a Time* by Addis and Martell (2004).

Case Illustration

Mr. Smith was 72 when his wife of 48 years died suddenly in her sleep of heart failure, just two months after he retired. In the year since the loss, he had become increasingly socially withdrawn, spending long, tearful hours sitting in a chair in his living room ruminating about the “good old days” and the unfairness of his wife’s death. Prior to the loss Mr. Smith was an outdoorsman who regularly fished and hunted, enjoyed skiing, went to church regularly, and was a member of the local Elks and car club. He and his wife had a large circle of friends with whom they regularly socialized. Mrs. Smith had been a bookkeeper and had taken care of their finances and had cooked every meal since they had married. Since the death, he had stopped all activities except church, only leaving his house for church and grocery shopping in the last six weeks. He had lost significant weight and was subsisting on frozen dinners, as he never had learned to cook. He was receiving collection notices as he had not paid bills and his cable TV had been turned off despite adequate finances.

At intake, Mr. Smith met diagnostic criteria for MDD (persistent depressed mood, loss of interest, weight loss, psychomotor retardation, loss of energy, thoughts of death) and the proposed prolonged grief disorder criteria (intense sorrow, preoccupation with the death, excessive positive reminiscing, avoidance, detachment, diminished identity, difficulty pursuing interests). Therapy consisted of: (1) education/normalizing symptoms, identifying goals/values related to functioning, particularly around what his wife

would want for him, and orientation to treatment; (2) introduction of, practice with, and problem-solving his resistance to using activity monitoring sheets; (3) functional assessment of the link between situations, responses, and the experience of symptoms in the client's day-to-day life, as well as the contingencies maintaining passive/avoidant responding; (4) activity scheduling, monitoring, and problem-solving to have the client engage a controllable, recurring situation in a more adaptive way that results in some identifiable reinforcement (which can be nontangible, such as fulfilling a treatment goal or acting in accordance to one's values) or to remediate a skills deficit previously leading to punishment and avoidance; (5) generalization of skills to other grief loops; (6) consolidation of gains and skills; and (7) termination.

In Mr. Smith's case, use of activity monitoring during the functional assessment identified three antecedents to his main grief loops, what he came to call the three M's: mail, meals, and mornings. Each of these strongly reminded him of his wife—sitting at the table and talking with her as she opened mail and paid the bills, skipping dinner because of his avoidance of the awareness of her absence and his inability to cook, and waking alone in the morning. As a result, he spent a great deal of time ruminating and reminiscing, avoiding reminders of her death, and preoccupied with thoughts of his own. His response mainly followed the same sequence in all three circumstances: exposure to the painful cues of her absence, tearing up, feeling acute loss of energy and control, and sitting in a chair by the window ruminating on life's unfairness, reminiscing about good times spent with his wife, or, more worryingly, suicidal thoughts. The immediate consequence of these actions was a brief escape from sadness, loneliness, and feelings of being overwhelmed. However, the long-term consequences were to feed his sense of helplessness, hopelessness, and sense he could not function without her. It also fed another grief loop that we discovered during the course of activation: his growing distress at his ongoing emotional dysregulation and his fear of his frequent tearfulness being seen by others. Treatment entailed promoting behaviors incompatible with rumination/reminiscing and passive suicidal ideation to increase his sense of agency by achieving sets of small goals. Treatment also focused on reducing the frequency and intensity of his symptoms by minimizing engagement in ruminative behavior and by changing the consequences of exposure to cues of distress. Instead of practicing passive reminiscence or avoidance, Mr. Smith was coached to engage in active, goal-congruent behaviors, which (1) linked to positive moods (e.g., working on his '67 Mustang), (2) provided meaning and renewed purpose (e.g., calling grandkids, planning a hunting or fishing trip), or (3) were problem-solution focused (e.g., paying bills, taking cooking classes). This also involved altering environmental contexts particularly evocative of recovery-interfering behavior (e.g., packing up wife's belongings in the bedroom, settling the estate to reduce financially oriented mail).

Concluding Thoughts

In the only study of CBA to date, 25 bereaved people were randomized to either an immediate or delayed start of an open trial of CBA for the proposed criteria for PGD (Papa, Sewell, Garrison-Diehn, & Rummel, 2013). The sample was mostly female, White, lower-middle class, ranging in age from 22 to 72, whose loss was on average 2 years prior. Participants were assessed four times at 12-week intervals. Treatment/no treatment comparisons indicated that CBA appeared to ameliorate symptoms of PTSD ($d = 1.03$), MDD ($d = 0.84$), and PGD ($d = 1.47$). While more research is needed, it appears that CBA's focus on reducing avoidance

and promoting re-engagement and goal-orientated responding effectively addresses core avoidance/disengagement symptoms common to each symptom cluster in this sample.

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Part IV

Attending to the Body

21

Welcoming What Is

Christine H. Farber

Clients for Whom the Technique is Appropriate

Adolescent and adult clients who are ambivalent about or resistant to moving forward through the process of grieving can benefit from the practice of *focusing*. Focusing may not be appropriate for those experiencing acute trauma symptoms, such as flashbacks, dissociation, or intrusive imagery. Clients who are unfamiliar with turning their attention inward may benefit from specific didactic instruction first.

Description

A poignant challenge of some grief therapies is that moving forward through grief requires that the mourner accept what he or she most wishes to reject: the fact of the loss and its meaning and accommodation within his or her present life (Rando, 1993). Moving forward can be experienced as many things, including a betrayal of the deceased, a threat to one's internal connection with the lost other, or a tacit approval of the loss and its associated changes. Understandably, some mourners will resist this forward movement, creating a dilemma within the therapy.

Focusing (Gendlin, 1996) provides a respectful and effective means of addressing resistance or ambivalence. Similar to analogical listening, focusing is a technique that entails attending to a client's experience in a way that deepens the therapeutic process and invites "a fresh way forward" (Neimeyer, 2012, p. 55). Both techniques require attention to the *something more*, which is held within a client's experience, lies beyond rational discourse, may be somatically sensed, and contains a wisdom that ought to be welcomed on its own terms. Focusing posits the existence of a bodily *felt sense* of a given lived-situation, which is distinguished from a thought or a feeling. The technique consists of a series of specific steps that facilitate attention to the felt sense and assumes that this particular way of attending co-creates the something more that is ushered forward.

The steps below, adapted from Gendlin's (1996) method, can be used when you sense that a client is ambivalent about or resistant to moving forward in his or her grief. I find that using the client's own words and images whenever possible, and vague and suggestive language otherwise, is supportive of this process. Using their own words allows the client to begin to trust

his or her own internal wisdom, regardless of how unclear it may be initially (J. Hopkins, personal communication, August 7, 2014).

1. Welcoming the Resistance

Referencing the client's words or behaviors, ask him or her if it would be okay to pause and linger with the ambivalence or resistance. "You mentioned feeling irritable and not wanting to be here today; is it okay for us to stay with that, to create some space for that now?"

2. Inviting a Felt Sense

A felt sense is experienced directly, bodily yet vaguely by the client. It is often accompanied by an unclear or hazy discomfort. Suggest that the client tune in to a bodily sense of *the whole situation*, or ask where he or she feels a sense of the situation in their body. I like to use the word "something" to capture the quality of the felt sense as not-yet-fully-known. "There is something about feeling irritable, something about not wanting to be here. Do you have a bodily sense or sensation of the whole situation of not wanting to be here? See if you can tune in to how not wanting to be here feels in your body."

3. Attending

Invite the client to tune in to the felt sense as an autonomous something, to accept rather than judge or analyze it, and to witness it rather than merge with it. "Just welcome that bodily sense of the whole situation of not wanting to be here, welcome the something that is there. Allow your attention to just touch that bodily sense of it all."

4. Articulating

Gently invite the client to describe the quality of the felt sense using a word, phrase, or image. "Ask your body if it has a word or image that best captures the quality of the whole situation of being irritable here." Some clients will speak spontaneously about this, with no prompt needed.

5. Resonating

Facilitate the process of the client's (a) "listening" for the words or images that best capture the sense of the whole and (b) checking those descriptions against the whole. Watch for a resonance of the client's articulation of the felt sense and the internal sense itself. "Being here feels like there is no air? Okay, allow space for that; check to see if that captures your felt sense."

6. Sensing a Stopping Point

Watch for a shift in the client's *bodily experience*, which can be a natural stopping point for the focusing episode. Steps 3–5 may be repeated several times before step 6 is achieved. In our example thus far, the client's initial mention of irritability has morphed into a description of "no air." Although this is a step, it is not the *felt shift* we are looking for. Tears, laughter, a deep sigh, or change in posture might indicate such a shift, which would then offer a natural stopping point. A felt shift indicates that something has changed for the client, and there is usually a quality of relief, release, or lightness that accompanies this. Once the process feels finished, the client and therapist can then integrate any shifts and offer an expression of gratitude for the client's embodied wisdom.

Case Illustration

At 34 years old, Matt lost his fiancée in a diving accident a year prior to beginning therapy with me. He initiated therapy because he was at risk of losing his job as a software engineer due to his arriving late to work, inability to concentrate while there, and difficulty engaging with clients and colleagues. Four months into therapy, he had become increasingly ambivalent about our work together and began one session by saying, “I just feel so angry that I still feel this way and can’t pull it together. I feel so stuck. I’m so tired of it all.” I then chose to introduce some focusing.

T: Matt, I’m wondering if we can just stay with that for now. You may want to close your eyes, take a few deep breaths, and just see if you can welcome that. Feeling stuck. Being tired of it all. Maybe check in with yourself and see if you have a bodily sense of being tired of all of it.

M: I feel so powerless. I feel it in my gut. I really didn’t expect it to be this hard for so long. I just want to be over it. Not over her, but over IT—all the heartache.

T: Ok, so get a feel for the whole of that: feeling powerless, wanting to be over it. See if you can welcome all of that. Just touch that gut sense with your attention.

M: Well, it’s like I want it to all be over, to get past it, but then I feel butterflies. (Matt’s face flushed as he reflected this, indicating that his words were matching the felt sense.)

T: There is something there about wanting to get past it, to get over it. And you feel those butterflies.

M: I feel so sad now. It’s like I’m stuck, or, or more like I’m holding on for dear life.

T: Allow space for the sadness. Lots of space for the holding on dearly for life.

M: Yeah, I’m holding on because I don’t want to let go. It doesn’t feel right.

T: Check in with the sense of the whole and see how that feels. Letting go doesn’t feel right.

M: It feels like I’m cheating on her.

And with that, Matt opened his eyes and straightened-up his posture. His words surprised him. A proverbial light bulb went off for both of us as we sat with his revelation. Even though this awareness, “it feels like I’m cheating on her,” was challenging and difficult in its own way, Matt experienced a sense of relief at realizing this. Something had changed for him. During the remainder of the session, we discussed this further and offered gratitude toward his inner self for the insight and shift.

Concluding Thoughts

Based in the tradition of humanistic psychology, focusing assumes a self-actualizing tendency within the client—a propensity for fulfilling one’s potential when one’s environment is supportive of such—and posits a series of steps for facilitating this movement in a given situation. It is a technique that models unconditional acceptance of what is and an unwavering dedication to understand the client on his or her own terms. It begins with welcoming what is and offers the potential to usher the client forward from there. As such, it is well suited to address resistance or ambivalence within grief therapy.

Research provides support for the effectiveness of focusing within psychotherapy and suggests that its effectiveness can be improved by the therapist’s knowledge of the theoretical background of the technique as well as by the therapist’s and client’s practice with it (Hendricks,

2001). Further instruction and theoretical material are available in the focusing references provided below as well on the website of the Focusing Institute (www.Focusing.org).

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The Relaxation Response

Heather Stang

Clients for Whom this Technique is Appropriate

Bereaved adults and children who experience physiological symptoms attributed to stress are likely to benefit from relaxation training. This technique does not explore the narrative of the loss, but instead turns attention to the physical body, and is thus suited particularly well for persons in need of a refuge from psychological and/or physical pain, or people unable to articulate feelings because of emotional overwhelm. Once this response is mastered, clients are better positioned to profit from narrative and emotional exploration of their loss experience.

Description

The relaxation response is the physiologic opposite of the fight-or-flight response, credited with the ability to reverse the harmful effects of stress by decreasing heart rate, blood pressure, rate of breathing, and relieving muscle tension (Benson & Proctor, 2010). First identified by cardiologist Dr. Herbert Benson at the Harvard Medical School in the early 1970s while studying the heart health of people who practiced Transcendental Meditation (TM), the relaxation response is proven to significantly reduce, and in some cases cure, stress-induced diseases and symptoms. Long-term practitioners experience altered genetic activity with physiological benefits, including a “switching off” of genetic expressions that are tied to stress-related disease. The research indicates that 20–25 minutes of daily practice for a minimum of eight weeks is required to begin to activate the positive genetic expressions; however, many clients report an increased feeling of calm, clear mental focus, a better ability to problem-solve, and feeling more “in control” of emotions in just one session, which fosters a sense of self-efficacy. Many return to the technique to self-soothe and regulate emotions.

Several physiological symptoms associated with grief have proven responsive to the relaxation response, including, but not limited to, insomnia, nausea, high blood pressure, bodily pain, tension, migraine and cluster headaches, mild to moderate depression, and anxiety. While the relaxation response is often used as a stand-alone practice, and may be coupled with traditional medical interventions without side effects, it is important to have any physiological symptoms evaluated by a health professional to ensure that all treatment options are addressed.

The relaxation response can be elicited in a one-on-one counseling session or group using the Benson–Henry Protocol. I have adapted it into a guided meditation for the bereaved that I

refer to simply as the “Four R’s: Relax, Repeat, Return, and Remember.” I offer clients a hand-out summarizing the steps and benefits of the relaxation response, and encourage them to keep a practice diary to reinforce consistent practice. Begin by preparing the client for the practice:

- Offer a brief overview of the clinical success of the relaxation response to remove skepticism and give incentive for practice.
- Ease performance anxiety by sharing that the exercise does not need to be done perfectly for the client to experience the benefits. I often explain that “more stress does not need to be added to the stress management process.”
- Normalize the experience of getting distracted. Explain that when people catch themselves in a distraction, they can “begin again” without engaging in negative self-talk.

The Four R’s Meditation Script (20–25 minutes, spoken slowly)

Relax

- Find a comfortable seated position, or lie down on the floor on supportive blankets. Close your eyes, or gaze softly at a point in front of you. Imagine you could soften your belly, and take 3–5 full, deep breaths.
- Return back to a natural, easy rhythm of breath. As I mention a part of your body, imagine the possibility of releasing all tension. Imagine just letting go of anything you’re holding onto in your bones, joints, and muscles. Simultaneously, notice the rhythm of your breath.
- Feet. Calves. Thighs. Buttocks. Belly. Lungs. Back. Shoulders. Arms. Hands. Neck. Allow your face to soften. (Alternatively, substitute progressive muscle relaxation, inviting the client to tense and release major muscle groupings.)

Repeat

- Choose a word or short phrase that you find calming or relaxing. This could be a word such as “relax,” or a phrase, like “I am letting go.” Maybe it’s a prayer from your religious or spiritual practice, a mantra such as “Ohm,” or something neutral like a number or color. The word or phrase doesn’t matter so much as how it makes you feel, so you may “try on” a few until you find the right one. Once you have your word, here are the simple instructions: Each time you exhale, silently repeat your word to yourself. That is all you have to do. Just repeat your word or phrase each time you breathe out.

Return

- Of course it is natural to get distracted. There will be times when you forget to repeat your word, and this is no big deal. Once you recognize you got lost, just start again with your next exhale, repeating your word or phrase to yourself. You can say to yourself “Oh well,” or “No big deal,” before you start again. And then, just start again.

During the first few sessions I quietly offer a reminder from time to time, such as “this word, this breath,” or “if you get lost, simply begin again.” After 12–15 minutes, invite the client to let go of their word, and focus their attention on their natural breathing rhythm before moving on to the next section.

Remember

- Imagine a peaceful scene in which you are completely healthy, relaxed, and stress-free. This might be an image from the past, or an aspiration for the future. If you have an injury or ailment, or feel your heart heavy with grief, you may want to picture that part of you

healed. If it is difficult to imagine yourself in this way, picture a landscape such as the beach, or a relaxing color such as blue. Alternatively, you may wish to continue to repeat your word or phrase.

After 8–10 minutes, invite the client to gently move and stretch, and open his or her eyes. Allow a few moments of silence before inviting the client to share the experience if that is appropriate.

In addition to the exercise above, the relaxation response can be accessed through repetitive aerobic exercise (walking, running), Eastern meditative practices (yoga, tai chi, mindfulness meditation), repetitive prayer, progressive muscle relaxation, playing a musical instrument or singing, listening to soothing music, engaging in a repetitive task (woodworking, knitting), natural triggers (watching the ocean, stargazing), and guided meditations. If the client already engages in one or more of these activities, introduction to the relaxation response concept may encourage them to recommit to a practice that has served them in the past.

Case Illustration

Sonja, an only child, was 19 when her father died by suicide. Between the ages of 56–58 she experienced the death of her paternal aunt from lung cancer, the death of her stepfather from bone cancer, and her mother received a diagnosis of dementia. Sonja was now her mother's caregiver and the administrator of her stepfather's estate. I met Sonja when she was 59. One month prior to our meeting, Sonja thought she was having a heart attack and went to the ER. Extensive tests revealed she had had a panic attack. Two weeks later, Sonja admitted to herself that she had been drinking for what she described as “40 years straight to numb the pain,” and felt the panic attack was a “wake up call to get help before I wind up like everyone else in my family—sick or dead.”

Sleep-deprived and overwhelmed, she told me she did not know how to pull herself out of what felt like an endless cycle of anger and stress. I let her know that she did not need to “figure this out” right now, that we could start with the body and reduce some of the stress from the inside out, rather than the outside in. This seemed to put her at ease.

I invited her to lie down on the mat, and as I led the meditation I observed her rate of breath decrease, and her face seemed to soften. Afterwards, I asked her to share her experience. “I am surprised—I have never felt that clear before. I didn't think I could do it—meditate I mean. I thought it would be hard. But focusing on the word, well, compared to everything else in my life, that was easy. It gave me a place to focus inside—somewhere other than out there.”

Sonja's primary symptoms were insomnia and anxiety, so I recommended she split her home practice into two 10-minute sessions—one in the morning and one at night—so she could learn the practice while awake, but also tap into the relaxation power right before bed. On the fourth week she replaced the morning self-guided practice with a 15-minute recorded breath meditation. Although the recording did not specifically instruct her to repeat a word, and I let her know that following her exhale would have the same result, Sonja chose to keep her phrase.

My word is “let go, let God.” I still have periods of anger here and there during the week, and sometimes I feel overwhelmed, but then I say my word, or I try to remember how I felt after my last practice. I even used it in the car the other day when someone cut me off! I was driving to Mom's—at first I felt so angry at that driver—and then I realized I don't have any control over him. But I do have control over me. Not drinking. Doing this practice. Those are the two things I can do, even when I can't do anything else.

Concluding Thoughts

While no single study has offered insight into the relaxation response's effect on bereavement specifically, a plethora of articles highlight its efficacy on grief-related symptoms in children and adults in a variety of cultures, including anxiety in 5th-grade Lebanese children in a war-zone (Day & Sadek, 1982) and perceived depression, anxiety, and stress in adults (Denninger et al., 2014). Future research should observe the effects of short-term versus long-term practice, and follow study participants over time to track health consequences. A wide range of mindfulness-based practices and guided meditations designed to induce the relaxation response, as well as case studies, can be found in Stang (2014), with special emphasis on their application to grief.

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23

Meridian Tapping

Cecilia Lai Wan Chan and Candy Hio Cheng Fong

Clients for Whom the Technique is Appropriate

Originating in traditional Chinese medicine, meridian tapping is a body technique that can help alleviate both somatic and emotional expressions of intense grief. Body tapping and physical exercises require no emotional disclosure and are suitable for bereaved persons from all age groups and background, especially those who are unable to express their emotional, psychosocial, and spiritual pain. However, for bereaved people suffering more complicated grief, body work should not be considered a stand-alone treatment, but instead should be used as part of a more comprehensive treatment that includes verbal psychotherapy and other expressive approaches.

Description

The pain and sorrow associated with the loss of a loved one can be difficult to articulate. It is common for bereaved people to manifest grief through a wide range of psychosocial or somatic symptoms, problematic behavior, and irrational thoughts such as isolation, insomnia, constipation, loss of appetite, fatigue, forgetfulness, problem gambling, alcoholism, stealing, self-harm, high-risk behavior, and suicidal ideation. These are especially true for bereaved populations who are less able to verbalize their grief, or those who are experiencing traumatic or disenfranchised grief.

In traditional Chinese medicine, meridians refer to a dynamic system of energy networks that allows energy to flow inside the body. This system consists of 14 key energy channels connecting the various internal organ systems and interacting with the external environment to maintain an equilibrium contributing to health and well-being. Evidence supporting the existence of a meridian-like structure has been provided by advanced body imaging techniques (Yang, Xie, Hu, Chen, & Li, 2007).

According to the meridian theory, bereaved individuals can be stuck in the entanglement of unresolved grief and complex emotions that disturbs the energy flow in the human body. Disequilibrium of the energy system may lead to the above-mentioned grief, behavioral, and somatic symptoms. Through meridian tapping, bereaved individuals can regulate the energy flow of the body without emotional disclosure, and gradually restore health and well-being. Particularly relevant for bereavement would be the lung meridian, which governs sadness and grief.

There is growing evidence for the use of meridian tapping in alleviating somatic symptoms of emotional distress. Studies from acupuncture and acupressure, in which stimulation is applied to acupuncture points that lie along the meridians, found that these therapies help to relieve body pain, fatigue, sleep problems, depression, anxiety, and other trauma-related symptoms among a variety of patient populations (e.g., Posadzki et al., 2013). Other forms of meridian tapping such as Emotional Freedom Therapy (EFT), Thought Field Therapy (TFT), and Tapas Acupressure Technique (TAT) were also found to be effective in reducing trauma-associated symptoms and avoidance behaviors (for a review, read Feinstein, 2012). The application of meridian tapping with a bereaved client will be illustrated below.

Case Illustration

Sania is a single 57-year-old retired secondary school teacher who lived with her elderly mother throughout her life. Being a mathematics teacher, Sania trusted science and numbers and focused on rational problem-solving. She lost her mother and elder brother within 14 months. Sania had to retire early when her mother was diagnosed with an end-stage lung cancer 5 years before. Trying to keep her mother at home, Sania injured her back during the process of caring. Her mother died six months after diagnosis. Soon after her mother's death, her elder brother, who was divorced and living alone, was also diagnosed with an end-stage colon cancer. The brother moved to live with Sania who took on the primary caregiver role until the last days of his life when he died in a hospital. Since then, Sania suffered from severe insomnia, chest pain, low mood, and chronic fatigue.

Sania participated in a clinical trial of body–mind–spirit intervention for insomnia as the inability to sleep worried her every evening before she went to bed. During the pre-group interview, Sania shared her experience of insomnia and felt totally frustrated as she had tried everything, including Western medicine, Chinese medicine, acupuncture, and herbs in the past few years, though nothing had helped.

Sharing her sleep problem with the group, Sania was reassured to learn that many group members suffered insomnia as a result of losing a loved one. Several body activities were introduced in the group, and Sania particularly found tapping on the meridians useful to her. Her sleep improved within a few weeks to a point that she no longer worried about her insomnia. The essential steps in the tapping exercise are described below:

- *Posture*: Stand with two feet firmly planted on the ground a shoulder-width apart. Keep knees slightly bent with gentle up-down bouncing movements through the whole tapping exercise. Use both palms to tap on different meridian points on the body with a count of 9.
- *Warm up*: Rub the hands with palms in prayer position, use one palm to rub the back of the other hand with palms facing down, fingers crossing for 20 times to warm up the hands before tapping.
- *Meridian tapping*: Quickly tap the body with moderate intensity in the following sequence (see Figure 23.1):
 1. Head—Top of skull
 2. Face—both cheeks
 3. Shoulders—cross hands to tap on both shoulders
 4. Chest—cross hands to tap on chest
 5. Arms—with left hand held straight out, palm facing upwards, use right palm to tap from forearm to palm with a count of 9. Then turn palm downwards facing to the ground, and hit again from fingers to forearm with a count of 9. Change to right hand and repeat

6. Upper abdomen—both hands to tap on upper abdomen
7. Lower abdomen—both hands to tap on lower abdomen
8. Back—both hands to tap on lower back
9. Leg meridian (outer)—form fists to tap from upper leg to lower leg on the outer side of the legs by bending down
10. Leg meridian (inner)—form fists to tap from lower leg up to the upper leg from inner side of the legs by standing upright again
11. Knee (4 sides)—form fists to tap on the outer side, inner side, front part, and back of the knee for 9 times each
12. Massage the lower abdomen in clockwise followed by counter-clockwise direction 9 times each
13. Repeat entire set of exercises 2 more times, for a total of 3 sets in each practice.

The exercise can be found in Figure 23.1 and YouTube (www.youtube.com/embed/vVGiubHD3IQ?rel=0). The whole process takes less than 10 minutes and it is not physically demanding.

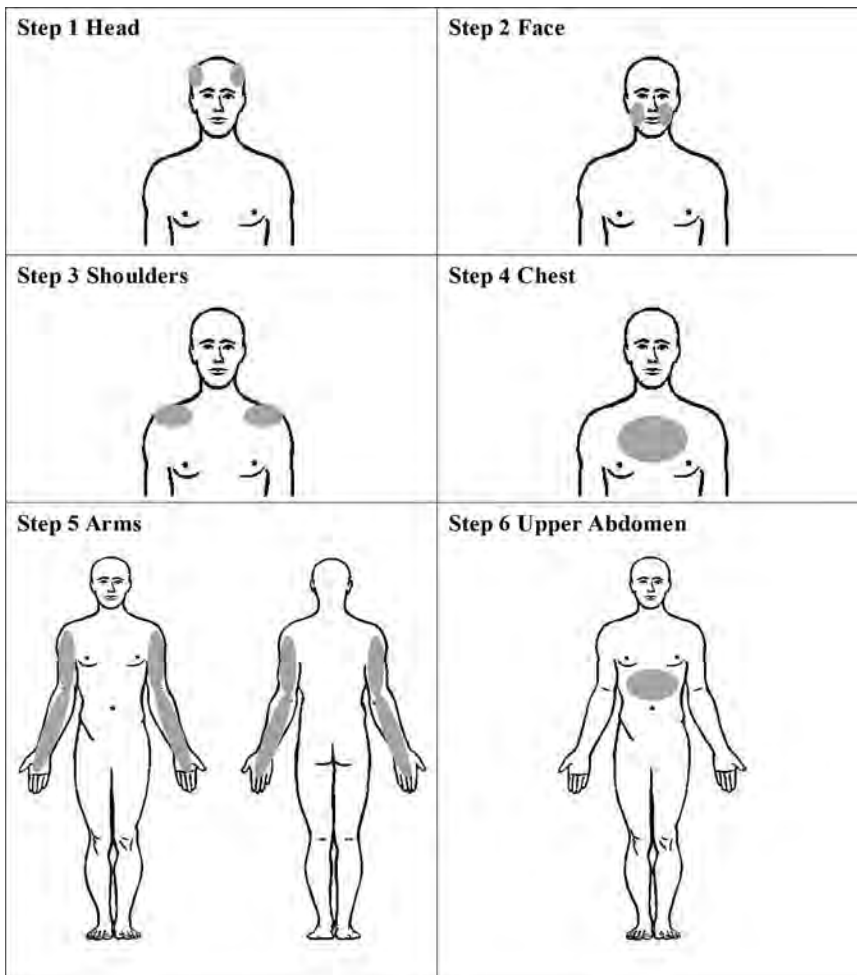


Figure 23.1 (continued)

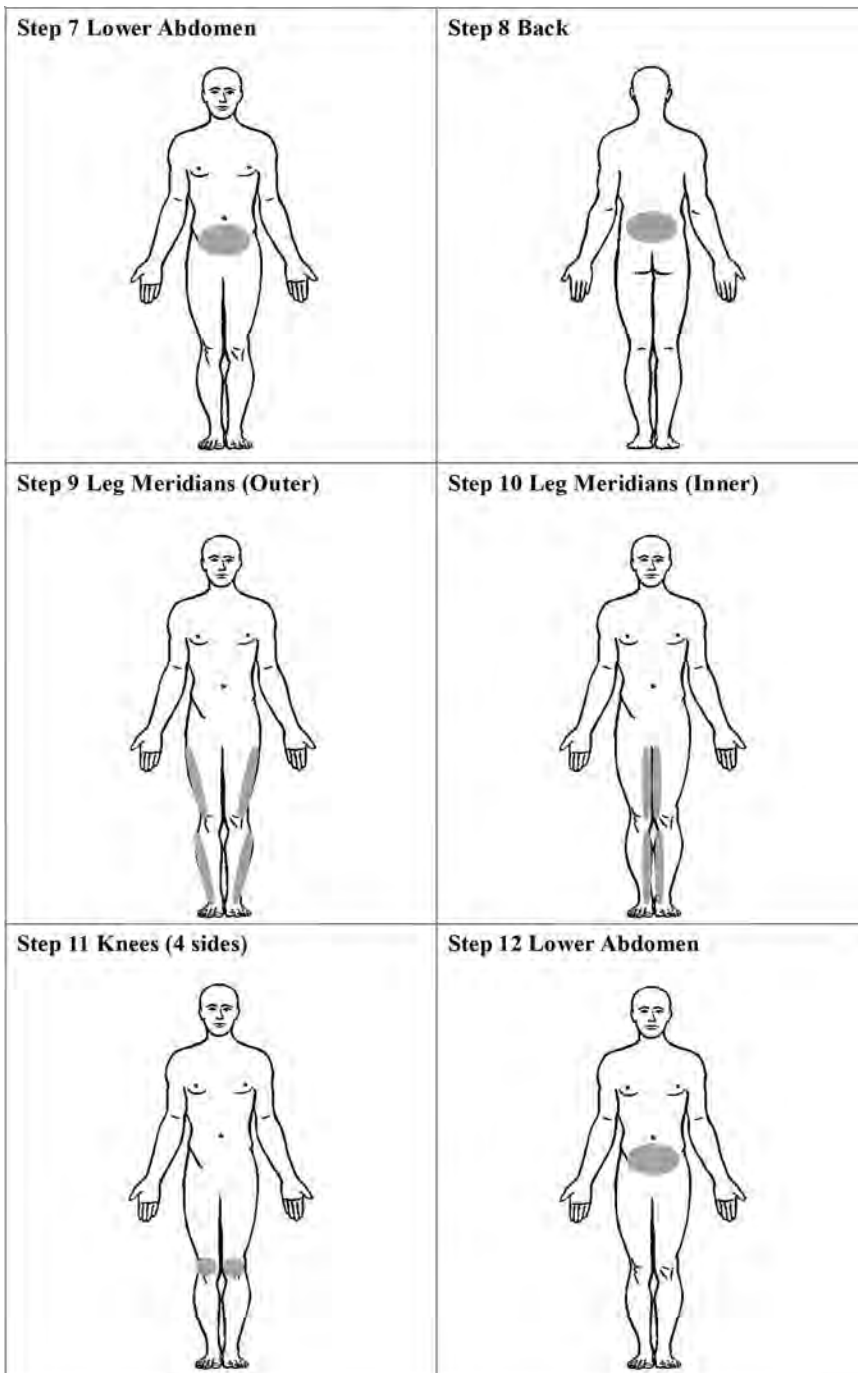


Figure 23.1 Steps for meridian tapping exercise

Sania practiced these tapping exercises 3 times a day every day (early morning before breakfast, afternoon before lunch, and in the late afternoon). As instructed, she drank lots of warm water during the day and found that this set of exercise helped her sleep better, improved her appetite, and reduced her constipation.

Concluding Thoughts

Grief is often suppressed and disenfranchised in populations such as children and the elderly, in cases of unrecognized relationships, or when grieving is considered as culturally inappropriate in terms of duration and intensity. In such cases the sorrow and pain of loss will often find expression through psychosocial and somatic symptoms that can have long-term detrimental effects on physical and mental health. Meridian tapping is a holistic technique that can be simply taught as a physical exercise and one that requires no emotional disclosure. This easy body exercise allows bereaved individuals to regulate their health and well-being through facilitating smooth energy flow in the meridian systems. The physical exercises provide a structure to help bereaved individuals regain a sense of control over their body and their grief symptoms. Although meridian tapping is introduced as a stand-alone technique in this chapter, it can be integrated with other grief interventions, in particular those adopting an integrative body–mind–spirit approach (for example and illustration, refer to Chan, 2001, and Lee, Ng, Leung, & Chan, 2009).

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24

Yoga for Grief

Heather Stang

Clients for Whom this Technique is Appropriate

Yoga for Grief is ideal for bereaved adults who experience somatic symptoms, including body tension, insomnia, fatigue, restlessness, or who feel physically or emotionally disconnected, but do not present with a dissociative disorder. Yoga works particularly well for clients who use their body as a metaphor to describe their grief experience, feel emotionally “stuck,” or have difficulty articulating their feelings. However, when the loss is complex or traumatic, it is usually better considered an ancillary intervention rather than a stand-alone treatment.

Description

Yoga is a philosophy rooted in ancient India and recorded around 400 CE by Patanjali in the *Yoga Sutras*, which describe an eight-limbed path intended to unite mind, body, and spirit so the practitioner can reduce suffering and achieve enlightenment (Satchidananda, 2012). *Asana*, the physical practice of yoga, combines prone, seated, and standing postures while utilizing controlled breathwork. Practitioners often report feeling calm, relaxed, clear-headed, and a sense of integration with their own life-force and inner wisdom, which in turn validates thoughts, sensations, and emotions, enhances self-efficacy, and fosters posttraumatic growth (Stang, 2014).

Yoga is credited with reducing fear, anxiety, sadness, and insomnia in bereaved practitioners (Telles, Naveen, & Dash, 2007), and significant improvements on the Vitality Plus Scale, Positive States Survey, and an upward trend on the Satisfaction With Life Scale (Philbin, 2009). Though yoga can provide an effective adjunct treatment for several mental health concerns, including posttraumatic stress disorder, clients with any diagnosis should consult with their mental health provider prior to beginning a yoga practice. Likewise, physical conditions should be assessed by a qualified medical professional prior to beginning a yoga practice, including heart disease, high or low blood pressure, glaucoma, spinal and head injuries, among others. It is highly recommended that any beginning yoga student seek out a certified yoga teacher or yoga therapist familiar with each posture’s contraindications to prevent injury (Broad, 2012), and although yoga training may be found in books and other media, professional support is recommended when addressing issues related to complicated grief.

Grief professionals with yoga training can easily incorporate yoga into the therapeutic setting, while those without have three options: refer clients to a yoga class, recommend private yoga therapy, or collaborate with a yoga professional to facilitate a Yoga for Grief group.

Yoga Classes

The westward migration of yoga has resulted in styles that range from contemplative to competitive. Those most compatible with grief-work focus on the internal awareness of experience, rather than the external expression of the postures, and teach their professionals to value physical and emotional safety over fitness (credentials can be verified through the Yoga Alliance or the yoga training institution where the professional received certification). Instructors comfortable with their own relationship to grief are better suited to work with bereaved clients, and grief professionals should not hesitate to ask how the yoga professional's philosophy supports grieving students.

"Brand-name" styles of yoga well suited for grief-work include Kripalu, Phoenix Rising, LifeForce Yoga for Depression, and Yin Yoga, and appropriate "generic" class styles include "gentle yoga" and the no-impact "restorative yoga," which is particularly useful for clients with limited mobility. Physically fit clients may enjoy a more moderate style of yoga, however in my experience the majority of people drawn to yoga as a grief intervention prefer the slower, gentler classes. Daily practice is recommended.

Private Yoga Therapy

Private yoga therapy is suited for people who are not comfortable in groups or wish to benefit from a one-on-one experience. Phoenix Rising Yoga Therapy combines yoga-based bodywork with client-centered dialogue. The goal of the practice is to deepen present-moment awareness, and explore whatever arises without trying to change, fix or adjust it, which gives the bereaved client an opportunity to explore the wide range of emotions and physical sensations that accompany grief in a nonjudgmental environment. The result is often a deep release of physical and emotional tension. Each session ends with a manageable action plan that will allow the client to move forward toward his or her goals.

Yoga For Grief Groups

Yoga for Grief combines the support of group therapy with the physical practice of yoga. The sum is often greater than the parts, with many participants reporting life-changing insights and physical benefits that last years beyond the group. As a yoga therapist and thanatologist, I developed a Yoga for Grief group that meets for 2 ½ hours over eight weeks, each of which is focused on a theme, including relaxation, compassion and forgiveness, and getting unstuck (Stang, 2014).

The group schedule, detailed below, may be modified based on the group's needs. For instance, if I plan to lead a strength-themed yoga sequence, but the participants are exhausted, I modify the sequence to include more restful postures in the beginning, and "read the room" to determine the rest of the sequence, a skill seasoned yoga teachers and yoga therapists are usually able to cultivate. Since the group is made up of individuals with unique physical and emotional concerns, participants are instructed to listen and respond to their body's needs, even if that means resting in *savasana*, a relaxing posture, during the entire yoga practice. I am an expert on yoga and grief; my clients are the experts on their bodies, minds, and spirits, and thus uniquely positioned to support themselves in ways no other person can. This self-care on the mat teaches the importance of self-care off the mat, and for many is yoga's greatest gift during, and beyond, acute grief.

Yoga For Grief Group Schedule

During the first session, participants gather in chairs in a circle, introduce themselves and share their story of loss. Personal safety and boundaries are discussed: refrain from socializing,

honor each other's experience without interference, and always practice the first rule of yoga, *ahimsa*, which means nonviolence towards the self and others. This last point is announced before every yoga practice for the entire eight-week period. With the exception of the first and last week, reserved for preliminaries and a closing ritual, the following is a typical schedule for each session:

- *Opening meditation* (5 minutes): Guided breath meditation and a brief seated body scan transition participants from life “off the mat” to the contemplative experience “on the mat.”
- *Sharing* (10 minutes): Intentionally and briefly, participants share victories, pitfalls and concerns encountered during the prior week, and set an “aspiration” for their practice. Examples include “I want to be less reactive with my family,” and “I just need a break from thinking.”
- *Savasana* (15 minutes): Participants rest on their back with optional supportive blankets and are guided through a breath exercise designed to facilitate relaxation (Figure 24.1).
- *Yoga* (55 minutes): Practice typically begins with the “Wake-Up, Warm-Up Exercise” found in the Phoenix Rising Yoga tradition (Lee, 2005), and ends with at least 5 minutes of *savasana*. *Asana* practice is structured around the weekly theme.
- *Meditation* (20 minutes): Participants sit in chairs or on blankets, and are encouraged to use walls or other props to create a supportive and alert posture. A period of mindfulness meditation is followed by a guided inner wisdom meditation (Figure 24.2).
- *Journaling* (20 minutes): Writing prompts and stream-of-consciousness journaling help group members externalize and explore their experience and record insights.
- *Closing circle* (20 minutes): Each participant is invited to share a significant moment from their practice or journaling experience, as well as their action step for the coming week,



Figure 24.1 Savasana pose to facilitate relaxation



Figure 24.2 Meditation to promote mindfulness and guided inner wisdom

which is often inspired by the inner wisdom meditation. Action steps may be similar to “I need to start swimming again,” “I am going to ask my friend for help with the taxes,” or “I am going to go grocery shopping alone one time this week.”

- *Housekeeping* (5 minutes): Home practice assignments for the week are reviewed, which may include yoga postures, relaxation, journaling, and/or expressive arts. I provide access to mp3 recordings of yoga and guided meditations to support home practice.



Figure 24.3 Child's pose

Case Illustration

Molly, 19, joined my Yoga for Grief group six months after her father died from colon cancer. A sophomore in college, she was struggling academically and had just ended a 2-year relationship because her partner said Molly was “too moody,” a description Molly did not deny. Before the fifth class, Molly reported that during the previous week she experienced pain “like I was being stabbed in the back.” During yoga practice, Molly had this experience while engaging in child’s pose (Figure 24.3): “I was thinking about my father’s disapproval when I came out—and the days of silent treatment—lost days that I can never get back.” Molly began to gently weep. “But I know he too felt stabbed in the back. He handled it all wrong. But he didn’t know any better. It was just who he was.” Molly said she was able to soften her grasp on anger and recognize that while she could not excuse her father’s behavior, she could forgive him. Her action step was to write a letter to her father, and the next week she reported that the pain was no longer present.

Concluding Thoughts

Yoga can help grieving practitioners release tension and process difficult emotions. While there is no shortage of research detailing the benefits of yoga, few studies focus on grief, and those that do explore a small population size and short-term interventions. Interviews conducted 4 years after my early Yoga for Grief program (now called Mindfulness & Grief) indicate that yoga, meditation, and journaling have long-lasting positive effects for participants, not only increasing their ability to cope with grief, but teaching them how to live life fully even in the wake of loss. I believe in-depth research on Yoga for Grief will reveal the details of yoga and its ability to support the whole person during bereavement. Yoga sequences can be found in the books noted below, specifically designed for grief (Stang, 2014) and stress (Lee, 2005).

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Part V

Working with Emotion

Disentangling Multiple Loss

Robert A. Neimeyer

Clients for Whom the Technique is Appropriate

Adults who have lost multiple loved ones simultaneously or within a short period of time can benefit from this procedure for distinguishing between the relational implications, grief-related feelings, and needs associated with each. However, stabilizing interventions to support emotion regulation should be given priority when the losses are recent, and the technique might not be appropriate for young children who have difficulty with the abstract processing required to take perspective on each loss.

Description

The term “bereavement overload” is often used to refer to circumstances in which a grieving individual confronts multiple losses simultaneously or in rapid succession, such that one loss cannot be accommodated before another occurs (Neimeyer & Holland, 2005). Although this overload can be triggered by a great range of situations (e.g., deaths of multiple friends or family members in a vehicular accident, war, fire, natural disaster, or even from unrelated causes over a short span of time), the resulting bereavement complication can be the same: a complex and overwhelming fog of grief that leaves the survivor with a sense of unreality and helplessness. Much of what is known about this condition stems from research on AIDS-devastated communities, whether in developing nations or during the 20-year HIV pandemic in the United States, when it was not uncommon for community members to experience dozens of such losses in the span of a few years (Nord, 1997). A cascade of predictable and unpredictable losses may also characterize later life, as one’s parents, older relatives, and eventually siblings, spouse, and peers age and die in increasingly quick succession. Feelings of helplessness, guilt about outliving other family members, and diminished self-esteem are common responses to this seemingly relentless progression, especially for older adults who themselves are in failing health or who suffer from social isolation. Whatever the circumstances that confront mourners with multiple losses, they frequently benefit from clarifying conversations that help them sort out the emotional and relational entailments of each.

The technique of “disentangling the strands” of interwoven losses draws on the intuitive metaphor of separating tangled or knotted strands of other sorts, as of hair or strings, so that

each can be followed from its source to its conclusion. In the case of multiple bereavements, the clinician helps the client “comb through” the threads of each slowly and carefully, teasing apart their meanings at several levels of specific relevance to the client. As a visual aid in this process, the clinician can construct a simple table to track the gist of the conversation, presenting it to the client as a guide to action or further clinical intervention, as illustrated below.

Case Illustration

At 84, Dorothy had already lost many and much, but had coped resiliently with the normative deaths of parents, partner and peers over the last 30 years. Now, however, she found herself overwhelmed and “frozen” by a complex multifaceted grief in the aftermath of three untimely deaths in the past 15 months: of her youngest sister, Laura, who had succumbed to an illness exacerbated by a lifelong developmental disability; of her middle son, Bill, who died suddenly of a heart attack; and of her youngest grandson, Kenny, whose cause of death in his late teens was concealed by his mother, but which Dorothy suspected was drug related. In the midst of so much anguishing loss, she felt adrift in the pervasive sadness, unable to engage her characteristic resourcefulness and lift herself—or other struggling members of her family—out of the sea of grief.

After reviewing the general timeline of her bereavement experiences and how she was coping with them, we returned to the three cardinal losses—of Laura, Bill, and Kenny—and placed their names at the top of three columns on a single sheet of paper. Intersecting with these we spontaneously created five rows suggested by our previous conversation, corresponding to (1) the special qualities of each of her loved ones, (2) their unique role relationship with her, (3) how Dorothy experienced herself in the relationship, (4) her dominant feeling in the wake of the loved one’s death, and finally, (5) what would help with her grief for that specific loss now (Table 25.1).

Working across the rows, I began by asking about Laura’s special qualities, summarizing Dorothy’s answers in her own words in the corresponding cell of the table (“She was smart, with strong opinions. But her disability could make life difficult, because she had no self-restraint”). To promote comparisons and contrasts to her other family

Table 25.1 Disentangling Dorothy’s multiple losses

Feature	Laura (sister)	Bill (son)	Kenny (grandson)
Special qualities	Smart, strong opinions. Disorder made relationship difficult at times, as she had no self-restraint	Remarkable sense of humor. Soft hearted and caring	Musically talented, curious, and surprisingly mature
Role relationship	I was her protector. She depended on me	He was the “fixer,” always practical and reliable	I introduced him to the world and to travel
How I was with . . .	Careful. I had to take care	Open, would ask for help	Caretaker, guide
Dominant feeling	Loss of what I meant to her	Loss of companionship. Loneliness	Waste of a special life. Ongoing pride
What would help with grief now	Spending more time with great granddaughter, Lidia, who also needs care, and at 2½, says what she thinks!	Getting closer to Michael, grandson, who has Bill’s sense of humor. Invite him and his mother to a neighborhood restaurant	Send artistic grandson Darren some of the art books I was going to give Kenny, books I loved when I used to paint

members, I then shifted to Bill, hearing stories of his sense of humor, soft heart, and caring nature. Finally, we turned to Kenny, as Dorothy smiled sadly but proudly, relating shared moments in which his musical talent, curiosity, and surprising maturity were evident from an early age. As I nodded appreciatively, sometimes asking a brief follow-up question, we segued naturally to the second theme concerning the unique role relationship she had with each, again working across the columns, teasing out the unique features of each. Exploration of her own position relative to each of her family members followed, along with consideration of her grief-related feelings and her sense of what concrete step would help most in relation to each (see Table 25.1). The result was surprisingly enlightening, as Dorothy began to identify specific actions that could constructively address the needs implicit in each different loss, which she began to implement in the weeks that followed. Interestingly, she also discovered a converging theme that integrated her response across the three strands of her relational web: her generative, giving role as the loving matriarch to the grandchildren of a family that had known far too much traumatic loss.

Concluding Thoughts

When losses are multiple and overpowering, clients often benefit from assistance in reflecting on the unique features of each, understood in terms of the relationships, feelings, and implicit steps required for them to move toward healing. Of course, the cross-cutting topics that intersect with the distinct strands of grief can vary somewhat from client to client, so that therapists might find it useful to add topics like “Obstacles to moving forward,” “Questions for the deceased,” or “People who support me in this loss” if these are more salient for a given mourner. In most cases, however, it is useful to begin with a row corresponding to the special qualities of the loved one, include another concerning the survivor’s dominant emotion regarding the loss, and conclude with what would help him or her now in relation to each particular death.

In Dorothy’s case, she required little more than therapeutic encouragement to pursue the “bottom-line” needs of each strand of grief once these were disentangled. However, more complicated and intractable grief presentations marked by preoccupying separation distress across many months or years may require specialized interventions to help the bereaved reorganize their attachment to the deceased, make meaning of the loss, and overcome the avoidance coping that contributes to their inability to integrate the loss and move forward in life (Shear, Boelen, & Neimeyer, 2011). At other times, the “wordlessness” of unspeakable losses, once distinguished from others, could call for expressive arts interventions that promote their symbolization and exploration in creative, nonverbal media (Thompson & Neimeyer, 2014).

A final word is in order about the implementation of “disentangling” conversations of the kind presented here, and that is the necessity to balance structure and responsiveness. Greater clarity regarding the various strands of multiple loss arises from touching on the material in each cell meaningfully but briefly, summarizing the essence of the client’s remarks in his or her own language, but reserving elaboration for more focused work on each strand after the table is completed. Used in this fashion, this simple technique can help honor each of the losses, recognize the relational matrix that gave rise to different forms of grief, and help the bereaved find through-lines toward a changed future that connect meaningfully to a cherished past.

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The Healing Power of Guilt

Celeste Miller and Paula Loring

Clients for Whom the Technique is Appropriate

This technique is for bereaved adults who are grieving and find themselves suffering from repeated and intense thoughts of guilt. It is less appropriate for group counseling, where the presence of others could inhibit the expression and exploration of this experience.

Description

Guilt is defined here as the feeling of culpability for perceived offenses. It is often accompanied by regret, remorse, negative self-evaluation, and feelings that one should atone (Rando, 1993). Most people who experience a significant loss will feel some kind of guilt. Many resolve this feeling with time, while some find themselves stuck and suffering. Guilt is haunting and can block positive memories of the deceased (Kosminsky & McDevitt, 2012). This triggers a sense of alienation, creating more guilt, causing the bereaved to stay in the past rather than to live in the present. According to Rando (1993), extreme guilt is dangerous and can lead to punitive and self-destructive behaviors including suicide, and may precipitate severe depression.

Guilt comes in different forms. It is difficult to face because the deceased is not available for reconciliation. Whether rationally or irrationally, mourners cling to it as a form of self-punishment and a way of creating justice. The guilt can become a way of making sense out of the loss, and a defense against helplessness. It creates a false sense of connection to the deceased insuring that they will not forget their loved one. Whether real or imagined, the bereaved experiences the guilt as authentic, demanding one's energy and attention while preventing the person from continuing in the normal processes of grieving (Rando, 1993).

In an attempt to alleviate pain, friends, family, and sometimes clinicians try talking the person out of their guilt, minimizing it and/or ignoring it all together. This lack of understanding triggers feelings of shame and insecurity and the guilt goes underground. This technique gives the bereaved a place to sort out their guilt and frames it as a powerful emotion that can facilitate healing. The process creates a sense of control, renews a more positive

relationship with the deceased and allows the bereaved resolution and integration of his or her life story. Within a safe therapeutic relationship, the counselor offers acceptance; giving the bereaved courage to claim their guilt. The counselor's willingness to venture into this kind of pain facilitates resolution. It is broken down into steps here for clarity, but each client will find his or her own way.

1. *Normalize the guilt.* Encourage the client to recognize that guilt is often essential in grieving a loved one. It arises out of relationships that are meaningful and fulfilling. Therefore, the task is not to try to make the guilt go away, but to ask, "Who do I want to be in my guilt?"
2. *Embrace the guilt.* The counselor facilitates accurate assessment. Is it unrealistic guilt? Is the guilt survivor's guilt? Or is it causation guilt? ("It is my fault."). It is acknowledged that it is haunting and reminds one that what happened cannot be changed. When a person is given permission to feel guilt, ambivalence can come up. The bereaved may vacillate between confession and trying to talk themselves out of it. There is dread at the thought of living with it and fear of facing that there is true and real regret. Mindfulness techniques can assist in facilitating this claiming of guilt.
3. *Discover the healing.* As they embrace and sort through guilt, the bereaved discover how they can move forward by asking several key questions.
 - *Would it help to do some act of penance?* This is a concrete and yet symbolic way of holding ourselves accountable for the wrong that has been committed. Penance can be instrumental (some action or ritual) or intuitive (fully expressing feelings) (Doka, 2002).
 - *Do you need to suffer or serve a sentence?* Suffering can help the person live with the guilt; integrating it into their life story without becoming self-destructive. Determining a release date can insure that the sentence is not a life sentence. Allowing the bereaved to suffer gives opportunity to live out the guilt in the world, making it count for something.
 - *Do you need to repent or ask forgiveness?* It can be healing to hold ourselves accountable, even if the guilt is irrational or excessive. The following *Guilt Prayer or Inventory* can be used by the client to clarify what he or she feels guilty about and own it instead of argue oneself out of it.

Guilt Prayer or Inventory

- List some things you would have done differently.
- List how you were doing the best (or were not doing the best) you knew how to do.
- List some things you know now that you did not know then.
- Accept the reality of what you can and cannot do, who you are and who you are not.
- Now take a deep breath and as you let it out say a simple prayer of appreciation that you were able to complete this exercise. It is a good step towards acknowledging your regrets and longing for healing.

Forgiveness is not as easy as it sounds. The counselor must ask how the client will know when they are forgiven and will they allow themselves to feel worthy of it.

Exploring these options empowers the bereaved to choose how they want to live with guilt rather than simply making the guilt go away. Often the counselor is the only person who hears about the guilt, because the bereaved is ashamed or angry that others have tried to talk him or her out of it.

Case Illustration

Sherry lost her 21-year-old son, Adam, to an accidental overdose on the day that she had let him convince her that he was ready to leave the rehab center a day early. The death was the culmination of years of struggle with drug addiction. Shortly after Adam's death, Sherry and her husband started attending a support group for parents who have lost a child. They gained great comfort and developed coping skills, but found it difficult to talk about the death because of the shame and guilt it evoked. Over time the couple sought counseling to work through issues of blame, marital conflict, and their need to grieve differently. Sherry even spent time processing the severe physical abuse of her childhood, which finally allowed her to face her deep and painful guilt.

The Need to Suffer

Initially, Sherry spent her sessions being angry at herself or her son. Her anger would not allow her to have positive memories of him. When she did manage to recall a positive memory, she would over-analyze it until she found evidence of her bad mothering and Adam's unwillingness to accept help. This was Sherry's period of suffering in her guilt. The counselor's role at this point was to be present to Sherry's struggle, allow her to suffer, and continuously question who she wanted to be in her suffering. She vented her anger and discovered that it had deep-seated roots in her abusive childhood. She did trauma work processing the abuse, facing her anger, shame and feelings of betrayal and abandonment. One day she expressed her despair. "I am feeling stronger now that I am getting free of the past, but it breaks my heart that Adam had to die in order for me to do this." She spent many sessions vacillating between holding herself responsible for her son's demise and trying to talk herself out of her guilt.

Paying Penance

Sherry began to come to terms with her suffering by trying to make up for "being a bad mother." Her penance was to become a support to the mother of one of Adam's best friends who was also struggling with serious addictions. She set up a grief support workshop in her church. These acts of penance were very gratifying for Sherry. She gained confidence and felt less shame, though her feelings of guilt continued to haunt her. The core of her pain was the conflict between her inability to recognize that she had done all she could and the misery of facing that she had contributed to her son's death. At this phase of treatment it is tempting to minimize the continuing struggle because the client is doing well in the world. However, it is just as important to recognize that she was still deeply troubled by her inadequacies and to encourage her to keep exploring these feelings. The counselor continued to ask questions: "Who are you becoming as you struggle with this guilt?" "Is that the person who you want to be?" "What would it be like if you could resolve this guilt rather than go back and forth in the conflict?" "What would you need from yourself and/or others to begin to resolve the guilt?"

Forgiveness/Reconciliation

The turning point arrived when she started her session by saying, "I am so tired of trying to figure out if I'm guilty or not. Was I the worst mother in the world or the best mother in the world? I think I need to decide once and for all that I did some things that were very, very

wrong, and get you to help me face the worst kind of pain I have ever experienced.” The counselor was deeply moved by the intensity and raw honesty of her sorrow. The rest of the session was spent bearing witness to this sorrow and listening to Sherry’s litany of her guilt. There was agony in owning that she needed her son’s love so much that she allowed him to manipulate her. Her fear for his safety was so overwhelming that she often broke boundaries that she knew could have empowered him to face his addiction. “I knew I should not have let him come home that night, but I was so afraid he would check himself out of the rehab and wind up on the streets. I was terrified that he might die alone. At least he died in his own home.” The counselor was a container for the pain and a comforting presence.

Sherry took the outline for the guilt prayer home with her and agreed to work with it over time. The next session she came with a tentative smile on her face and exclaimed, “You know, ever since I decided to surrender to my guilt, I have felt less guilty.” They reviewed her guilt prayer and she was able to talk about things she “should” have done differently with more strength in her voice: “It’s still very painful, but I think I’m going to be able to bear it.” Over the next few months, she began to claim her dreams of being a good mother to Adam. She had hoped to make up for some of the mistakes she had made with her two older boys. Gradually, she was able to admit without conflict that Adam was very different from her other boys and had had serious emotional problems since he was very small. She reviewed all the things she had done to get him help and acknowledged that she left no stone unturned.

Soon Sherry came in with a bag of pictures of Adam from birth to his death. She told the counselor story after story about him and how special he was to her. She recounted long talks they had, cherishing their closeness, in spite of his unwillingness to accept help. She ended the session with a deep sigh saying, “It feels so good to connect with him again. Even though I could have done things so differently, I am so grateful that I had him.”

Living On

Sherry’s case is a magnificent example of the healing power of guilt. It took great courage, unflinching support from her counselor and family, and a genuine willingness to trust that she could bear her guilt. There are still times when she must revisit it, but she reports that each time she uses it to heal rather than punish herself.

Concluding Thoughts

Guilt must be surrendered to in order for it to heal. This requires much courage from both counselor and client. It is a long process and it is often tempting to use techniques with a hidden agenda of making the client feel better rather than helping him or her learn to bear the pain. Counselors are encouraged to examine their own guilt and who they have become as a product of facing it, before they attempt to help others with this painful, but often necessary part of the grief process.

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Compassion and Loving-Kindness Meditation

Heather Stang

Clients for Whom this Technique is Appropriate

Bereaved adults and children with feelings of guilt, anger, vulnerability, anxiety, loneliness, low self-esteem, or fear may benefit from the practice of compassion and loving-kindness meditation. It is particularly useful for clients who feel alone in their suffering. This practice is not well suited for clients who are not able to regulate their emotions.

Description

When a loved one dies, the pain of separation is often accompanied by feelings of guilt, self-blame, and isolation. Some bereaved people feel abandoned or betrayed by preexisting social and spiritual supports, particularly when the loss is minimized with platitudes. This can contribute to a myopic outlook: I am separate, I am alone, I am unworthy of attention. Contemporary theories of grief suggest that both social support and a heightened sense of self-efficacy contribute to a healthy outcome. The Buddhist *metta* meditation practice is based on the principle that all human beings are connected in the desire to be happy and free from suffering. Often called the “prayer of loving-kindness,” *metta* practitioners send well-wishes to six groups of people: the self, a benefactor, a beloved friend, a neutral person, a difficult person, and finally all sentient beings (Stang, 2014).

Contemporary research indicates that compassion meditation, including *metta*, may increase resilience (Pidgeon, Ford, & Klaassen, 2014), reduce stress-induced immune and behavioral responses (Pace et al., 2009), and enhance traditional mental health interventions, increasing one’s ability to manage interpersonal struggles, such as marital conflict and coping with the strains of long-term caregiving, as well as depression, social anxiety, and anger (Hofmann, Grossman, & Hinton, 2011). Believed to have been taught by the historical Buddha as an antidote to fear (Salzberg, 1995), in my experience this practice reduces the sense of loneliness, separation, self-blame, self-pity, and vulnerability.

An authentic attitude of loving-kindness and compassion cannot be forced. During the practice, if a focus person comes to mind and there is no capacity to *pretend* to offer loving-kindness, meditators are instructed to choose someone else. It is paramount that a “worst enemy” is not the object of focus during the “difficult person” portion of meditation.

It is suggested that the meditator select people (or pets) who are still living, and for whom there is no sexual attraction, as this tends to blur the line between loving-kindness and sentimentality.

Care should be taken when teaching *metta* to clients who are diagnosed with a severe mental illness, including dissociative disorders, and people with active suicidal ideation. However, I have had success in both cases when working in tandem with a trauma therapist. Survivors of loved ones who died by suicide, homicide, or in accidents where there is a culpable person may certainly benefit from this practice, but it is important to caution them against using the culpable party as a focal point during the meditation unless they are able to do so in the true spirit of loving-kindness. This is not a sign of failure: By honoring the client's own need to feel safe and free from suffering, the spirit of the practice is further enhanced.

Metta may be taught to individuals, and also works well as a bonding exercise for bereavement groups. I will often add a section between the "difficult person" and "all beings" that consists of sending well-wishes to the members of the bereavement group, and find this is a satisfying way to end a bereavement group meeting. The script below may be used in either situation, and meditators should be encouraged to practice *metta* daily.

Metta Meditation Script (30 minutes, spoken slowly)

The language of the script below may be modified to support the client's spiritual beliefs, for example suggesting a specific spiritual leader during the "benefactor" meditation. Additionally, the "well-wishes" can be modified as desired, and it may be helpful to encourage clients to write their own words of loving-kindness. Traditionally this meditation begins with the self, but because of the propensity for low self-esteem in Western cultures, many practitioners find it easier to "warm up" with a person or animal that is loved unconditionally—called the "benefactor."

- *Preparation:* Find a place where you can sit comfortably, either on a chair or cushion, and where you will be undisturbed. If you wish, close your eyes or softly gaze at a point on the floor in front of you.
- *Instruction:* During this practice you will imagine offering well-wishes to yourself and others, recognizing that all beings are united in the desire to be happy, safe, and free from suffering. Consider the possibility of feeling in your body what it is like to offer kindness without conditions. Your breath is the anchor to the present moment, so if you find you get distracted or disrupted by thoughts or emotions, remember all you need to do is come back to your breath and continue to practice.
- Let your next breath be full and expansive—allow your exhale to fall out of your mouth with a sigh. Repeat this five times (pause to allow this action). Now let your breath be natural, and notice the place in your body where your breath is the most prominent. Bring your attention to that point—focus on each inhale, each exhale, and the space between.
- *Benefactor:* In your mind's eye, imagine being in the presence of someone you respect and love unconditionally, such as a teacher, mentor, spiritual leader, or your beloved pet. Notice what it feels like in your body to be in the presence of such warmth. Imagine sending these well-wishes:

May you be happy, as I wish to be happy.

May you know peace, as I wish to know peace.

May you be free from suffering, as I wish to be free from suffering.

- *Self:* Now replace that person's image with the image of yourself. Meet your own eyes, and smile. Cultivate the same sense of warmth for yourself as you did for the last person,

recognizing that just like him or her, you deserve to be loved unconditionally. Send these well-wishes to yourself:

May I be happy.

May I know peace.

May I be free from suffering.

- *Beloved friend*: Bring to mind the image of someone you consider to be a good friend, or maybe a beloved family member, and recall how you feel in his or her presence. This person deserves to live a happy and peaceful life, and you wish nothing but the best for this special being. Imagine looking him or her in the eyes and sending out these well-wishes:

May you be happy, as I wish to be happy.

May you know peace, as I wish to know peace.

May you be free from suffering, as I wish to be free from suffering.

- *Neutral person*: This is of a person you have encountered in the past who you neither like nor dislike. A neutral person you see occasionally, but may not know her or his name. A clerk in a store, someone you pass on the street, for instance. Send these well-wishes:

May you be happy, as I wish to be happy.

May you know peace, as I wish to know peace.

May you be free from suffering, as I wish to be free from suffering.

- *Difficult person*: Scan through the people in your life for someone you find difficult, but who is not your worst enemy. Maybe this person is irritating, or rubs you the wrong way. Select someone to whom you can at least pretend to send well-wishes. Consider the possibility that this person has good traits as well as bad, and that just like you she or he wants to be happy and free from suffering. Imagine saying to this person these words:

May you be happy, as I wish to be happy.

May you know peace, as I wish to know peace.

May you be free from suffering, as I wish to be free from suffering.

- *All sentient beings*: All beings want to be happy, to know peace, and to be free from suffering. In that regard, no one being is that different from another—we all are united in one common goal. As you feel your breath in your body, imagine that you can send well-wishes out to all living creatures everywhere:

May we all be happy.

May we all know peace.

May we all be free from suffering.

- Allow the client to sit in silence for several minutes before inviting her or him to open the eyes. While journaling is not a part of the traditional practice, it can be very supportive.

Case Illustration

Megan, 38, joined the Yoga for Grief group after Chris, her boyfriend of 1 year, died of an overdose. Unaware of his infrequent but fatal habit, she felt blindsided and betrayed—by him for using, and by her own intuition for not knowing, particularly since her first marriage ended because of alcohol abuse. The mother of two small children, Megan spent the majority of her nights at her own home, staying with Chris only when her ex-husband (now in recovery) had custody of their children.

“I thought we were going to get married. What else did he do on those nights when I wasn’t with him? We were living a lie.” Chris’s family had not acknowledged her loss in the way she had hoped, and her own family was telling her that Chris’s death was “for the better.”

Megan was constantly telling herself she was a bad mother for choosing another addict for a mate and that she was unworthy of the support she so badly needed. Her feelings for Chris vacillated between love and disgust, and at times she felt guilty for not spending more time with him. “Would I have noticed and gotten him help? I feel like in a way, I deserve this.”

Metta practice allowed Megan to view herself as a person worthy of love and support. After several weeks of practice, she was able to recognize that she had protected her children as best as she could by not rushing into another relationship, but allowing it to develop slowly and putting them first. After focusing on Chris’s mom as the “difficult person” during *metta* practice, Megan realized that his mother must be in a tremendous amount of pain. She also realized that her own family’s harsh words were rooted in fear.

Megan scheduled a visit with Chris’s parents, and set the intention to feel the compassion that arose for them during *metta* when they met in person. “It was like I was meeting her for the first time, and I could see clearly into her very broken heart, which gave me the ability to see Chris, his family, and myself in a new light.”

Concluding Thoughts

Metta has the power to transform feelings of guilt, shame and blame (“I didn’t do enough”) to feelings of compassion (“I tried my best”), and may contribute to meaning-making and post-traumatic growth. As the lens widens on the shared human condition of love and suffering, many practitioners feel a strong desire to be kinder to others, reduce negative self-talk, and engage in altruistic and volunteer activities. Although there is no conclusive research on *metta* meditation and its impact on bereavement, non-grief-specific research and anecdotal accounts indicate tremendous promise for the practice as a valid adjunct grief intervention. Additional compassion and loving-kindness practices, guided meditations, and case studies specific to grief can be found in Stang (2014).

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Ambivalence in Grief

Celeste Miller and Paula Loring

Clients for Whom the Technique is Appropriate

This technique is appropriate for ongoing grief support groups whose members are ready to explore their grief more deeply. It should not be used initially. The group members should have developed some sense of trust and safety between each other and the facilitator. It is contraindicated for groups with members who are fragile and cannot regulate their emotions. It would be more appropriate for these clients to experience the exercise in a one-to-one setting with a counselor.

Description

Ambivalence is defined here as the simultaneous experience of two or more conflicting feelings at once about a person, situation, relationship, or the self. It is a natural part of grieving (Schreiner, 2014) with the ultimate conflict being between “life before the death” and “life after the death.”

Ambivalence in grief can be extreme (as in cases of the deceased being physically abusive) or more subtle, and yet no less difficult to face and resolve. The common tendency in grieving is to magnify the positive and deny the negative. No one wants to face the reality that life might have been difficult. When conflicting emotions do surface they often feel like they can never be resolved because the loved one is dead. There is the fear of having to live in these feelings with no hope of reconciliation. So the bereaved adheres to “not speaking ill of the dead” and compartmentalizing the more negative painful aspects of the loss. Avoidance of ambivalence is often rationalized as a protection of the deceased or themselves. There is a fear of defaming the deceased or that others will judge the life lived.

Resolution or integration of ambivalence is difficult and sometimes frightening work. It means acknowledging positive and negative aspects of a lost lifestyle, the relationship with the deceased, or the mourner’s sense of him- or herself. Unfortunately, denying the existence of ambivalence causes it to go underground, becoming a form of disenfranchised grief (Doka, 2002). This only serves to complicate grief, creating a vague sense of being “stuck” and/or incomplete. Often people will keep these painful memories a secret. They feel alone. It takes a great deal of energy to keep the darkness at bay so there is little left to forge into the future.

Facing the ambivalence, however, allows the bereaved to develop the strength and courage to embrace the reality of the relationship and more fully integrate the death into their life story (Neimeyer, 2012). The bereaved discover that negative aspects of the relationship can be as productive as the positive, because these aspects have contributed to the tapestry of who they have become. Allowing ambivalence helps the relationship with the deceased to become more rich and whole. It also allows for discovery of the mourner's ability to hold two feelings at once, thus freeing them to claim the negative (anger, guilt, disappointment) while still being firmly grounded in such positive feelings as love, forgiveness, and gratitude. Ironically, ambivalence can be a powerful healer and enable the bereaved to grow into a new life.

This technique can be used in grief support groups to gently invite members to explore their own ambivalence as they grieve. It is powerful in a group setting because it:

- *normalizes ambivalence*—members hear that most participants experience some kind of conflicting feelings as they grieve and receive permission to name and claim them;
- *allows group members a safe space* to feel the fear of facing the full reality of their relationships with the deceased;
- *gives group members the opportunity to share their struggles and successes* with resolving or integrating conflicting feelings;
- *can serve as a tool for the group to deepen in their processing of grief* without the facilitator being overtly confronting;
- *facilitates members' acceptance of each other* as they reveal varying levels or intensities of ambivalence.

The technique, which we sometimes call “Putting Humpty Dumpty Back Together Again,” is a simple imagery exercise. The stage is set by inviting the group to do an exercise that will allow them to explore different aspects of their relationship with the deceased. It is important to emphasize that the exercise has no right or wrong answers and each member will experience it in a unique way. A general orientation to the exercise follows.

Let's begin by taking a deep breath and letting it out fast . . . Now close your eyes, take another deep breath and as you more slowly exhale, let yourself drift back and forth through time, remembering some of the positive qualities of your loved one . . . the characteristics or achievements that you admired and contributed to your life together . . . As you remember these special qualities, keep breathing and allow an image, or a color, or a texture to come to mind . . . This image is a symbol of the positive aspects of the person you have lost. Now you can imagine the image shrinking into something that can magically be held in your right hand, even if it is as big as a pick-up truck or a father's rocking chair. Just take a few moments (10–15 seconds) to simply enjoy what it feels like to connect to your loved one in this way.

As you hold this in your right hand, I want to invite you to take another deep breath and remember some less desirable aspects of your loved one . . . those characteristics or mistakes that were difficult to live with, or somehow impeded his or her *or your* ability to live life fully. This may be painful, but these things are just as much a part of who he or she was and they can also become, in a mysterious way, precious . . . And again, allow an image, color, or texture to emerge. This is a symbol of the darker side of your loved one. Notice what it is like to hold this image in your left hand . . . Very gently allow yourself to acknowledge your feelings about this aspect of the person. Imagine the comfort and compassion you might need to bear this, for just a few moments (10–15 seconds).

Now keeping your eyes closed, take a few more moments to focus back and forth between each hand; acknowledging that both are the reality of who the person was and both are still a part of your connection to that person (10–15 seconds).

Still with your eyes closed, take another deep, deep breath in and as you exhale, bring your right and left hands together in your lap . . . Notice what happens. . . Watch to see how the images and feelings might change or stay the same. Take a moment to experience what it is like to bring the conflicting feelings together. Does another image emerge? Is there a shift inside? Do other feelings come up? (20–30 seconds)

Now take a last deep, deep breath and as you exhale, slowly open your eyes. When you have settled back into the present and this room of safe, supportive people, we can take some time to share what this exercise was like for each of you.

The group shares and the facilitator is careful to keep responses nonjudgmental and supportive of whatever awareness each member has. There are usually people in the group who choose not to share. Others may discover that they used the exercise to explore aspects of themselves rather than the deceased. Some may use it to process the death experience. Typically, most will share that they were able to feel a sense of wholeness from the exercise.

The beauty of this process is that it is a gentle way for participants to discover some fresh aspect or perspective of their relationship with the deceased and sets the stage for further integration and healing.

Case Illustration

The Older Women's Group is one of several weekly grief support groups sponsored by a local funeral home. The facilitator is a licensed professional counselor assisted by a lay pastor (also a seasoned widow). It is an open and ongoing group that has been meeting for 12 years. On any given Wednesday it is made up of 15–25 widows ranging in age from 60 to 85. Members may choose to stay as long as 3 years, or come only once, with the average time in attendance being 18 months. The format is open, with participants sharing their struggles and successes on a week-by-week basis. Themes often emerge and the facilitator uses the themes to forge connections between members and across time. Her role is to facilitate the development of coping skills, and integration of the loss into each member's life story. Often a more seasoned member will support a woman newer in her grief and there are times when a new member's perspective will inspire healing in the veteran.

When tender themes emerge, the facilitator may guide the group in an exercise that allows members to examine it in a more structured way. Ambivalence is often an undercurrent and the imagery exercise was used after a few meetings in which this topic seemed to be emerging and the facilitator felt that the members were connected and had sufficient ego strength to explore this topic more deeply.

The group began with laughter tinged with a bit of discomfort. Lyda started. She is a 70-year-old widow who was coming up to the first anniversary of her husband's death. "Hard to believe it has been almost a year. It seems like I have been thinking about Harold more than usual. Most are good memories, but the other day I was in the grocery store when I heard an old man on the other aisle cussin' like a sailor at the clerk. That brought back some memories I'd like to forget." She paused for a moment, and then said, "I sure don't miss the cussin'."

The group laughed nervously as Ida, whose husband of 50 years had died four months earlier, chimed in, "Yeah, it sure is strange not to have to immediately wash the dirty dishes he hated seeing in the sink."

Janet, a tearful woman of 67, responded, “Oh, I feel so confused when I think of feeling both angry and relieved, and still missing him so.” There was uncertainty in her voice.

The energy in the group seemed to be intensifying and receding all at once. This was a cue for the facilitator to step in and discuss the role of ambivalence or mixed feelings as we grieve. She presented it as a normal process which, if embraced, can actually help a grieving person feel more whole and connected to the loved one. She then asked the group if they would like to go through an exercise in which they could discover their mixed feelings about their husbands, rather than put them on a pedestal. While the newer members seemed reluctant, those who were further along in their grief trusted the facilitator and welcomed an opportunity to try something new. The facilitator then guided them through the “Putting Humpty Dumpty Back Together Again” exercise. The results were gratifying.

Initially, the women were tentative about sharing, saying it was difficult to talk about the negative traits of their husbands, but once Lyda and Janet took the lead most became eager to talk. Lyda revealed that her positive object was a coffee cup. He brought her coffee every morning until the day he went into the hospital. When she brought the two together the cussing became a whisper and the smell of coffee dominated. “He probably would have toned it down if I had ever had the courage to ask him. I thought it would make him madder. He was rarely mad at me, but he was sure hard on the kids.”

Janet continued to be tearful, but expressed relief to discover that she could talk about how she often felt jealous of her husband’s work. “He was so caring of his clients, I’m not sure he would have been the same person if he had not put work first. You may think of plants as a funny thing to be my symbol of him, but nurturing was his life work and he was so good at it.”

Sylvia’s husband died six months before. “He was a teddy bear. He was hard on the outside, but soft on the inside.” Throughout the years that softness turned to depression. “I wish he could have known that his goodness outweighed the bad.”

Margaret was usually quiet in the group. “I am so relieved to be able to talk about this. I have been feeling like everyone else’s husband was a saint. Edgar was not. His temper was a ball of fire and sometimes I was the brunt of it. But he also had a heart of gold. I can’t really tell what happens when the two come together. I want them to, but I go through days of fussing at him in my head one minute and missing him like crazy the next.”

The majority of the group shared something and many voiced the realization that the exercise was not only liberating about their husbands, but it also freed them up to recognize some of their own shortcomings as well. As the discussion progressed, many reported merging of positive and negative images: books symbolizing a love of learning merged with the husband’s nosiness to become “He always had something relevant to offer”; model airplanes and tools merged with disorderly piles of “stuff” to symbolize a husband’s creativity.

As the group progressed, the facilitator continued to normalize the women’s ambivalence and suggested that some of the conflicts could take time to heal or become whole. These could be topics of conversation in future meetings or with an individual counselor if they needed more privacy to explore the unfinished business of their relationships.

One woman chose not to speak. The facilitator knew that her husband had committed suicide and respected her choice not to share this. Several months later she was able to talk about it, revealing that the “Humpty Dumpty” session was the first time she realized that it might be alright for her to talk about the suicide with the group.

Concluding Thoughts

Clearly, ambivalence can be a powerful healer, but it should be emphasized that it can also be a destructive force. The facilitator must walk the fine line between inviting group members to share painful unresolved feelings and providing enough safety and structure so that members do not feel overexposed, or judge themselves too harshly. The goal is to facilitate the group becoming a container where the conflict can be held and ultimately healed.

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Clients for Whom the Technique is Appropriate

Patients living with a cancer diagnosis can benefit from this technique to help them identify living losses, share their unique meaning, and explore how to balance sorrow and joy in a life lived with life-threatening illness. This exercise can be used during or after cancer treatment and can be practiced individually or in a group setting. Children and older adults may also benefit from this technique with developmentally appropriate adaptations. This exercise may prove emotionally overwhelming for newly diagnosed patients or for those in an actively terminal phase of the diagnosis.

Description

A cancer journey is filled with a wide range of tangible and intangible living losses (Harris & Gorman, 2011). Coping with cancer-related grief is often difficult and lonely for patients and family members who may feel pressure to only “look on the bright side” or “find the silver lining.” For families living with cancer, sorrow ebbs and flows along with illness-related milestones and transitions and patients and loved ones are not always emotionally “in sync,” further complicating the exploration of painful losses. When cancer strikes young adults it is especially challenging to find meaning in losses that are vastly out of step with the life experiences of a majority of their peers (Zebrack & Isaacson, 2012). Patients and caregivers frequently fail to identify, honor, or grieve losses that do not involve death, yet the cumulative impact of these losses can be emotionally devastating if left unattended (Boss & Couden, 2002). Helping professionals should employ creative ways to help patients identify and explore their many losses, while also supporting them in orienting toward joy, hope, and restoration of a “new normal” (Stroebe & Schutt, 1999).

“Loss Boxes” serve as a vehicle to bring loss out of the shadows of the cancer experience. Through this simple exercise, patients can safely identify important losses and explore their unique impact and meanings. Individual losses are written on small bits of paper to honor this too-often-overlooked aspect of a cancer journey. Identified losses can be read and re-read privately, or in community, and then safely tucked away inside the box for further discovery whenever the patient feels a need to re-explore the pain. Each box also provides a literal and metaphorical container to store grief at times when emotional energy is needed elsewhere. Each patient is provided with much-needed personal control by having sole permission to open and

close the box lid, thus titrating the individual grief story as feels personally appropriate. In a group setting each individual's losses are deeply heard and held by the entire community to help ease the burden of a subject that may be quite challenging to convey to loved ones sharing the journey.

Case Illustration

In an effort to support complex emotional needs and combat the isolation experienced by younger adult cancer patients I created a healing retreat specifically for female patients between the ages of 18 and 45 years old. After spending time getting to know one another and building trust in the group, each participant was encouraged to create a vibrantly decorated "Loss Box" reflecting her life and honoring cancer-related losses. For the first half hour each woman used markers, stickers, glitter, and glue to decorate a box in a way that represented her authentic self and the important people, places, and things in her life. A festive air permeated the room as these women creatively explored the totality of their lives. They needed no encouragement to share their stories with other participants and the completed boxes were truly things of great beauty (Figure 29.1).

When the box decorating wound down I next asked the women to write down all the losses each had experienced related to their cancer journey on small pieces of paper I provided. Everyone was reminded that there were no rights or wrongs and that losses could be shared with the group or kept totally private. The room fell silent as the women took a few moments to think, write, and then read what they had put down. Some had tears in their eyes and others put their head on the table. The mood was somber. As activity slowed I asked if anyone wanted to share what she had written. Most did. Common



Figure 29.1 Loss boxes constructed by group members living with cancer

losses included hair, body parts, relationships, confidence, employment, trust, health, fertility, youth, and innocence. Some faced mortality and had lost the expectation of a long life. One was losing the ability to see her children grow up. Powerful stories were told; each one given the reverence it deserved. Tears flowed, women looked deep into each other's eyes, nodded, and hugged. After anyone who wanted to share had spoken I asked that they put the slips of paper into their box and put the lid securely on. I suggested we take a silent moment to honor the loss and grief we had just shared and witnessed for one another. I then reminded the women that while we chose now to put away the sorrow and grief, we could return to it by opening the box any time we wanted. Again the room got quiet.

After a quiet moment or two I asked how the exercise felt. Some shared that it felt good to share the pain with others who “get it” and others admitted it was hard to see all the loss written on paper. All felt it was important to be heard and appreciated that they could put the grief away when they wanted. Before ending this portion of the day I pointed out that each beautifully adorned box represented the sum total of each woman's life and that though loss was present inside of each box, it was only a part of the whole. I encouraged each woman to honor loss as an important and worthy part of themselves, but to also give themselves permission to close the lid on loss in order to turn energy elsewhere, as needed. “We can do both,” one woman stated. “We control the flow.” “Exactly,” I answered. Our exercise was complete. It was time to shift our attention elsewhere. As the dessert that had been waiting in the wings arrived, the energy in the room again turned joyful and much laughter could be heard throughout the room. Well-honored grief was quiet now. Actively seeking joy (and cookies) returned, reminding the women that sorrow and joy can coexist, even in the most challenging of circumstances.

Concluding Thoughts

When losses are ambiguous or disenfranchised it can be helpful to pause to acknowledge and honor their meaning in a concrete and structured way. Since cancer-related losses are often chronic it is also useful to have a way to contain them so that a transition toward active living can be made. Though emotionally challenging, most patients will, in a safe space, be able to explore cancer-related losses. For some this is too intense and the exercise should be altered to honor their emotional needs. In my retreat a small cohort of participants preferred to call the boxes “Worry Boxes” and were encouraged to make this alteration. Helpers should always take care to meet the patient where she is and not push a loss agenda if the client is not ready. Honestly honoring loss and grief can help patients integrate their losses and open more internal space for orienting toward hope, joy, and thriving despite cancer. The Loss Box technique gently supports patients in honoring all parts of themselves as cancer survivors and can be a powerful salve for wounded and weary souls.

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The Grief Drawer

Darcy Harris

Clients for Whom the Technique is Appropriate

This technique is applicable for clients who avoid their grief due to fear that they will be overwhelmed by it or for individuals who do find themselves overwhelmed by their grief to the point that they are unable to attend to everyday functioning. It may be less relevant for clients who are adequately modulating their emotion, but struggling with other practical and relational adjustments to their changed lives.

Description

Many bereaved clients express concern about being overwhelmed by their grief. Many also express concern that if they engage fully with their grief, they will not be able to be present to their loved ones or be able to fulfill the commitments of their daily lives. While any good therapist will normalize these feelings, clients may need some assistance to engage with their grief in a way that provides structure to assist them in regulating their reactions to grief-laden triggers. The Grief Drawer provides a means for clients to practice the ability to engage deeply with their grief and then to disengage from its intensity when they need to turn attention to the life that now exists in the midst of their loss experience.

Acute grief can be accompanied by pangs of intense emotion, often experienced as distressing and difficult to navigate. Inability to adequately regulate these emotions has been hypothesized as one of the crucial factors leading to the development of complicated grief (Gupta & Bonanno, 2011). Grieving individuals may actively avoid reminders of their loss in an attempt to try to regulate their emotions. This type of underengagement is consistent with the widely studied concept of experiential avoidance, a form of emotion regulation characterized by avoidance of disturbing emotions, thoughts, memories, and physical sensations (Kumar, Feldman, & Hayes, 2008). Grief-related avoidance with the intention to regulate strong emotions and/or avoid confronting the painful reality of the loss can be pervasive and impairing. On the other side of the coin, grieving individuals can also have difficulties with unrelenting rumination and emotional flooding related to their grief, which can lead to paralysis in their daily functioning (Shear et al., 2007). There is substantial evidence that both avoidance and overengagement with emotions are associated with worse psychological and physical health outcomes (Kumar et al., 2008).

When clients are concerned about their ability to disengage from their grief in order to function, or if they share that they try to repeatedly distract themselves or “stay busy” so that they can avoid experiencing intense emotions (usually described as maintaining a sense of “control”), I will often suggest that they create a “grief drawer.” With this technique, the grieving individual gathers together objects, pictures, written work, music, and any other type of reminder of the loss or the deceased loved one. I then advise them to find something that will allow them to keep time in a way that will not be obtrusive, such as using specific tracks from a music CD, a small tea candle that will stay lit for a short period of time, or a gentle sound programmed to the timer on their phone. All of the items associated with their loss are to be placed in a drawer and the drawer is then shut. If some of the items will not fit into the drawer, they are covered and placed in proximity to it.

I then ask clients to set aside a specific amount of time each day to open the drawer, go through its contents, and enter into their grief as fully as they need to do so. We discuss and decide upon the timing and terms by which they will set up and access the drawer, emphasizing that the time spent poring over its contents will be limited by the ending of the music, the tea light burning out, or the timer gently signaling an end. At that point, all of the materials are placed back in the drawer and the drawer is shut. Clients may choose a closing ritual that signifies re-entry into everyday life and its responsibilities afterwards. Some clients need to start the process of planning the drawer’s contents and how they will access it in their therapy session before transferring it to their home, where they will complete it on their own.

Case Illustration

Jan was a 46-year-old widow with three children, ages 5, 8, and 11. Her husband, Kevin, went through intensive treatment for lymphoma over the course of 3 years, including a bone marrow transplant. He died from complications related to the transplant. Since Kevin’s death six months ago, Jan had kept the door to Kevin’s home office closed because she does not want to be “overwhelmed” by the reminders of him in that room. She spent most of her energy trying to help her children to adjust to the loss of their dad. The youngest had recurring nightmares and had regressed in her behavior, with toileting “accidents” and tantrums. Her oldest child was failing in two subjects at school. Jan was currently on leave from her job as a high school teacher.

Jan found that when she tried to go to sleep at night, she was overwhelmed by sadness, loneliness, and memories of her life with Kevin and images of what he looked like when he was very ill. She often felt very tired in the mornings because she had not slept well. She missed Kevin deeply, but she actively avoided her grief by focusing on her children and the demands of everyday life.

Jan was initially dubious about the suggestion of a grief drawer. She voiced concern that she didn’t have time and she worried that once she began to allow herself to really enter into the grief her ability to function would be even more compromised. She also recounted a family history of depression, with her mother receiving electroconvulsive therapy when she was a teenager and her concerns that she could end up like her mother. However, after deciding upon a brief time limit and deciding when she might be able to engage in the exercise when the children were in school, she agreed to give the suggestion a try.

Jan put one of Kevin’s favorite shirts in the drawer. She then added his watch (which was a gift she had given him), several pictures of him from various times in their lives, a pendant he had given to her, letters from when they were dating, and pictures of when each of their children was born. Kevin loved Van Morrison’s music, so Jan burned a disc with several of his favorite songs, including one entitled “Brown-Eyed Girl,” which he

used to sing to her when they were dating. The first time she worked with the drawer, Jan had set aside 20 minutes. She turned on the CD player, opened the drawer, and began to gently go through the items that were there. The songs she had burned onto the disc finished after 15 minutes. During the time the music played, she allowed herself to cry, and then to write a brief note to Kevin about what she missed the most about him. When the music ended, even though tears were still streaming down her face, she put everything, including the note she had just written, back in the drawer. She then closed the drawer, left the room, and turned on the TV while she folded laundry. In the beginning, there were times when she could not bring herself to go to the drawer to do the work. When she did go to the drawer, she often felt exhausted when she was done. However, she also realized after a few weeks that she could think more clearly and focus her attention better. She was also sleeping better.

Over time, Jan set up a routine to go to the drawer twice a day, after dropping the children to school and again after they all went to bed. She burned other CDs with music that she and Kevin had shared together or that seemed to give voice to her feelings. She also began adding other things to the drawer that she found. She eventually put all the notes she wrote to Kevin during these times into a journal that provided a place that felt sacred for her innermost thoughts and feelings.

One day, Jan entered the room and found her oldest son looking through the drawer. She explained what the drawer was and he asked if he could also have a drawer for his dad. Instead of a drawer, he decided to use his dad's fishing tackle box as the container. Jan reported that she felt a sense of relief that her son was also finding a way to honor his grief.

Concluding Thoughts

This idea for clients was originally based upon the Dual Process Model of Coping with Bereavement (Stroebe & Schut, 2010), which describes the normal oscillation of grief between focusing on the loss and aspects of the loss (loss orientation) and attending to daily life and new roles and possibilities (restoration orientation). Clients who have difficulties engaging with the emotional aspects of their grief and loss experiences may find this technique helpful to cultivate emotional flexibility and a greater sense of competence in working with the more emotionally difficult aspects of their experience. This technique is also useful for clients who experience other types of losses that may not involve the death of a loved one, where the associated items may represent aspects of what has been lost or of a time in one's life that is lost. For example, I have had clients who have immigrated use the drawer for their familiar items that remind them of their homeland and what they left behind when they moved to a new country, and I have also had clients who have experienced infertility use the drawer as a place to grieve the loss of their hopes and dreams for a biological child.

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Part VI

Reconstructing the Self

Building Self Capacities

Laurie Anne Pearlman

Clients for Whom the Technique is Appropriate

Self capacities are inner abilities that allow for self-regulation. While all bereavement clients may benefit from building them, this work is especially important for those who have experienced the sudden, violent, or untimely death of a loved one; who are experiencing painful grief and trauma over a prolonged period of time (traumatic bereavement); or who have had additional early or severe experiences of neglect, abuse, or unresolved traumatic loss.

Description

Self capacities form an essential foundation for the work of trauma processing and mourning the sudden or untimely death of a loved one (Pearlman, Wortman, Feuer, Farber, & Rando, 2014). They are built through a caring relationship with a dependable other. Therapists can help clients build these capacities by, for example, (1) treating them with compassion, respect, and mutuality in the relationship, which helps to instill self-worth and provides a foundation for inner connection; (2) helping them to develop coping skills that give them a sense of mastery over their symptoms, contributing to both affect tolerance and self-worth; and (3) helping them locate or develop, internalize, and draw upon internalized relationships with caring others, which, combined with the therapist's authentic presence, begins to instill inner connection. In this process, the therapist serves as compassionate supporter, source of information, and coach, using the four "E" strategies (explore, empathize, educate, and encourage) (Pearlman et al., 2014).

Case Illustration

Jenny came to therapy about a year after the death of her adult daughter in a terrorist attack in London. She reported that she was frozen and unable to relate to friends, family, or her husband, Fred, in the ways she had before Lydia's death. She stated that she felt she had to control everything and everyone to avoid another loss. Jenny was deeply affected by nightmares and intrusive imagery of the murder. She had continued her work as a teacher, but stated that she was not really able to engage with the children any more.

Jenny called to cancel the second session. She said she didn't want to talk about her daughter or her death, because she was afraid she would cry, and what good would that do? How would she return to work if her feelings were opened up? I assured her that she could be in charge of what she talked about, and that I hoped she would come in for another session, which she did. At that time, we agreed to focus on building her resources, not exploring past events.

In the next session, Jenny confided that she had a history of childhood abuse, but she had never wanted to talk about it. Now, she was experiencing the same feelings of loss of control and rage that she had worked hard to master as a young woman. I affirmed her success in managing the painful feelings from her childhood experiences in a way that allowed her to maintain a rewarding career and healthy family life. I observed that she might need different coping skills to respond to her current challenges. She agreed to engage in some positive coping behaviors, such as returning to her art work, which she had given up after Lydia's death. She also was able to identify a friend across the country who had been very close to her at the time of her marriage. She thought she could confide in Rachel, and agreed to write to tell her about Lydia's death. In each session, we discussed what Jenny had done to support herself, to confront rather than avoid Lydia's death, and to reconnect with Rachel and Fred. I reinforced her courage for continuing in the treatment and facing the pain.

We introduced additional support activities in each session. When she spoke negatively about herself (e.g., "I'm such a crybaby," "They say you're supposed to be over it in a year; what's wrong with me?"), I reflected the feelings her statements suggested (e.g., "you sound frustrated with yourself"). I also asked her how she thought someone who cared about her (e.g., Fred, Rachel, or I) might respond to those statements. This practice evolved into her ability to ask herself that question when she became aware of self-deprecating statements, and to reply with some compassion (e.g., "Maybe I'm scared of being stuck here—who wouldn't be?").

For some time, she would call Rachel when she became upset. Once when she had not been able to reach Rachel, I had the opportunity to ask her, "What do you think Rachel would have said?" This pointed Jenny to the possibility of drawing comfort from her internalized experience of Rachel's kindness; when she was upset the next time, rather than picking up the phone, she asked herself, "What would Rachel say?" In our next session, we agreed that Rachel's willingness to listen without judgment was her most valuable asset as a friend just now. Jenny thought she could try to give herself some of that same compassionate care, and felt proud of her ability to feel the pain and respond to it constructively, like a loving mother to herself, rather than avoiding it, as she had done for so long.

Concluding Thoughts

As described in detail elsewhere (Saakvitne, Gamble, Pearlman, & Lev, 2000), three self capacities develop naturally through positive early attachment experiences. These include inner connection (the ability to maintain an internal relationship with benevolent others), affect tolerance (the ability to manage strong feelings), and self-worth (the ability to maintain a sense of self as valuable and worthy of respect). These capacities may not develop adequately because of problematic childhood experiences. Traumatic experiences—such as the sudden, violent death of a loved one—later in life can also disrupt self capacities, making them temporarily inaccessible to survivors.

How does a therapist know when to focus on building self capacities? Clients who consistently avoid or feel flooded with strong feelings, experience affect dysregulation, dissociate, or engage in self-destructive or potentially addictive behaviors or aggression may benefit from this work. Self capacities can be assessed through conversation with clients about how they cope with stress and distress, or through a formal test such as the Inner Experience Questionnaire (Brock, Pearlman, & Varra, 2006) or the Inventory of Altered Self Capacities (Briere & Runtz, 2002).

Some clients will require more time to develop enough trust in the therapist to engage in behavioral experiments, like reaching out for social support or attempting creative activities such as art or movement. Writing in a journal is another excellent way for survivors to connect with feelings they may have been avoiding. (For more examples, see Pearlman et al., 2014; Saakvitne et al., 2000.)

One essential element of building self capacities is to collaborate with clients in determining the pace of the work so they can stay within the “therapeutic window” (Briere & Scott, 2006), that place where any more challenge would create too much anxiety for the client to participate in the work, and any less would diminish motivation.

A second essential element is to elicit activities from the client rather than suggesting or assigning them. Of course, one may offer suggestions when the client feels stuck and wants assistance. But ultimately, the therapist is accompanying the client on a journey rather than driving the bus.

Finally, it is important to understand that the coping activities are helpful in themselves (often increasing affect tolerance), and the client’s ability to generate and engage in them also spawns confidence that can increase self-worth. The therapist’s acknowledgment and praise reinforce the behaviors, and also contribute to the client’s self-worth. The therapeutic relationship is supportive, and the client’s ability to internalize it also contributes to inner connection. Thus, each of these instrumental aspects of the treatment also has deeper, long-lasting psychological benefits for the client.

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Wendy G. Lichtenthal and William Breitbart

Clients for Whom the Technique is Appropriate

This technique may be helpful for adults struggling with changes in their sense of identity following the loss of a loved one. It may be especially helpful for individuals who are experiencing secondary losses of roles or activities related to their loss. This technique is not appropriate for individuals who appear to have longstanding identity disturbances, depersonalization symptoms, or borderline personality features.

Description

The loss of a loved one often challenges a griever's sense of identity in profound ways. They may perceive valued roles, activities, and characteristics that were brought out by the deceased as forever gone, resulting in painful secondary losses. As part of Meaning-Centered Grief Therapy (MCGT), a therapeutic approach we developed for parents bereaved by cancer (Lichtenthal & Breitbart, 2015), we employ an exercise called "Who Am I?" to help address these identity issues. This exercise, and MCGT more broadly speaking, were adapted from Meaning-Centered Psychotherapy for advanced cancer patients (Breitbart et al., 2012; Breitbart & Poppito, 2014), which incorporates the work of Viktor Frankl (Frankl, 1984) and other existential theorists (Yalom, 1980).

A meaning-centered perspective highlights the link between someone's sense of meaning and their identity, as how they view themselves is strongly linked to those things that they find most meaningful. The "Who Am I?" exercise focuses on discovering the griever's authentic sense of identity and the challenges they may be facing in living life authentically in the context of any role changes that may have occurred. In particular, it assists with transforming the role held in relation to the deceased, be it husband, wife, mother, father, child, sister, brother, friend, or other. The griever who loses someone to whom they were a medical caregiver may experience this role as "lost" as well. Given that many of our relationships involve caregiving in some form, the "Who Am I?" technique aims to facilitate this transformation of the caregiver role and foster the continued bond by highlighting ways the griever continues to nurture, care for, and love the deceased.

In addition to supporting grief over lost roles and the continued bond, a goal of this technique is to assist grievers with developing a coherent self-narrative (Neimeyer, Klass, & Dennis, 2014) by examining their sense of identity in the past and present as they develop

their personal story and look toward the future. The therapist can help with the processing of grief over and foster acceptance of unwelcome changes and support adoption of changes that align with the griever's values (e.g., valued changes in priorities), carefully supporting benefit-finding and posttraumatic growth as it emerges in the griever's narrative.

To elicit these themes, the "Who Am I?" exercise invites the griever to respond to a series of questions about their sense of identity. This includes a question about the individual's sense of identity while their loved one was ill, as much can be learned about the way the griever approached the role of caregiver; however, this question can be omitted for those who experienced a sudden death. Grievors are encouraged to write their responses down and to then share them with the therapist. In order to promote reconnection or new connections with sources of meaning, a major goal of MCGT, the therapist helps elicit the griever's perceptions of who they "are" (as well as who they believe they "are not") to further elucidate what has been and currently is most meaningful to the individual. Through the "Who Am I?" exercise, the therapist encourages the griever to reflect on aspects of self that feel most authentic, how the loss may have changed their sense of identity, and what aspects of self seem most important to nurture moving forward. In essence, the exercise facilitates the self-awareness and mindfulness of being that are believed to be necessary for authenticity (Yalom, 1980). The exercise questions are as follows:

1. *Think about a time before your loved one became ill.* Write down four answers to the question, "Who was I before my loved one became ill?" based on how you viewed yourself then. These can be positive or negative, and may include personality characteristics, beliefs, values, things you did, roles you held, relationships with people you knew, etc... For example, answers might start with, "I was someone who _____" (e.g., was passionate, optimistic, organized, worried a lot) or "I was a _____" (e.g., homemaker, entrepreneur, sister, brother, mother, father).
2. *Next, write four answers to the question, "Who was I while my loved one was ill?"* These can once again be positive or negative responses, and include personality characteristics, beliefs, values, things you did, roles you held, relationships with people you knew, etc.
3. *Now write four answers to the question, "Who am I now?"* These can once again be positive or negative responses, and include personality characteristics, beliefs, values, things you did, roles you held, relationships with people you knew, etc. Take some time to think about how your loss has affected your answers and your sense of identity. How has what you've been through affected who you are, what you value, and the things that are most meaningful to you?
4. *Finally, write down four answers to the question, "Who do I want to be?"* Consider the person you would like to be in the future. Your responses may include characteristics, values, or roles you've already listed or some toward which you hope to work.

Case Illustration

A little over 3 years ago, 54-year-old Rick lost his only child, Jason, to osteosarcoma at age 15. Rick initially presented to me with his wife for couples' grief counseling, but continued on in individual counseling with me, expressing that he felt "lost" about what direction his life should take and that he feared forgetting Jason. After he enrolled in our trial of MCGT, Rick shared with me that although he never had strongly aspired to be a father, the experience of raising Jason quickly became his most prized role. "I finally found something I knew I was good at," he expressed. He had quit his job as a database manager to care for his son while he was ill. After losing Jason, he did not return to

work, though he remained active in his suburban community, advocating for changes to enhance residents' lives and safety. Still, he felt confused about where to go from here.

During his fifth session of MCGT, Rick shared his responses to the Who Am I? exercise, which he had completed in advance of our meeting. Rick described how before Jason had become ill, he defined himself as a professional supporting his family, a community leader, a loving husband, and father to Jason. I noted to Rick that his responses only included roles, without mention of qualities or traits, and invited him to share personal characteristics that each of these roles brought out or demanded. We fleshed out each of these roles as I asked him *how* he was in each of these roles and about his traits and values, those things that make him uniquely "him," so to speak. These included being a problem-solver, loving, and loyal. I highlighted how what he cares about (i.e., his sources of meaning), which included his family, the community, and the wellbeing of others, were very much linked to his sense of identity.

In response to the second exercise question, Rick described how he was not only a loving father when Jason became ill, but also a caretaker, medical researcher, and ombudsman for his son. Although he had quit his job, he maintained his other roles—though his primary focus was his son's care. As we transitioned into discussion of Rick's current sense of identity, since Jason died, he tearfully expressed that he did not know what to do with himself since Jason was such a big part of his life. I described to him how part of this work is figuring out how much he wants to keep his role as Jason's father a part of his life over time, reminding him that this is within his control. Rick also expressed that his identity now included being a "grieving parent." He noted while this role began with him seeking help from the bereaved parents community, he now was actively helping others through his role in a local bereaved parents' organization. I pointed out how much advocating for others seemed prominent throughout his responses, as Jason's caregiver, as a community activist, and as a supporter of grieving parents.

Responding to the question about who he wants to be in the future, Rick expressed that he wants to remember Jason and to stay connected to others who knew Jason to preserve his identity as "Jason's dad." He also stated that he wanted to financially support his family, but in a meaningful manner—though he was not sure what this could look like. As we reflected on Rick's qualities as a problem-solver and advocate, and as someone who learned through Jason's illness that he had a natural ability to understand medical information, I asked him if he had considered becoming a patient advocate or navigator at a medical facility to help patients get their needs met. He expressed that he had not been aware that such positions existed, but as we discussed what is involved in these positions, he expressed that this had great appeal to him—that it felt like it "fit." In short, using the simple statements Rick provided through this exercise, we were able to create a cohesive self-narrative, connecting his core traits and values, which seemed to naturally point to his potential as an advocate for medical patients, a position which would keep him connected to Jason as he looked toward the future.

Concluding Thoughts

As the griever shares brief statements characterizing personal traits, roles, activities, or values, the therapist can help deepen the response, underscoring those aspects of the griever that appear most important to preserve and that help make them feel most connected to their lost loved one. It is of course not necessary to limit the discussion to only four responses, though the therapist should be mindful of what the griever chose to highlight when asked to list only four responses to each question.

If the griever is challenged to respond to any of the questions, the therapist may ask the griever what responses they might have given before experiencing the loss or what their deceased loved one would have wanted for the griever to get a better sense of values, sources of meaning, and life goals. The therapist may also ask how the deceased may describe the griever. When the griever indicates that they are disturbed by identity changes experienced, the therapist should emphasize the similarities between the way the griever was before and after the loss, recognizing core aspects of the griever's sense of identity that remain constant and that may be viewed as core and "authentic." When you are being authentic, you are in fact more in touch with and true to your own unique essence—an essence that is by definition imperfect, vulnerable, and reflects a sense of existential guilt in failing to live to your sense of unique and full potential. Authenticity also refers to the "Who" that you are as opposed to the "What" that you are. Philosopher Jacques Derrida described the *Who or What (Qui ou Quoi) of Being* as being at the heart of authenticity (Breitbart, 2013; Derrida & Kamuf, 1991). It is often expressed in MCGT as the difference between "ways of being" and "ways of doing." Being authentic and "Who" we are is immutable and cannot fall away with age or disease or imperfection or changes in physical state. The "What" of who we are, the qualities, the actions, the appearance, the abilities, and so on, are mutable and can change over time. They are evanescent and thus superficial reflections of "Who" one is. That is why the exercise is most powerful when we ask "Who am I?" and do not merely focus on roles and actions and "what" a person is.

That being said, the therapist may also draw attention to changes that the griever appears to value and would like to maintain (e.g., those that reflect appreciated changes in priorities). In these instances, the therapist might highlight the growth while being careful not to imply that the griever has gained from this experience or "turned lemons into lemonade." Rather, the therapist can convey how striking it is that, despite the griever's suffering, they are able to recognize valued aspects of themselves. Through this exploration, the griever may become mindful of their core sense of self, of their unique potential and limitations, and of the possibilities that lie ahead (Yalom, 1980).

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Healing through Internal Compassion

Derek P. Scott

Clients for Whom the Technique is Appropriate

The Internal Family Systems (IFS) method developed by Dr. Richard Schwartz is appropriate for working with a broad range of bereaved people, although it is most helpful with complex grief due to the respectful engagement with the client's protective system. Once the concerns of the protective system are addressed, blocks to the process are no longer necessary and grieving can proceed apace. However, clients who are disinclined to engage in mindfulness and self-reflection and more concerned with practical life adjustments following loss might be better served by a behavioral approach.

Description

IFS is less about technique than it is an orientation to the multiplicity of the personality system with a methodology that naturally flows from that orientation. The model articulates roles held by the different parts: *Exiles* or *Protectors*. These parts are understood to populate the internal landscape, to engage with each other and form relationships, and to determine much of how we engage in the external world. Exiled parts often have their origins in early life and hold burdensome feelings and/or beliefs that they have taken on in response to external events. The protective system of parts may be either proactive '*Managers*', seeking to ensure that exiled parts do not get triggered and overwhelm the system; or reactive *Firefighters* seeking both to distract from the distress held by an exiled part once it has been triggered and often to provide comfort to the system. *Managers* are concerned with running our day-to-day lives and wanting to ensure that we present well. They will often use the "shoulding" critical voice to keep us on track. Firefighters are only concerned with the immediate need to prevent the system being overwhelmed by burdens and will use strategies involving alcohol, drugs, sleep, overwork, gambling, pornography, food, and cutting, to name a few. Generally, managers do not approve of firefighter activity and are polarized with them.

In addition to the parts of the system, but of a different order, is *Self*. Self has specific qualities: compassion, curiosity, creativity, calmness, courage, and a desire for connection, harmony, and healing. It is when the parts of the system are willing to "step back" that Self is present. The IFS method that arises from this understanding requires the IFS therapist to be a Self-led parts detector. Recognizing that clients have all the resources they need to attend to and heal whatever distress may be presenting in their system, the IFS therapist invites them to

engage with the burdened parts that may be activated in the course of bereavement. We not only bring clients our “compassionate curiosity” (Wolfelt, 2006, p. 85), we also invite them internally to engage their own.

Case Illustration

Gordon was a 45-year-old man who initially came to see me about relationship difficulties related to self-esteem. During the course of his therapy his beloved dog, Bailey, died.

- G: It's crazy but I can't stop thinking about her; I mean, she was just a dog.
 D: (Understanding how disenfranchised grief is often accompanied by a minimizing protective part) Gordon, would it be okay for the part saying she was just a dog to soften back and allow you to hear more from the other part that is seeking your attention?
 G: (Looking thoughtful for a short time) Okay, it's willing to do that. But really there's just no point going over it—she's gone and that's that!
 D: This sounds like a part that believes you just need to resign yourself to “what is” when you lose someone or something that you care about. Is that right?
 G: Yeah, that's right.

This protective part of Gordon seemed very firm so I invited him to get curious about it.

- D: Gordon, see if that part can let you know where it learned that this is the best way to deal with grief.
 G: Well, he says it's just obvious. It's what you do.
 D: I get that, Gordon, and I'm also guessing that this part picked up that belief somewhere along the way. See if it can separate out from you a bit so you can get to know it. Maybe ask it how long it has been around.
 G: Oh, a long time.

As the part unblended it had a story to tell. Gordon's family had emigrated from Kenya to England when he was 6 years old. As his parents prepared the new home, Gordon, who was English, was sent to stay with his Irish grandparents whom he had never met. His young parts had found them harsh and mean as well as culturally alien. After a couple of weeks in his grandparents' house, Gordon sat down at the kitchen table to write a letter to his best friend in Kenya, Jane. Halfway through the letter his grandfather asked to whom he was writing and then pointed out that Gordon did not have Jane's address. He and the grandmother laughed at Gordon's stupidity. Realizing that he had lost his best friend forever, Gordon had begun to cry, amusing his grandparents until his red-faced sobbing made them angry. His grandmother had called him a cry baby, cuffed his head, and threatened to give him something real to cry about if he didn't stop. A resigned protective part stepped in to tell Gordon that nobody wanted to hear about his feelings and that you just had to get on with life. This part still dominated his system, denying access to grieving parts.

Gordon thanked the resigned part for all his work, assuring it that the system had aged and it was now safe to hear from his sad part.

- G: Wow, this little boy is so sad. He's so alone and just wants to be back home with his friends and his teachers. And he's telling me he hates his grandparents for making him feel ashamed.

D: (Checking to ensure there is a Self-to-part connection) Does he know you're there? (Gordon nods). Great. How are you feeling towards him? (This question is designed to assess if there is a sufficient amount of Self energy present for the part to feel compassionately witnessed.)

G: I feel awful for him, poor kid.

D: Okay, Gordon, ask him how it would be for him to not have to carry all these difficult feelings. Would he be interested in that if it were possible?

G: He's nodding, yes.

D: Alright, then check to see if there's anything else he needs to let you know about what's hard for him . . . (Gordon shakes his head). Then invite him to release all that shame and pain of longing. He no longer needs to hold onto it because you know about it now. He can release it to air, water, fire, earth, light, or anything else; and in such a way that it will never come back.

G: He's sending it to the sun to be burnt up.

D: Great. Now that he's made space inside see what qualities he would like to take in for himself.

G: He's taking in that it's okay to be sad sometimes . . . that he's okay.

In subsequent sessions Gordon was able to attend to the parts grieving his dog. It transpired that Bailey's unconditional love had been a balm for young parts, raised by an abusive mother, who longed to be nurtured. His grief was intense as the parts that had lost the only source of maternal care they had known needed to be witnessed in their sorrow. Gordon later told me that being able to listen to them in this way, with Self-energy, affected his relationship with his surviving dog. "Each morning now I lie down with him and give him a cuddle. I know he'll die one day and I know I can handle it. So I'm just going to love him up while I can."

Concluding Thoughts

What most engages my clinician parts when working with the IFS model is that it allows me to incorporate directly much of the wisdom from the bereavement field in my work. The importance of Gordon's loss history is evident as both exiled and protective parts reveal their origins. Wolfelt's (1992) description of the common strategies of minimizing, somaticizing, replacing, displacing, and postponing, often present in complicated grief, can be understood as parts of the protective system doing their best to ensure that we do not become overwhelmed and unable to function, reframing "experiential avoidance" (Thompson, 2012, p. 39) as a salutogenic strategy. When the natural oscillation described by Stroebe and Schut (2010) between a grieving "cluster" of parts and a restoration "cluster" is inhibited, I can get curious about which parts are concerned about allowing the process to unfold. Employing mindfulness techniques can be very helpful, and sometimes the mindful observer part needs to be asked to soften back to allow a compassionate and actively healing engagement from Self. The challenge to one's sense of narrative coherence (and) identity (Neimeyer & Sands, 2011) alerts us to the needs of parts whose worldview may need revisioning. Our client's capacity may be built not solely through a caring relationship with a dependable other (Pearlman, 2016, Chapter 31) but also through the parts' recognition of Self as the "primary, loving attachment figure" (Schwartz, 2013, p. 2).

A word of caution if you are interested in working with this model: It is very common for a Self-like part to attempt to work with the method and that is likely to fail. If you are curious to see this work in action please visit my site www.derekscott.co, which has a brief

video demonstrating how to work with a “client.” For a more detailed description of how the IFS model supports grief work please see my chapter on “Self-led grieving” (Scott, 2015). For information about training in the model please visit the Center for Self Leadership at www.selfleadership.org.

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34

Letters to Self

Cynthia Rollo-Carlson

Clients for Whom the Technique is Appropriate

Adults working through the grieving process who feel cheated or that life is unfair due to the loss of a love one often find this therapeutic writing process beneficial. This technique allows for the bereaved to bring about self-nurturance and to reinvest in new emotional relationships. It is not advised for use during initial phases of traumatic grief.

Description

Writing, rather than speaking, often allows one to escape the silent abyss of despair. Expressive writing also can facilitate a process of discovery that allows one's mind to gently address the pain involved in loss. At a point when others often cannot validate the most intimate meanings of the loss, writing can foster the self-reflection needed to construct new meaning as individuals attempt to readjust to a changed life. Building new meaning is central to heart mending, which is key to intimacy not only with others but also and more importantly, with the self.

Adult clients experiencing grief due to loss of a loved one will often mention that they have a "hole in their heart," an emptiness that cannot be filled. They cannot, nor do they want to, replace that person even though they may be ready to move into a new phase of the grieving journey. This hole, which is often so filled with conflict and pain, can benefit from a healing process fostered through letter writing to oneself. Unlike memoirs, which are written "about" oneself, or writing letters to others as a form of real or abstract connection, writing to oneself can be seen as self-nurturance that solidifies a new sense of identity. Compassion from others begins to dwindle as time goes on, yet clients tell me that the hole is still open and empty long after the death. Neimeyer and his colleagues (2010) note the importance of making meaning through construction of stories and the use of metaphorical language. The letter-writing technique described here gives the grieving individual an opportunity to reconstruct a story metaphorically, and in so doing reaffirms that the mourner does in fact have the strength from within to make meaning of the loss. By addressing the self at three different points within the life timeline, one can bring about transformation through shifts in wording from one letter to the next. The alternative phrasings can trigger a self-reflective transformation as the writer looks not only at the past but also towards the future (Chavis, 2013).

Step 1: Writing from Adult to Child

Writing heart-mending letters to self entails a three-step process of renewal. The first letter is written from the client's adult self to the self as a young child. The adult self, in the present, is aware of the pain the client has suffered up until this point in his or her life. The adult, knowing the hardships and struggles, returns to the child, through a letter, to tell the child what he or she may need to know, but did not, to prepare for the journey through life. It affords an opportunity for the adult to give the inner child encouragement, strength, and hope for the future. As the therapist, as journey guide, walks with the client, the two are able to help clarify beliefs and experiences, some clearly remembered and some reconstructed. Berzoff (2011) states, "grief can undo the mourner, resulting in guilt, self-hate or blame" (p. 268). This process is a way to re-do or mend what has perhaps been undone. The client begins to rebuild a new foundation as core beliefs are newly constructed.

The grieving client is asked to write a letter answering the following questions, being specific with his or her thoughts.

- What do you want to tell your "child" so that you are prepared for your future life?
- What do you wish you had known that would have prepared you for your life ahead?

Step 2: Writing from Child to Teen

The second letter is from the little child, the innocent child full of wonder or uncertainty, who is about to embrace the life ahead. The client is asked to write this letter with the opposite hand, as this will also look more childlike, tapping into the opposite side of the brain, and into newness and the unknown. In this letter, the child writes a letter to the teenage self, as the adolescent becomes more aware of the world, including the harsh realities of life, along with the seriousness, anxiety, depression, and pain that may have begun to resonate within. This is a chance for the child, through self-nurturing, to bring a message to that serious and hurt teenager, reminding the adolescent of what she or he may be growing away from, and yet needs to be aware of on the threshold of adulthood, so that these characteristics remain available throughout life. Suitable questions to cue this include:

- Have your young, innocent "inner child" write a letter to the "teenage you" who may have become serious, discouraged, or self-conscious. What would the child remind the teen that the adolescent might be forgetting?
- What does your "child" want you to hold on to that could get lost in adolescence?

Step 3: Writing from the Present to Future Self

This letter, written with the dominant hand, focuses on current pain and fear, along with the hopes the client has for the future now that the loved one is no longer in their life as they were. Commonly in this position, clients are very aware that the deceased will not be returning and that the empty hole will not be filled, although precious memories will never be forgotten. This bridges the present to past to ongoing connection to the deceased while moving toward reinvestment in the future. Questions to address this include:

- What are your biggest fears of this "new beginning" as you face death and loss?
- What is your biggest excitement as you take new risks? What are you hoping to change for the future?

All three letters are written during the same session, on various forms of stationery chosen by the client, and all are placed in one sealed envelope addressed to the self. The letters are not read aloud to the therapist at this point. I ask clients to sign their name on the seal so that they know the letters will not be shared and will be kept as confidential. Depending on the duration of therapy, I will mail the letter to the client so that they are received in the mail at the client's home prior to the final termination session. Before they write this letter I inform clients that they will receive it in the mail.

I also let them know that when they receive the letter in the mail, they have the choice to open it then, to open it at any time before the next session, or to bring the envelope to the session to open. The purpose of this is twofold. First, they did not have a choice in losing the person who died. This ability to choose when to open the letter brings some sense of control to a situation in which they had none. Second, reading the letters to the self often provokes strong emotion, so the client is forewarned of this and then given a choice as to when they want to revisit that emotional space. They could not choose the time that they were forced to enter the loss but they can choose the time that they are willing to re-encounter this wound and the strong emotions that it evokes.

Whether they choose to open the envelope before the session or bring it to the session, the client's experience of reading the letters is processed with the therapist. Often clients will say that they wished they had had this "advice" when they were younger to bring to the future with them. Although we cannot undo time, this is a way for the client to receive this nurturance, in the present. As they read the letter from the child to the teen self, I will often hear clients say that they will remember to hold onto a lost sense of innocence and wonder. They are now able to recapture this in the present. Reading the letter that was written to the future self, which is the self "now," I find that clients are often surprised at the progress they have made. In addition, they will frequently comment on how they remember feeling so discouraged when they wrote about their fears and hopes, but those very feelings of despair have lifted and they notice that they truly are reinvesting in their "new normal."

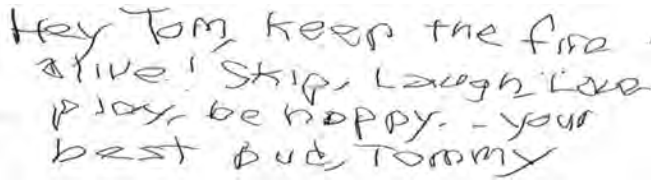
This process gives them hope for the future while at the same time healing wounds from the loss. The combination of all three letters brings about restoration. Neimeyer and Currier (2009) have found that restorative techniques that focus on future goals along with fostering present relationships are important factors in evidence-based interventions. This technique allows the client to nurture the relationship with the self, which I believe is necessary before entering new relationships with others. Clients can keep the letters knowing that they can revisit them at any time when in need of affirmation and comfort.

Case Illustration

A 48-year-old man struggling with the death of his wife from breast cancer some nine months earlier wrote the following letter.

Letter 1 (written in dominant adult hand)

Dear Tommy, You can do anything. Everyone loves you. You're the man. You're gonna have a lot happen in your life and you will have the courage to handle it all! Don't ever forget that. You will see that you are very strong and very brave. You are a fast runner and will win all those races. When you want to run away sometimes, don't run and hide, run forward instead. You will win!
Love ya! Thomas

Letter 2 (written in the non-dominant child hand)


Hey Tom, keep the fire
alive! Skip, Laugh, Love
play, be happy. - your
best bud, Tommy

Letter 3 (written in the dominant adult hand)

Dear Thomas, The end isn't near even though you feel like you can't go on. Strengthen your mind and apply yourself. You're just as good as anyone else. You have what it takes. Go for it . . . LIVE! I'm with you and I know you can do it, Take care of yourself and reach out to others. People really do care about you if you just give them a chance. You won't feel alone forever. – Me

Thomas found the exercise moving and affirming as he reached through the pain of grief to embrace a changed life.

Concluding Thoughts

As the therapist, as journey guide, walks with the client, he or she is able to help the client put into words core beliefs, some clearly remembered, and some reconstructed, in a way that provides orientation to a changed life. Use of letters from the self, to the self, about the self can give the grieving individual a precious opportunity to rebuild a foundation of core beliefs while creating a new narrative that links the past to the future across the bridge of the present. Through this new investment the grieving individual is able to give the self a transformative gift that fulfills the heart as new meaning is constructed.

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Part VII

Re-storying Narratives of Loss

Dramaturgical Listening

Gail Noppe-Brandon

Clients for Whom the Technique is Appropriate

People across the lifespan who are grappling with a loss of self or other will benefit from the therapist's use of this form of interaction. Secure attachment to one's own authentic story, and to a listener who can listen without distortion, is the best medicine for healing of any kind, although consolidation of a new story often benefits from supplementation with other written and spoken methods.

Description

In sociological terms “dramaturgy” is the study of human interaction; in theatrical terms “dramaturgy” is the shaping of a story into something that can be acted on. Not unlike a dramaturge working to unearth and illuminate the meanings in a new play, clinicians and coaches can work with a client's story in order to make sense of a life lived, and discover how the meaning of that life is held and reshaped. This interactive shaping of a coherent narrative can be accomplished through deep explorative questioning and close readings of client text, both spoken and written. When therapists listen and question as a dramaturge, they are inviting their clients to find answers in their own material without imposing assumptions or theories. This radical listening can be aided by the careful creation of verbatim transcripts that are fed back during sessions, and further unpacked both in and out of session.

Case Illustration

What follows is a slice of dramaturgical work done with a client I shall call Ruth, a recently retired child of Holocaust survivors. Ruth was referred to me because she desperately wanted to articulate and share the harrowing intergenerational story of loss and suffering that she had held for a lifetime. She had long wished to share it with friends, relatives, members of a faith community, in a support group, in a blog—*anywhere*. However, after decades of therapy, medication, and eye movement desensitization and reprocessing (EMDR), Ruth still could not bring herself to do so. She was seeking new meaning in her life, and was tired of being isolated and disconnected from others; Ruth had grown

deeply depressed as a result of remaining mute and alone. For financial reasons, we initially planned only four sessions. Through this sharing I hope to demonstrate the ways in which obstacles to meeting Ruth's goals were quickly identified, rapidly understood, and ultimately unfrozen through dramaturgical listening toward narrative reconstruction.

What's The Story?

In our first session, I began the way I always begin: by asking Ruth to tell me "the story of her." As with most clients who have lost themselves, she spent most of the session telling me, in a somewhat dissociated manner, the story of *other* characters in her life, in Ruth's case her parents. The narrative portal chosen by any given client is a crucial dramaturgical noticing, and often points to the locus of lost selfhood. Ruth reported in great detail that her Jewish-born mother had been a Hidden Child during the war, and was raised in a convent. Her Jewish father also had lost his parents and siblings while a prisoner in Auschwitz. Ruth herself, she added briefly, was born in the refugee camp where her parents met; she came to the States with them as a toddler. Neither of her parents had ever received support for, or spoken of, their traumas during the war. After this initial sharing, I gently pointed out that she had told me nothing of her story beyond early childhood, or of her life here in America. In this enormous omission it was clear that her own story/suffering had been completely obscured by that of her parents, and that flow in her self-narrative had been ruptured at the age of 2. It subsequently became apparent that, like many children of immigrants, her arrival in America marked the end of her time to *be* a child. In the last five minutes of the session—and in response to my noticing—she quickly and dispassionately summarized her own life. Ruth had been abused, confused, and isolated, with a boundary-crashing father and a depressed, raging, and probably borderline mother. Ruth herself had grown up very quickly and became a social worker. She never married or had children of her own. Period.

Completing the Sentences

After Ruth caught her breath and grounded herself in my empathic response to her tragic account, I helped her to articulate the barriers she felt to the stated goal: that of sharing her story with others. Through the following sentence completions we handsomely unearthed the following list of "coherent" reasons for her silence (Ecker, Ticic, & Hulley, 2012). I began each sentence fragment by summarizing and repeating back to her what I had recorded as she spoke, and then asked her to finish each thought:

T: "As much as I want to express myself, tell my story, have a voice, and push back against the *injunction of silence* . . ." (a dramatic phrase she had used about her parents' unwillingness to give voice to their horrific experience, which I deliberately harvested here).

She spontaneously completed the sentence with:

R: "I have so much shame about my story that I fear no one will really relate to it."

To further unpack the shame, as she held it, I then offered this fragment for completion:

T: "If I really speak my truth. . . ."

Again, she spontaneously completed with:

R: "I'll incur the anger of the community for speaking ill of survivors, and of the temple for speaking ill of the dead."

Because one of Ruth's issues was profound isolation, and historically she had little or no connection to any community, I encouraged her to express what this telling would also mean for her more personally, and she added this:

R: "I'll have to feel things that I've had to bear alone, and have learned not to feel."

With this utterance, she closed her eyes and placed a containing hand on her aching chest. This painful knowing elicited the first tears she had shed, and illuminated the greatest potential challenge to her sharing. She indeed had four very compelling reasons for maintaining her silence. In the hope of smoking out any remaining obstacles to her desperate determination to prevail—I had her complete this last one:

T: "In addition to all of these prohibitions. . . ."

Following a moment of contemplation, she completed with:

R: "I still mostly blame myself for having had to suffer in silence all these years, so it's better to just go on keeping it all inside."

Reframing the Story

After living with this daunting list of obstacles all week, at the next session Ruth reported a growing anger that she might not get to have her say. She had realized that everything in her life had been done to protect others, and that she wanted to do something for herself. . . she wanted to write a memoir. After that clear desire arose between our meetings, in session she bumped into yet another prohibition, and was now concerned that she "didn't deserve to share her story." Although she agreed with me that she had been a courageous survivor herself, she was not proud of how her own story had turned out: another coherent reason for not sharing it. In order to connect Ruth with her own accomplishments, her next narrative assignment was to reflect upon and write about the clients she had helped via her casework throughout her career. She initially rolled her eyes at this challenge, claiming that her work had been forgettable. However, when she actually sat down to reflect upon it, this non-writer came back with five pages of anecdotes about people whose lives she had changed, and had told her so. As is often the case with first writings, Ruth had barely taken in her own findings; they had been documented by her brain and typed by her fingers but were not yet held in her heart. In order to connect these channels, I invited her to listen. She re-rolled from bit-player *in* her life, to audience member *to* her life. In the process of hearing me read aloud what she herself had written she began to feel differently about how her life story might actually sound to others, and was deeply moved by her own account. This stoic woman was able to affirm, through tears, "I was actually a very good social worker." This was a particularly crucial narrative reframe for her because another one of her prohibiting schemas was that, "Jewish people only want to hear success stories." Previously, she had felt that hers was one of failure. Being healed by one's own words is a clean kind of healing that is undistorted by the lens of another. This taste of self-appreciation also led her to a more compassionate position toward her parents, who had been tortured and had, in turn, tortured her. She languaged this further reframe as follows: "It's remarkable that no matter how difficult my parents were, I still came out a nice girl; because, fundamentally, they were decent people. . . who had been tortured." This was news she could use, as going public about the pain they had endured presented a very different risk than only going public about the pain they had inflicted. Ruth was beginning to hold both knowings now: as in a well-wrought piece of dramatic writing, a fuller and more balanced narrative was emerging in which there were no pure good guys nor bad guys; a major step toward moving what had been frozen.

As preparation for our fourth session, I asked her to take all of these new knowings and write a blurb about herself that might appear on the back of her future memoir; an exercise that is equally useful for clients with no interest in writing or publicly sharing their reframed self-stories. Bear in mind that this client was not a professional writer and, like most of my clients, was writing for the first time with me. What follows is an excerpt of what this terribly humble, muted, and shame-filled woman wrote about herself:

In this memoir Ruth confronts painful taboos as she tells of life in a world that placed the blame for the Holocaust on its victims, because people were either unprepared or unwilling to face their realities, or help them . . . hers is a brave, intimate account of a tortured Jewish daughter who needs to find her own way to make sense of history.

Consolidation

Finding her way to make sense of history indeed. Hearing this read back to her, Ruth smiled fully and expressed animated amazement that her own words had captured empathy both for herself *and* her parents. Having begun to articulate her story thusly, she was already beginning to be liberated from the story; Ruth realized that more than actually writing a book, her greatest desire was to simply be free to be herself—*apart* from the Holocaust. Ruth wanted to be able to relate intimately to others without shame and to feel pleasure in so doing. The brief but intense time we had already spent together was her first such experience of deep and joyful relating on the other side of shame.

Concluding Thoughts

When clinicians listen as dramaturges, it allows clients to discover the answers they already hold; it is a guided form of self-discovery that helps clients uncover and voice where and why they are stuck and what has been misunderstood, distorted or forgotten in their own life stories. At almost 70 years of age, Ruth went on to complete a Bat Mitzvah, visit the refugee camp where she was born, become an activist in her synagogue community, and at the time of this writing is still working productively on completing a bold and affecting memoir.

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For more information about bringing narratology and dramaturgical listening into clinical or coaching practice, visit www.gailnoppebrandon.com

Internet-Based Writing

Birgit Wagner and Andreas Maercker

Clients for Whom the Technique is Appropriate

This cognitive behavioral intervention is aimed at bereaved adults suffering from prolonged grief and experiencing intrusions related to the death, avoidance behavior, and dysfunctional thoughts (e.g., feelings of guilt). This trauma-focused intervention is not recommended for clients experiencing dissociative symptoms, at risk of psychosis, or suffering from strong suicidal ideation. Clients should be able to express themselves in written text.

Description

Interpersonal communication and relationships have changed dramatically with the growing influence of the Internet. In recent years Internet-based support has been established in the social media for bereaved populations, which includes online support groups, memorial websites, and discussion forums. Parallel to the use of social media, new forms of psychotherapeutic interventions—therapist-supported or self-help—have been developed for a variety of bereaved client groups. Lange and colleagues at the University of Amsterdam were among the first to develop an Internet-based intervention (*Interapy*) using protocol-driven cognitive behavioral therapy for posttraumatic stress disorder (PTSD) and pathological grief (Lange et al., 2003). The treatment consisted of structured writing assignments based on the theoretical background of cognitive behavioral therapy and a written disclosure procedure developed by Pennebaker and colleagues (Pennebaker & Beall, 1986). These studies showed a large reduction in PTSD symptoms and high treatment efficacy, comparable to face-to-face cognitive behavioral interventions (Lange et al., 2003). Based on this treatment manual for PTSD, Wagner and colleagues have developed an Internet-based intervention for prolonged grief and found similar treatment efficacy (Wagner, Knaevelsrud, & Maercker, 2006). Meanwhile, Internet-based psychotherapeutic interventions have been developed for a variety of bereaved client groups. Accumulating research has shown particular benefits of cognitive behavioral interventions for prolonged grief (Litz et al., 2014; Wagner, Knaevelsrud, & Maercker, 2006).

The Internet-based intervention for complicated grief consists of three modules: (1) self-confrontation, (2) cognitive restructuring, and (3) social sharing. As the therapy is conducted exclusively over the Internet, a detailed online diagnostic procedure is needed to ensure that

this form of therapy is appropriate for the client. The client receives 10 writing sessions in a period of approximately five weeks with two weekly 45-minute writing sessions. The communication between therapist and client is based exclusively on text-based communication. After every second essay clients receive feedback and further writing instructions from the therapist. These instructions are based on a cognitive behavioral treatment protocol but are individually tailored to each client's needs.

Every treatment phase begins with detailed psychoeducation on the principles of the treatment module and sets a date and time to complete the writing assignment.

First Phase: Self-Confrontation

Imaginative confrontation is a technique that encourages the client to revisit feelings, emotions, and images surrounding the death of a significant person that are repressed or trigger fear. Participants were instructed to write their essays in the present tense, in the first person, and without worrying about grammar, style or the logical chronology of events (Lange et al., 2003).

Second Phase: Cognitive Restructuring

In the second phase, the clients are instructed to write a supportive and encouraging letter to a hypothetical friend (Lange et al., 2003). They are asked to imagine that this friend has also experienced the loss of a significant other and is now facing the same difficulties. The letter should reflect on guilt feelings, challenge dysfunctional automatic thinking (e.g., self-blame regarding the responsibility for the death) and correct unrealistic assumptions. Clients are encouraged to re-access positive memories of the deceased, and to identify ways of activating resources such as positive competences and experiences to help them develop a life without the deceased. Further, clients are instructed to develop rituals or activities to remember the deceased and to give the deceased person a place in their life and to reactivate social networks and increase social support. The aim of this treatment phase is to foster the development of new perspectives on the death and its circumstances, as well as to help the bereaved to define a new role and identity for themselves after the loss, to identify the lessons learnt from the death, and to regain a sense of control of their lives.

Third Phase: Social Sharing

In this final phase, clients take symbolic leave of the traumatic event by writing a letter to a significant person, to someone who witnessed the traumatic event, or to himself or herself. The letter could be sent after finishing the therapy, but this is not obligatory.

Case Illustration

Ursula is a 50-year-old woman who worked as a veterinarian in her own practice. Two years ago, she lost her 52-year-old husband, Franz, who committed suicide by lying in front of a train. In the months before the suicide there had been some difficult times in the relationship between Ursula and her husband. They had even discussed at one time the possibility of a divorce. However, at the time of the suicide, the relationship seemed to have improved. Therefore, Franz's death was unexpected and came as a great shock to her. Ursula's thoughts revolved around her husband's decision to commit suicide. The intrusive memories included visual images of her husband lying down in front of the train and she imagined the pain her husband must have gone through.

In the first essay Ursula was asked to write about the circumstances of the suicide of her husband. She was instructed to focus on one moment that kept intruding on her thoughts, but that was so distressing that she could hardly bear to think about it. She was asked to express all her fears and thoughts about this specific situation and to focus on sensory perceptions in as much detail as possible.

In this first essay, Ursula described how two police officers came to her house and informed her that her husband had committed suicide.

I come home after a day in the veterinary practice. I feel tired because it was a stressful day. I am in the kitchen and start to prepare dinner for Franz and me. I start to cut the onions. I try to phone him but he doesn't answer the phone. I think that he must have gone to the supermarket to pick up some wine for tonight. I want to ask him to bring some extra basil for the spaghetti sauce. I am a bit angry, because he always leaves his mobile phone in the car when he goes shopping. At this moment the door bell rings. I go to the door and see two police officers standing in the door. I think "not again because of the parking." Then I notice, that they are behaving strange, as if they feel uncomfortable. The female officer asks me if they can come in. We go to the living room, still standing. The woman says: "We are here because of your husband. I am very sorry, but he has committed suicide this afternoon by lying in front of the train in Hanover. We already came here two hours ago, but you were not at home." I feel cold, I feel totally unreal. As if this is not me standing in front of the two police officers. My mind races like mad. I scream: "No, this is not him. He is in the supermarket." My heart starts to beat stronger and stronger. I kneel down on the floor, suddenly I feel very weak. Our dog comes and lies next to me. I feel his warm body. Thousand thoughts go through my mind at the same time. I try to remember when I talked to him the last time. He phoned me at lunch time in the office. He sounded normal, he said he gets the wine and some dessert for dinner. I am full of disbelief. I go though the wallet the officer handed to me. It is his wallet. I feel cold. I am frozen. At the same time I start to shake. My whole body shivers as if I fell into a frozen lake.

Ursula completed the 10-session writing program, corresponding every second session with her therapist in a way that helped inform the subsequent assignment. She showed substantial clinical reductions in both PTSD and complicated grief symptomatology over the course of her participation.

Concluding Thoughts

Internet-based interventions for bereaved individuals are still a relatively new psychological treatment alternative. One of their major advantages is their anonymity and the lack of geographic boundaries. Translating experiences into language and constructing a coherent narrative of the event may enable participants to integrate these thoughts and feelings into their lives. Further, the anonymity of the Internet helps clients overcome their initial shame, encourages them to confront themes such as guilt, and helps them to disclose painful feelings. Therefore, structured writing assignments offer a promising modality in bereavement care.

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Spiritual Journaling

Michelle J. Pearce and Melissa A. Smigelsky

Clients for Whom the Technique is Appropriate

Bereaved adults who identify religion or spirituality as important to them or who report changes to their spiritual beliefs and/or identities as a result of their loss can benefit from this spiritual meaning-making method. Depending on individual preferences, clients may or may not wish to share their journaling with their therapist. Spiritual journaling is typically less appropriate in the immediate aftermath of the loss, when supportive and stabilizing interventions could be more useful.

Description

A central aspect of grieving is the attempt to find meaning in the loss, and the ability to do so is a better predictor of grief adaptation than is the passage of time (Holland & Neimeyer, 2010). The inability to find meaning and rebuild a functional worldview is predictive of continued distress and poor health. Directed journaling (i.e., writing about the sense one has made of loss or the learning found in it) is one way to create meaning out of loss and to facilitate health and bereavement resilience (Lichtenthal & Cruess, 2010). Religion/spirituality (R/S) is another powerful meaning-making resource. Many people report finding solace and meaning in their R/S beliefs and use them to cope with bereavement; however, between 20% and 50% of religiously inclined bereaved individuals experience a serious and disorganizing grief response resulting from spiritual and existential crises following the loss of a loved one (Burke, Neimeyer, Young, Piazza Bonin, & Davis, 2014). Known as complicated spiritual grief (CSG), this condition entails even greater suffering through the deterioration and/or loss of R/S beliefs, community, and sense of identity for this subset of the bereaved population. CSG is predictive of prolonged grief disorder (PGD).

Spiritual journaling is a tool that actively engages an individual's self-defined R/S framework to promote meaning-making and adaptive cognitive processing of the bereavement experience. Consistent with the meaning-making model, through spiritual journaling, bereaved individuals can use their pre-loss R/S understanding of the world to make sense of their post-loss experience (e.g., God was ready for him to go). Or, they can change their R/S worldview to better fit the loss experience (i.e., resolve discrepancies between what they believed about the

world and what they experienced) (Wortmann & Park, 2009). The “Instructions for Spiritual Journaling” (see Appendix 37.1) present the process used to introduce this reflective writing method to clients. The purpose of spiritual journaling is to promote grief processing, facilitate resilience, and provide spiritual care.

Case Illustration

Kaisha, a 27-year-old woman, self-identified as being of “mixed” racial background and Christian. She completed three sessions of spiritual journaling that incorporated her religious/spiritual beliefs as part of a research study on the effectiveness of this procedure in alleviating bereavement-related suffering. In her first entry, Kaisha described the senseless murder of her best friend, Abbie, which occurred 3 years prior, and her feelings of responsibility and guilt over the loss. As a result of a fight they had had, Abbie was avoiding Kaisha, and Kaisha blamed herself for not forgiving Abbie and keeping her out of harm’s way that fateful night. Kaisha believed God did not make mistakes, and she even accepted that God had protected her by not allowing her to be with Abbie at the time of the murder. Yet despite these beliefs, Kaisha continued to feel anger toward God and worried that God was punishing her for failing to forgive Abbie. Still, Kaisha pleaded with God to help her understand why Abbie was murdered and why she had not been there to prevent it.

In her second entry written five days later, Kaisha described her anguish at the constant reminders of her best friend. Those reminders prompted her to question God, asking “all types of questions, even though I was raised not to question what He does in our lives.” In the midst of her questions, Kaisha maintained her belief that God did not make mistakes and would reveal the answers to her questions in time.

In her third and final entry the next day, Kaisha shared this realization: “As I have done this exercise, I have paid more attention to what it is that I am asking God to provide me with, and I have realized that maybe He is not giving me what it is that I am asking for because I am not ready—or He knows that it is not what I need to continue to grow in this life.” As Kaisha reflected on what God had provided, she recounted a dream in which she could hear, talk to, and touch Abbie one final time. In Kaisha’s words: “For so long I blamed God for taking her away from me, more than I have thanked him for giving me that one last chance to tell my best friend that I loved her.” Kaisha believed that God had forgotten her in her pain and suffering. Yet through reflective spiritual journaling, Kaisha discovered God’s unexpected provisions and acknowledged their profound power to help her heal.

Concluding Thoughts

As was the case with Kaisha, religious and spiritual beliefs are not only one of the most frequently used means of coping with death, they can also shape the bereavement experience and trajectory. Spiritual journaling is currently being tested among individuals who are bereaved. Prior research demonstrates that it has helped highly traumatized individuals to experience a greater reduction in symptoms of posttraumatic stress disorder (PTSD) and depression. Research has also shown that nonspiritual bereavement-specific writing results in fewer symptoms of PGD, depression, and PTSD and greater positive mood (Smyth, 1998).

Our study team, which also includes Debra Wiegand, Laurie Burke, and Robert A. Neimeyer, is currently collecting data in an ongoing randomized clinical trial to determine the effectiveness of spiritual journaling among those who are bereaved and who self-identify as spiritually inclined. We are specifically testing its effectiveness (compared to nonspiritual

journaling and a neutral writing control group) in decreasing symptoms of PGD, CSG, and depression, and improving ability to make sense of the loss, physical health, and signs of post-traumatic growth. Participants in the study complete three writing tasks over the course of one week on a confidential website (<http://tinyurl.com/m65kkt6>), which is open to all spiritually inclined mourners without charge. The study uses the spiritual journaling instructions as provided in Appendix 37.1.

In closing, we would like to share a few notes about the implementation of spiritual journaling. Clients should be informed that they may experience some initial distress after writing (which is often the case with journaling about a traumatic event), but that most people find this discomfort is temporary and is outweighed by the potential long-term benefits. Therapists may want to follow up with their clients to inquire about their writing experience and process any themes or conflicts that may have arisen, including spiritual crises. As for the number of writing sessions, in the research on directed journaling, participants usually engage in 3–5 writing sessions. This might be used as a general, but not firm, guideline in the clinical use of spiritual journaling, as clients may achieve and consolidate greater clarity or perspective after only one or two sessions of journaling, or may choose to continue to use it as a touchstone throughout the course of their grief journey. The effectiveness of journaling does not seem to be dependent upon the means used to write, thus clients can choose between writing by hand, typing their journals, or perhaps even dictating them into a recording device. We do know people do best when they journal about both the facts of the situation and the emotions they felt as a result of the situation. This is likely to hold true for spiritual journaling as well. The instructional prompt we provide is purposely broad, such that individuals of many religious traditions can benefit from it. It also does not make an assumption about the helpfulness of their R/S beliefs. Instead, it allows bereaved individuals to freely express and explore what type of effect, if any, their R/S beliefs have had on their experience and functioning, typically enriching and deepening the work of grief counseling and therapy.

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Appendix 37.1 Instructions for Spiritual Journaling

For the next 20 minutes, write about the most significant interpersonal loss you have experienced and about which you are still feeling distressed. Specifically, using a perspective that best reflects *your own religious and spiritual beliefs*, try to focus on the following:

- how you may have made sense of the loss;
- how the loss fits into your religious/spiritual beliefs about why things happen;
- any changes that may have occurred as a result of the loss.

Also using a perspective that best reflects *your own religious and spiritual beliefs*, you might consider writing about

- the effects the loss has had on your life, goals, relationships, and religious/spiritual faith;
- the potential value and significance of the loss in your life.

Overall, in your writing, try to let go and explore these topics *using your religious/spiritual beliefs*. You may write about the same issues or experiences on all days of writing or different topics each day. Do not worry about spelling, sentence structure, or grammar. The only rule is that once you begin writing, continue to do so until your time is up. Please do not go back through your writing to edit it. If you run out of things to say, either just repeat yourself or try to get more detailed. You can decide whether or not you would like to share what you have written with anyone else. Please complete this writing exercise three times over the course of this week.

Thawing Frozen Grief

Cynthia Rollo-Carlson

Clients for Whom the Technique is Appropriate

Guided poetry can unlock the “frozen blocks of time” that stop the natural flow of feelings that move the bereaved individual forward. This technique allows walls of ice that separate clients from their grief to melt. Poetry, as symbolic language, has the ability to express what talk therapy cannot by bridging the conscious and unconscious. As such, it is relevant to a broad range of adolescent and adult clients, though it may be inappropriate for clients with cognitive challenges or for very young children.

Description

The creative expression of symbolism in poetry permits a person to search deep within the self. This poetic space allows the person to remain in the secure rational self, while at the same time illuminating the inexplicable. Through poetry the griever is granted permission to exit the self momentarily, yet tolerate this perceived loss by projecting perceptions symbolically.

Though paradoxical, creative writing, particularly poetry, can give voice to the unspeakable. Ogden (1999) has explored the transition that takes place as the poet faces the challenge of expressing the richness, complexity, and movement of living human experience using language. It can be disheartening to be unable to transform the effect of experience into logical syntax, yet poetry opens the space for metaphorizing what is otherwise unsayable. In order to bring personal meaning to experience, one must transform unconscious chaos to an orderly linguistic form, as understanding of both real and imagined, conscious and unconscious thoughts structures self-identity. This creates a duality in the very development of the capacity to bridge both modes through exchange of various layers of language.

Through metaphoric language, which may not be understood by the listener or reader, the mourning individual can be given permission to preserve that sacred space in honor of their loss while continuing to move through the grieving process. This in-between space is often unnamable, and often cannot be spoken. It becomes an experience that linguistics cannot describe because people are limited to a container of words that are used to describe such an experience. Metaphor, according to Davis (2013), can connect the familiar with the unfamiliar, the past with the present, bridging thoughts with feelings in order to bring emotional meaning.

However, if the loss is indescribable, it remains unnamed and unknown. Grievers not only experience the loss of the person who died, but also their own loss of understanding, insight, and meaning when they cannot communicate this emotion to the rational self that wants to make sense out of chaos and confusion. In a sense, they remain frozen in a formless experience, without means to express or explore a dark inner space.

Although discovery is important, it is more than just the experience of expression that brings resolution. Simply expressing emotion does not provide the person with the necessary tools for effective functioning in the future. The goal is to find meaning. This can occur through the use of metaphor when we are willing to move from a rigid cognitive state to a fluid emotional space as we search for significance with the purpose of constructing meaning while simultaneously shaping a new reality. Poetry, according to Neimeyer (2008), is a way not only to find meaning but also to make meaning. Poetics is way to speak the unspeakable, name the unnamable, and bring sense to what is insensible and, therefore, make meaning. The following prescriptions provide a useful prompt for this process:

- Invite the client to write passionately about fear, anger, sadness, loss, love, or joy—a strong emotion associated with his or her grief.
- Instruct the client to include four of the following words: air, darkness, circle, black, sun, blue, water, wolf, leaves, ice, wild, tree, earth, flower, bird, circle, wall, white, wonder, fire, lost, red, dream, or similar words rich in symbolism.
- Permit symbolic change in wording as the poem evolves. For example, in the following poem, instead of using the word “air” the antonym “breathless” was included and the synonym “vision” was used instead of “dream.”

Situating the writing in genuine emotion and prompting with evocative key words that the client is asked to incorporate in a poem help the client move from the frozen to the fluid as he or she brings personal meaning to an inchoate experience.

Case Illustration

Before beginning the story of this journey, I feel compelled to lay the groundwork first since I am including my personal experience through the case illustration. I lost my mother to cancer when I was 16 years old. My second child died shortly after her birth. When my oldest son was 10 and my youngest son was 7 years of age, my husband, their father, drowned when snowmobiling over thin ice on the lake where we lived. I have found that without speaking of what I am supposed to bury physically and verbally, according to societal norms, I was partaking in my own spiritual and emotional death even though I was already a knowledgeable grief therapist at the time of my husband’s fatality. I then found that this creative writing process became a transformational reawakening. I have been able to move from the captivity of my own emotional turmoil to freedom through the following poem. This is not the first version of this poem; it had many shapes as my own personal transformation occurred.

Black	Ice
stronger than her denial	this nightmare
shores up thoughts	visions
of losing her mind	of suffocation
if her reality merges	it’s all too crazy

then there is no way	to stop
she will lose	freezing, numb
sensing death	time is up
frozen in darkness	drowning
things amiss	absorbing
remind her	loving memories
of breaking out	refusing
to say goodbye	to give up
as tears trickle	he sinks
to crystal	breathless

This poem can be read in three ways. If read from left to right the two parts of my conflicted self remain as one—inseparable—stuck in melancholia. However, when reading only the left column, I am bringing resolution to conflict within myself in order to move on. When reading just the right hand column, I am attempting to put myself into the last thoughts of my husband, bringing the unspeakable, and unknowable, to a place that brings meaning as I try to reconcile with the loss. As the two columns merge I trace my loss back to a primary feeling of abandonment.

Concluding Thoughts

James Pennebaker (1997) notes that writing can be a powerful method to discover meaning and self-understanding as one confronts unresolved issues. For me, this poem was a way not only to find a form of self-expression, but also to bring meaning and truth to the new reality I was seeking. By finding meaning in the loss, we can then find meaning in the sorrow following the loss (Kumar, 2005). This was true for myself as I allowed myself to enter the sacred inner space in order to find hope and move on in my own life. I have found this poetic process to be therapeutic for the clients I counsel who are dealing with grief and loss as well. To my surprise, once I have shared a piece of my poetry, other griever have told me that they have written poems or have been given permission to move into this poetic realm. By exposing my own in-between space allowing my vulnerabilities to be seen, those who have experienced loss have verbalized their own safety to share their poetry as a bridge to communicate their therapeutic process.

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Time Revisited

Patricia Ruiz and Kerry Menn

Clients for Whom the Technique is Appropriate

Children over the age of 7, adolescents, and young adults may benefit from the opportunity to playfully relive the past and perform actions or have conversations that were not possible at the time. Symbolic time travel could be less appropriate for very young children who may not understand the “as if” quality of the activity, or for teens who are too threatened by “regressing” to this form of serious play to accept the opportunity to “time travel” in an emotionally open way.

Description

Time and time travel have fascinated humankind for centuries, as expressed in literature, sci-fi fantasy, movies, video games, and dinner conversations around the world. When grieving the death of a loved one, time plays a particularly inherent role as we become aware of time in a more profound way. We realize the finite nature of life and often have wishes to return to those places in time in order to spend more time with a deceased loved one, wish to go forward in time to be reassured that things will be okay, and become more intentional regarding the time we have in the present. While well-intentioned people suggest that time will heal all wounds, it is actually what we do with that time that makes the difference.

Dramatic play and imagination is engaged in multiple venues at the Children’s Bereavement Center of South Texas. Tucked in the corner of the drama suite is a beautifully constructed time machine with settings for the desired date to visit, and its mate, a towering 7-foot blue booth that the client enters to be transported to that time (see Figures 39.1 and 39.2). The time machine and booth were designed in memory of a man who was himself a renowned scientist and a huge fan of the BBC’s *Doctor Who*. Children are in awe of it and adolescents typically are fascinated.

The time machine provides a medium for children to communicate through play. Landreth (2002) states that play is the natural form of communication for children. It is the way they explore and orient themselves to time, environment, people, and things. More specifically, play is a means for organizing their experiences and exercising more control and security in a world that bears uncertainty and fear, particularly when death has touched their lives and cracked their foundation. “A major function of play is the changing of what may be unmanageable in reality to manageable situations through symbolic representation, which provides children



Figure 39.1 The time machine with settings for date



Figure 39.2 The time travel booth

with opportunities for learning to cope to by engaging in self-directed exploration” (Landreth, 2002, p. 12).

Neimeyer and Thompson (2014) discuss the benefits of two overarching narrative processes that aid in meaning-making in the context of the bereavement process. The first part involves processing the *event story* of the death itself, seeking ways to understand why the death happened and what it means for us in our world. The second part involves exploring the *back story* of the relationship to the deceased including remembering, preserving legacy, and reconstructing a meaningful connection.

Drawing upon concepts from child-centered play therapy and narrative therapy processes of meaning-making, one can introduce a time machine within the therapeutic relationship and open up the session for self-directed play, choice, control, storytelling, and mastery.

Case Illustration

Carmen, age 11, had experienced the death of her grandfather (“abuelo” in her native Spanish) from cancer one year ago. Her guinea pig also died the spring prior to her grandfather’s death that summer. Due to a myriad of family dynamics and familial stressors, it was difficult for her to express herself, due in large part to her role as a parentified child. Carmen attended peer support expressive arts groups with her mother and younger sibling for a few months. As she approached the anniversary of her grandfather’s death, her mother began to bring her to individual sessions. She rather liked to use the sand tray and loved drawing, but when asked if she would like to visit the drama suite, she was ecstatic and said she always wanted to give it a try. We agreed to visit the time machine the following week. The following sessions offer examples of how the time machine is utilized, but also offer insight into the landscape of Carmen’s inner world and how she made use of events across time and according to the plot of her life story.

Therapist: Do you wish to visit the past or go into the future?

Client: Oh, I want to visit the past! (She quickly moved the hour hands and placed them on the calendar date of the death of her guinea pig. She pressed all the buttons and then entered the booth of the time machine to begin her travel. Closing the door behind her, she did not utter a word or sound. One to two minutes passed and as her time travel began, she began her narrative.) I had a test that day, and I knew that he was kinda dying. Mom made me go to school because of the test. He died at 3 o’clock. (During her time travel, she bid her guinea pig goodbye and kissed him. She then exited the booth. She quickly shifted to the present.)

Therapist: So are you back?

Client: I am here now. I think if we took him to the vet sooner, he could’ve lived. I remember everything.

Therapist: What do you remember—colors, smells?

Client: I remember I was wearing my black Van’s shirt and my Abercrombie jeans. I only had a year with him. (She became very tearful.) They have a life span of 5 years.

Therapist: And if you could have done April 13 differently?

Client: I would have stayed home and insisted he go to the vet ... he would have lived. This is the first time I spoke about the whole day.

The following session Carmen was very excited to return to the drama suite. She appeared to have thought about what she wanted to do because she volunteered that she would be time traveling into the future.

Therapist: So, Carmen, you want to travel into the future?

Client: Yes, I will travel to Heaven—after this life. I want to see my guinea pig.

Therapist: What age will you be in the future?

Client: I will be 95 years old, and I am going to visit my abuelo and uncle when I'm in Heaven.

Carmen pressed all the buttons, and entered the booth with a cheery “So long!” She uttered sounds like “typical time travel machine” noises. There was silence. Then she declared, “I’m ready to come out now.”

Therapist: How was your time travel to Heaven?

Client: Oh, it is like what everyone says—it’s a happier place. I felt happy. It feels like the paradise my *abuelo* talked about before he died. He told me that in paradise they would take care of him—you know the angels and stuff. My uncle told me that before he died, he felt my *abuelo* was pulling him to go to Heaven—so they could be together and fish together in Heaven.

Concluding Thoughts

The time machine can be adapted for use with clients of various ages and loss experiences. In the above example, Carmen was able to process her grief experience by revisiting the day of the death and creating a narrative to make sense of her experience and her reactions to it. She then chose to use the time machine to see happiness, peace, and perhaps relief by looking into the future. It is also interesting to note that while she began her journey to Heaven to see her guinea pig, she made a shift and instead chose to visit her family members who had died. Trusting in the inner strength and resilience of each individual, incorporating the concept of “revisiting time” within the bereavement process can add depth to healing, and create space to engage a young person’s imagination.

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40

Etched in Glass

Christine H. Farber and Stephanie Field

Clients for Whom the Technique is Appropriate

Clients in individual therapy who are going through a planned termination and are able to read and write can benefit from writing a goodbye letter to the therapist. However, those who are in bereavement support groups or enrolled in more psychoeducational interventions could find doing so awkward or inappropriate, as the therapeutic relationship might figure less prominently in the therapy.

Description

An ordinary piece of glass has the potential to reflect an image even as its clarity allows one to see through it. As Figure 40.1 illustrates, etching onto the glass elevates the ordinary material. It marks the glass, transforming it into something artful, beautiful, and unique and further shapes its capacity for reflection and its offer of seeing through to the other side. Like the art of glass etching, writing a goodbye letter to the therapist is a creative process that *marks* the therapy and its ending and, in doing so, further *shapes* the client's evolving sense of identity and relationship to the world as he or she looks back over the therapy, in review, and glances forward, toward the life that is ahead of him or her.

This technique is based in our understanding that significant loss effects shifts in a mourner's sense of identity, relationship with the deceased, and ways of being in the world (Attig, 1996) and that the therapeutic relationship functions as a container within which these shifts evolve. Saying goodbye to the therapist and reflecting on one's own transformation are, therefore, intimately related and are ideally part of an ongoing termination process. Writing one's goodbye to the therapist punctuates this process, marks the client's transformation, and grants him or her an explicit experience of living it.

Instruction for writing the goodbye letter is flexible, and the following points can be adapted as appropriate within a given therapy. (1) Invite the client to participate, offering this as an activity that you and the client collaboratively plan. (2) Offer the client prompts to help direct the writing if this is helpful; some clients will prefer to write without prompts. Suggested prompts are noted below. (3) Suggest that the letter be written outside of session when the client has uninterrupted time to reflect and to write; and instruct the client to take a pause from writing if he or she feels distressed at any point, without pressure to continue. (4) Invite the client to read the letter aloud in the penultimate session of the therapy, thereby allowing time to further respond to the goodbye in a final, subsequent session (Pearlman, personal



Figure 40.1 “This Must Be a Dream.” Etched glass by Linda Lichtman <http://www.lindalichtman.net>. Image included with permission of the artist

communication, [ca. 2013]). (5) Explore the client’s experience of writing and sharing the letter. (6) Make a copy of the letter so that you and the client each have one to keep.

The following writing prompts might help those clients who prefer more specific direction. These prompts can be used to explore termination more generally, as well.

Reflection on the Therapeutic Relationship

What will you miss about me and our sessions? When did you feel most vulnerable, comfortable, or close in our work together? What do you wish you would have said to me? What do you imagine I would say if someone asked me about you? How would you like to be remembered by me?

Reflection on the Therapy

What has shifted for you over the course of therapy? How do you think you are different, now, at the end of our therapy? What might you want to say to the version of yourself that first started therapy? What disappointments do you hold about the therapy? What have you most appreciated about the therapy? Of what are you most proud?

Looking Forward

What do you fear as you look ahead? What are your hopes for the future? What would you like to say to the version of yourself that is moving forward? Where might you find support for yourself in the future? What matters most to you in your life moving forward?

General Instruction

Take some time to reflect on your experience of therapy and our relationship. When you are ready, write “Dear [Therapist’s Name]” or, if you prefer, “Dear Therapy” at the top of a blank piece of paper or electronic document. Allow yourself to write freely, without regard for correct spelling or grammar. When writing about feelings, thoughts, beliefs, or meanings, you may wish to describe them as images, colors, shapes, textures, temperatures, sizes, weather conditions, or any metaphor that comes to mind (Adams, 1998). Your letter can be any length you would like. There is no wrong or right way to write it.

Case Illustration

Annette, a 26-year-old student, reluctantly came to see me after her previous therapy ended when she moved out of town to enroll in a year-long graduate program. In our first session, Annette described growing up in an alcoholic family, within which silence and secrecy prevailed. She poignantly illustrated some significant themes from her life story when she told me about reading outside for hours at a time as a kid, behind a neighbor’s shed, with no one coming to find her. “At first I went there to cry,” she said, “but somewhere along the way I stopped crying.” She also told me that her mother had died from cancer shortly before the beginning of her previous therapy. Not surprisingly, themes of silence, secrecy, and invisibility surrounded her mother’s death as well.

In the 10 months during which we met, Annette and I addressed multiple losses and layers of her grief. These losses included the death of her mother, the ending of her previous therapy and the less tangible losses of her childhood. Despite its relative brevity the therapy was powerful: From the young woman who looked at me with furrowed brows and experienced herself as invisible to the one who could own her feelings and experience the intimacy of sharing them, Annette’s transformation was palpable. Given the hard-won success of our evolving intimacy, it was particularly painful for both of us to think about the impending end of our therapy; but we did so, maintaining a spoken awareness of this loss throughout our work and directly exploring Annette’s thoughts, beliefs, and feelings about its end.

As the actual termination date approached, we discussed the possibility of her writing a goodbye letter to me. She was receptive to the idea, and together we created a plan for her to do so. I suggested she take some time to reflect on the therapy and handed her a sheet of paper with questions she could reflect upon before writing. I reminded her that this was her letter and that she could approach it in any way she wished. We agreed that she might read it to me or allow me to read it in the session before our last, though we left open the possibility that she could change her mind, thereby introducing my role as a potential witness and recipient while maintaining her ownership of the process. Her writing was eloquent and reflected the resilience she demonstrated throughout our work. She decided to read it to me at the start of our penultimate session.

“Dear Stephanie, I know I haven’t been an easy client. When we first met I was really shut down and afraid. Mostly I want to thank you for hanging in there with me.” Annette went on to describe ways in which she had changed throughout the therapy, including that she “no longer [felt] so invisible.” I was particularly struck by the following line from her letter: “I feel more alive, and even if that means feeling more pain, I know I can handle it now.” The word alive was new to Annette’s description of herself. We had not explored this previously. Moreover, this was exactly how I experienced her as she read her goodbye letter: present, alive, transformed. In the act of writing her goodbye, Annette found a new way to describe herself; and in the act of reading it, this creative transformation was visible. Annette ended her letter with a quote attributed to Rilke: “The angels love our tears,” she said, then looked up and smiled. “I finally feel as though I can love my own tears. Thank you.”

Concluding Thoughts

Termination assumes added significance in grief therapy. When addressed explicitly, throughout the therapy, and in a manner that supports an exploration of the client's associated emotions, meanings, and beliefs, termination can empower clients—offering an experience of preparing for and working through loss consciously (Pearlman, Wortman, Feuer, Farber, & Rando, 2014). Writing a goodbye letter punctuates the termination process; solidifies the transformations that have taken place, including the internalization of the therapeutic relationship; and provides an outlet for self-expression, which can promote physical and mental benefits (Pennebaker & Seagal, 1999). In addition, writing a goodbye letter is a *creative* act, which marks and shapes the client's evolving self, transformed through grief and in relationship with the therapist. Like a piece of art, the letter becomes a tangible object that the client can take with them after the therapy ends, symbolizing their creative transformation. For clients who cannot or prefer not to write, including young children, this technique can be adapted by utilizing visual art—a picture or a collage, for example—to express the goodbye.

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Part VIII

Reorganizing the Continuing Bond

Reintegrating Attachment After Loss

Adam Anderson

Clients for Whom the Technique is Appropriate

This technique is appropriate for individuals who are experiencing intense feelings of grief associated with the loss of a spouse or significant other. The techniques described could also be applied to work with an individual who has lost a parent, sibling, or close friend. The approach is designed particularly for those who are experiencing complicated forms of bereavement, or are feeling immobilized by the loss. The approach may need to follow other forms of processing, particularly in cases in which a relationship involved significant conflict.

Description

The sorrow of loss is intimately tied to the love experienced in connection and attachment to the deceased. We are each born with an innate system that motivates proximity and communication to important others. Bowlby (1980) provided a basic framework for attachment, and argued that relationships between parents and infants form the “blueprints” for relationships throughout life. Based on these templates, modified through years of interaction with others, we form meaningful patterns for interacting, self-regulating, self-organizing, making sense of our experience, and planning our activities and behaviors.

The loss of a significant other leads to significant, abrupt, and often unexpected changes. From the physical absence of the other, to reductions in the process of communication and emotional attunement, years of relational and neural programming, altered in an instant, can leave an individual without the structure and organization that was previously provided by a close attachment. Reorganization and adaptation can be thwarted by the experience of intense pain. Bowlby (1980) wrote that: “Loss of a loved person is one of the most intensely painful experiences any human being can suffer To the bereaved nothing but the return of the lost person can bring true comfort” (p. 7). C. S. Lewis (1961) wrote,

I think I'm beginning to understand why grief feels like suspense; it comes from the frustration of so many impulses that have become habitual. Thought after thought, feeling after feeling, action after action, had [my wife] for their object. Now their target is gone. . . . So many roads lead . . . to [her]. I set out on one of them. But now there's an impassable frontier post across it. So many roads once; now so many *culs-de-sac*. (p. 41)

Siegel (1999) noted that mourners who struggle with more complicated forms of grief can encounter an “impairment in the ability to make . . . alterations within the attachment system. States of mind continue to be activated in which connection to the actual attachment figure is expected” (p. 296).

Individuals who have experienced the loss of a significant other are frequently faced with the prospect of reorganizing their attachments during periods in which they have the greatest need for safety and security, and have often lost the attachment relationship in which their security and safety needs were most meaningfully met. Although others may try to provide solace, some comforts “can only be remedied by the integration of another emotional attachment or the reintegration of the one that had been lost” (Stroebe, Stroebe, Abakoumkin, & Schut, 1996, p. 1242). How would such a “reintegration” occur? What would it entail?

For Freud (1912–1913), the main goal of grieving is to “detach . . . from the dead.” In contrast, Bowlby (1980) observed that “for many widows and widowers it is precisely because they are willing for their feelings of attachment to the dead spouse to persist that their sense of identity is preserved and they are able to reorganize their lives” (p. 98). A focus on continuing bonds offers an approach that many people in mourning have not considered.

Maintaining bonds can take many forms, from holding onto cherished possessions to preserving memories, pictures, narratives, and many symbolic links to the dead. At least two empirical investigations of continuing bonds have utilized “empty chair” tasks in which an individual is asked to speak to their spouse “one last time” or asked to discuss a “topic involving their deceased spouse” (Field, Nichols, Holen, & Horowitz, 1999; Field, Gal-Oz, & Bonnano, 2003).

In intervening with individuals who have lost a spouse or significant other, I often include an attachment-based interview in the early part of treatment. I ask questions about childhood and early family relationships (particularly relationships with parents or caregivers during childhood, such as: Who did you grow up with? Who raised you? How was your relationship with each parent? What are some of the most important experiences you had with your primary caregivers?). I also ask questions about important attachment figures during adulthood (Who is your partner or most significant other? How do you feel about the relationship? Who are you closest to? Do you share personal thoughts and feelings with that person?). Questions inform me about past relationships, and about the sense clients have made of their relational experiences. Questions also ask about stresses clients have faced and ways they work with important attachment figures to solve problems. An individual’s responses to these questions provide information about his or her internal working model of attachments, including hypotheses about the security (or insecurity) of attachment, and can allow us to see how past adaptations are impacting relationships, with a goal of helping individuals to open themselves to relationships, while maintaining their sense of identity (Siegel, 2011, p. 75).

Following this, I use a technique that offers an approach to continuing bonds, which encourages conversation during a period of visualization. Within the session, we discuss the idea that relationships are not really “lost” when a loved one dies or is not physically present, but that the relationships have changed. We regularly maintain relationships with individuals in our lives who are not regularly physically available. There are a number of means of creating contact when others are not physically present, although the means available to us may not be our preferred methods of involvement. We discuss how our history of involvement with a loved one gives us an internal model through which we regularly predict or anticipate the responses of the significant other. We additionally discuss that the relationship invariably continues, and discuss that the question is not *whether* they will continue to have a relationship, but *how* they want that relationship to feel and operate. The procedure follows this basic structure:

- Close your eyes, and remember ____ as vividly as possible.
- Imagine that ____ is walking through the door of the office and into the therapy session.
- Describe how ____ would look. What expression would ____ have if he/she could see and talk with you now?
- What would your response be to see ____?
- What would you want to say?
- What would ____ say back?
- Describe how your life has been since ____ left.
- What would ____ say back?
- What kind of relationship do you want to have from this point forward?

These basic questions can be tailored by incorporating information about the person's attachment history gleaned in the earlier interview. For example, a client who is preoccupied with relationships and struggles with dependence and differentiation may be asked how he or she wants to handle bonds, or maintain elements of the relationship moving forward. In contrast, those who struggle with closer attachment, or may have experienced issues with linkage may be encouraged to express things to the deceased that had never been expressed. In this sense the dialogue with the loved one evolves from the interview, and the information about the individual's history of relating to important others.

Case Illustration

Jane was encouraged to attend therapy, and accompanied to a first session by her son. Her husband of 44 years had died 10 months earlier, and feelings of distress and disconnection were increasing rather than abating. She appeared quiet, fatigued, and withdrawn. In the initial session, she let her son do most of the talking, and simply shook her head in agreement intermittently. When spoken to, she offered only brief responses to questions, and appeared to be in visible pain. She identified a wide range of intense symptoms of depression, including anhedonia, and issues with appetite, sleep, and concentration. She also continuously experienced "images" associated with her husband, felt great longing for him, and felt intense sadness and loneliness.

A second session focused on discussing her relational history, including her impressions of relationships in her primary family. She felt close to her parents, but acknowledged some dependence that transferred from her family relationships to her relationship with her husband. She became noticeably more animated when she discussed meeting and dating her husband. She expressed that he was social and capable. He helped her to feel comfortable financially, and most of the important relationships with friends were shared relationships with couples that she met through her husband. He managed the finances. He took care of issues around the home. When faced with crises, he often provided support and assisted with problem-solving. She expressed that she had been known as her husband's wife for so long that "I don't know who I am anymore." She felt defeated and unable to tackle the demands of living without him. She also felt uncomfortable accepting invitations from friends, and her relationships with her three children and five grandchildren were additionally affected. Her family was the focus of her life, and she and her husband had planned to travel and spend time with them after their retirement. But, since her husband's death, she felt hesitant to spend time with her children and grandchildren, worrying that her tearfulness would make them feel uncomfortable.

In the third session I invited her to consider that the death of her husband did not mean that their relationship had ended. We discussed the ways that many relationships (including her relationships with her children who lived in a different state) occur with people who are not physically present, but are still important to us. Cued by our previous interview and its themes of anxious dependency, we invited a dialogue in session in which she was encouraged to speak to her husband and then asked to respond as she believed he would to her statements and questions. She was asked to close her eyes and imagine how he would look as he walked into the room, how he might be dressed, how he might smell, and how he might look at and respond to her. She visualized his presence, and became immediately tearful. She expressed that she had missed him. She talked about how hard it has been without him, and shared that she felt that she was currently “stuck” in painful and persistent feelings recurring in the home that they shared. I asked how her husband would respond. She said that he would express concern, and hope that she would continue to move forward with her life, and go ahead and do some of the things that they had planned. He expressed that he hoped that she would be happy in her life and be able to fully experience life and work, and to support and love their children and grandchildren as much as possible. She reported that he would tell her that he loved and missed her. As we drew the visualized interaction to a close, she discussed recognizing how much he would want her to have more happiness in life than she was experiencing. I asked how she wanted her relationship with him to feel and work as she moved forward. She expressed a desire to have him “live with her” in positive ways as he had when he was physically present. She discussed many of the reasons that their relationship was so strong, and began to feel a sense of how she might live with him differently. She said that interacting with him had provided a greater sense of freedom to begin to act in her life and pursue her goals.

In the session that followed, Jane announced that she was planning to go to visit her son and his family on the west coast, including a granddaughter who was chronically ill. After this trip, she began to spend increasing amounts of time with her children and grandchildren. Therapy focused on regulating emotion and managing stressors that she faced, and continuing to reconnect and build a new relational world that felt good to her. Jane went on a trip with a friend at the anniversary of her husband’s death, and reported that the trip offered a positive environment in which she could manage what she felt during the day, but could also focus on other things. She worked to learn more about how interactions with others could work for her, and the types of respite that she needed. Stress increased when Jane announced that she planned to sell the home that she shared with her husband for more than three decades and move to live nearer one of her children. She hired helpers, went through belongings (determining what to keep and what to release), and worked with a realtor. Jane ended therapy when she sold her home and moved to live nearer her son, his wife, and their children.

Concluding Thoughts

When a significant other dies, the pain of the loss can leave a person feeling disorganized, disoriented, immobilized, and unable to change feelings of longing and grief. Lost in the pain, the bereaved may not see options for exiting an emotional cul-de-sac in which they continually feel stuck in their pain. Striving to understand the attachments that have worked for clients in the past, and reactivating these attachment processes can assist an individual in a process of reintegration. Additionally, therapeutic work focused on continuing bonds with the deceased

can allow the individual who has lost a close loved one to move into an internal place where they can feel greater understanding and continued meaningful connection.

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Relationship Review

Joshua Magariel

Clients for Whom the Technique is Appropriate

This technique can be used as an individual intervention with those anticipating their own death or the death of a loved one, or as a relational intervention between a client and his or her loved ones. The technique is also appropriate in bereavement. This technique may not be suitable for bereaved who are experiencing acute grief in the immediate period following the death of a loved one.

Description

Relationship review was inspired by and adapted from one of the foundational interventions of developmental psychology known as life review (Haber, 2006). Life review remains an essential tool in end-of-life care and bereavement, as discussed by Jenko (2012). Relationship review evolved from an observation that while life review is a productive and effective tool for meaning-making and emotional resolution within an individual, there are many people in need of meaning-making and emotional transformation in their relationship with those who are dying or who have died. In its essence, relationship review is an adaptation of life review that is guided by the framework of attachment theory and the tools of narrative therapy. Its goal is to actively review the attachment dynamics of a relationship that are impacted by loss or anticipatory loss and to establish an integrated narrative of relationship that is adaptive and meaningful.

The process of life review has been described as both inherent to a developmental life stage and as a periodic life necessity. It is helpful when considering the process of relationship review to recognize that the need to review one's life is a "repeated experience that arises with each loss in adulthood, and this psychological adjustment may occur independently within each of several dimensions of life" (Haber, 2006). Relationship review is the experience that arises when the story of love or the narrative related to attachment dynamics requires adjustment. Loss and anticipatory loss and the resultant need to review attachment dynamics seem to correspond with the trajectory of integrated grief. The difficult and painful transition from acute grief to integrated grief occurs when the permanence of the loss begins to permeate and is then "integrated into attachment-related long term memory" (Shear et al., 2007).

It is not surprising then that relationship review will commonly evoke the following relational and attachment themes: feelings connection/disconnection, history of bondedness,

felt safety and security, functional or dysfunctional roles, being cared for, being a caregiver, restructuring boundaries and hierarchies, shared or lost meaning and purpose, loneliness, betrayal, forgiveness of self or other, loss of intimacy, and longing. These themes seem to also fit into three loss-related narrative categories: (1) the stories of the relationship before death; (2) the stories of illness, losing, and death; and, (3) the stories of how a connection is possible and can be maintained after a death. The relationship reviewing process examines, enhances, and restructures these themes into an integrated story.

Similar to life review, relationship review can be both a spontaneous and a highly intentional technique. Relationship review has the feel of a natural conversation while the clinician focuses on relational narratives and the importance of integration. It is also the role of the clinician to follow the client's lead in identifying which narratives are most important and to provide the necessary space for clients to create an authentic integration of their relationship narratives. The clinician identifies narrative disruptions, disorganization, dominant themes, and other obstacles that need to be restructured to allow integration to occur (Neimeyer, 2006).

Relational narratives can surface almost immediately in the first clinical interaction. Open-ended questions and curiosity can encourage the rest of their relationship stories. Remembering to follow the client's thematic lead, these questions can highlight some dynamics of their stories:

- If I were watching you earlier in life, what moments would I have seen that would help me best understand the connection you two shared?
- What were challenges in your relationship? What's your experience of those challenges now?
- What was the love like between you two? When do you feel close to him/her now? How and when do you know that love lives on in your heart?
- How did your relationship change over time?
- What was unique about your relationship?
- When did you two feel the strongest connection? When do you feel the strongest connection now?
- How did you two spend time together? How did that change when he or she was ill? What's your experience with those activities now?

Case Example

Linda was a 51-year-old woman, self-referred for bereavement counseling four months after the sudden, unexpected death of her husband of 19 years. Linda came home from work one evening to find her husband Rob lying face down on the living room floor. She later learned that Rob died instantly from a sudden, massive heart attack. Linda entered counseling with an expected sense of shock that was pervasive.

Our first meeting was spent with her telling the story of how Rob died, her concern that she may be clinically depressed, and a description of the debilitating nature of her grief. After ruling out depression and providing some basic education on acute grief, Linda began talking about how "dark" her home is now that the "light" of her life was no longer living. To examine the stories of their relationship before her husband died, I asked using an attachment framework, "If I were watching you two earlier in life, what moments would I have seen that would help me best understand the connection you two shared?" Linda smiled and shared the story of a relationship full of laughter, playfulness, encouragement, safety, and emotional intimacy. Appropriately in tears, Linda also shared the details of these stories with laughter. It is common for bereaved to either

idealize or demonize someone who has died or the relationship that was shared with someone who has died. However, hearing Linda's story it was clear that she was not idealizing their bond, which was truly and primarily good. I shared a similar insight, after which Linda added that this makes the death of her husband more difficult for her. I reflected to Linda that this helped me understand why she was hurting so much and why her home felt as "dark" as it did. From an attachment and narrative perspective, I was attempting to validate the pain of the loss that was a significant part in her relationship story.

During a later session, Linda focused more on the story of how Rob died. After therapeutically focusing on her posttraumatic stress response to finding her deceased husband, Linda eventually shared her feelings of helplessness and guilt that Rob was always there to care for her, while she was not there to care for him when it mattered most. To examine more fully the relational and attachment dynamic of caregiving in their relationship, I asked, "In what ways did you two care for each other? Did you openly let each other care for each other?" Linda shared a narrative that her husband did most of the caregiving in their relationship. While this may have increased Linda's feelings of guilt, she highlighted instead that while Rob took exceptional care of her, he did not take good care of himself. Linda also highlighted that she consistently expressed her concern that he did not take care of his health. Linda was restructuring and reorganizing her own story at this point, emphasizing that she attempted to care for him through encouraging him to be healthier. In retrospect, his sudden heart attack was not a total shock as she did try to be a caregiver to him.

Linda would often share her significant loneliness and longing during our work together. As a result, interwoven throughout our sessions was the use of relationship review to integrate a narrative of their continuing relationship. While Linda found meaning and connection in transitional objects, she had avoidance behaviors, including not wanting to move any of Rob's belongings from their exact location from before he died. I normalized this behavior and reinforced that she did not have to move his belongings, and finished by adding the word, "yet." Linda did not skip a beat adding that she knew she had a lot to confront, with time. Focusing on relationship review, while attempting to add to the narrative of how their relationship could be maintained, I inquired using an attachment perspective, "Was your husband the person in your life who would encourage you through difficult times?" Linda began to cry and said, "Yes." I attempted to normalize this and then asked her, "Do you ever hear his words of encouragement in your mind?" Linda laughed and shared a story from their wedding. When she met him at the altar she started to cry. To comfort her with humor, he whispered to her, "It's going to be okay, please don't cry." At her wedding, she said it made her laugh. Linda then shared that she has been hearing his voice in her mind saying, "It's going to be okay, please don't cry." It still made her laugh and Rob's voice had been giving her courage. I suggested to Linda that this story and his words could continue to give her courage when she needed it.

Concluding Thoughts

Grief therapy may be many things to many clients, addressing their unique experiences of loneliness, guilt, felt abandonment, unfinished business, quest for meaning, and more. However, as represented in this case study, relationship review appears to be an effective supplemental intervention that can help the bereaved gain perspective about the pre-loss relationship with their loved one, and often draw on it as a source of strength in their changed life after the death.

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43

AfterTalk

Lisa Bogatin and Larry Lynn

Clients for Whom the Technique is Appropriate

AfterTalk conversations can be helpful for clients seeking to access and strengthen a constructive continuing bond with the deceased. They may be less relevant when clients are struggling to process a troubling event story of traumatic death, which can initially overshadow the separation distress that is a central motive for corresponding with lost loved ones.

Description

AfterTalk.com is a website we created in 2012 to help people through life's most difficult time—the loss of a loved one. The website offers grief support tools through writing and sharing. It is free and non-denominational. AfterTalk is based on the concept of continuing bonds with loved ones, which play an important role in both the Two-Track (Rubin, Malkinson, & Witztum, 2011) and meaning reconstruction (Neimeyer & Thompson, 2014) models of grief, and incorporates the therapeutic benefits of writing to deceased loved ones (Neimeyer, 2012).

The heart of AfterTalk is its *Private Conversations* feature, a secure, private place for the grieving to use therapeutic writing to maintain a virtual “conversation” with their deceased loved one. We have found that grief can be alleviated by an ongoing dialogue with those who have passed, sharing the bereaved person's daily experiences, thoughts, feelings, joys, frustrations and memories with the loved one as they had during their time together. AfterTalk gives the grieving the opportunity to feel connectedness while the healing process progresses.

Sometimes sharing grief and memories with family and friends is also healing. AfterTalk's *Family/Friends and Therapist Page* allows those who are grieving to share a “conversation” with anyone they like, and invite a response or contributed thought.

We came to our belief in the therapeutic value of writing through personal experiences, as we respectively lost a father and wife. Both of us independently had been writing letters to our deceased loved ones. We believed that the computer, rather than paper and ink, was becoming the primary medium for people to write everything from emails to text messages to shopping lists. Through Facebook, Twitter, and other social media sites, people were expressing their lives. That led us to create AfterTalk. Once we had crafted and tested the *Private Conversations* component and had gotten feedback from other bereaved people and those who supported them, we realized that users wanted the ability to share their otherwise private writing with carefully selected family members and friends. As the AfterTalk site evolved, and through our

relationship with the Association for Death Education and Counseling (ADEC), we saw an opportunity to facilitate the work of grief counselors and their clients by offering a utility that simplifies the process for those grieving to complete therapeutic assignments that involve writing letters to deceased loved ones. AfterTalk added a *Therapist Portal* that makes it convenient for clients and therapists to share written work online.

Case Illustration

Wendy was a 37-year-old mother of two children—a daughter of 4 and son of 10 months—when her husband took his own life. He suffered from depression exacerbated by both the contemporaneous deaths of his father and his older brother and serious professional setbacks.

Wendy had to juggle her career, child rearing, and reorganizing her own personal life. Like most spouses in her situation, she experienced “survivor guilt,” wondering what she should or could have done to prevent her husband’s suicide. At the same time, she had to cope with her young daughter’s grief over the loss of her father. Wendy remarried less than 2 years after her husband’s death. Her second husband was a widower without children who happily welcomed Wendy’s children into his life, and devoted himself completely to fatherhood.

The experience of her first husband’s death, however, could never stay in the past. As the children passed through various phases of childhood and adolescence, they would process their biological father’s passing in different, challenging ways. As a consequence of this, Wendy was moved frequently to revisit her own feelings about the suicide. All family members availed themselves of professional help at various times.

Fifteen years after her first husband’s death, Wendy lost both her father and her brother over a 2-year period. She was very close to her father; she and her second husband had bought a home down the road from her parents 2 years into their marriage, and the family had grown closely attached. Her father passed gracefully in his late eighties of old age; her brother, however, developed a glioblastoma on the left side of his brain, and died within 18 months of diagnosis. His death was traumatic for the entire extended family.

Wendy knew of AfterTalk through her relationship with the authors. She was an early user of AfterTalk, and found it to be an effective tool for processing her grief for her departed loved ones. She not only uses AfterTalk for its *Private Conversations* component, but also has posted several pieces in its *Blog* section on various topics. She agreed to the publication in this book of two pieces: an AfterTalk letter to her deceased husband and an article she posted on the therapeutic value of a *Private Conversation*.

Allen,

Through AfterTalk.com, I finally feel I have a pathway to write to you even though you died 21 years ago. I realized that the only difference between writing a letter to someone who is dead vs someone who is alive is an expectation of being with that person in the future. In both situations the person is not with you in the present. I can’t conceive of an afterlife, but if there is one, then I will be curious to know if we can resume our dialogue where this conversation leaves off.

Our daughter was a little more than four and our son only 11 months old when you ended our lives together by your own hand. For over two decades, I have yearned to share you with our children. Larry and I have been married for

19 years and he has been their father much longer than you were. I'm sorry because I feel I have just hurt you by writing that.

I have been sad for twenty years because they feel the loss of not knowing you; I continue to feel remorse and guilt for not keeping you in their lives. You and I were physicians together and yes, you were in a severe depression, but I blame myself because I was a physician, I am our children's mother, and I was your wife and you were their father. I keep wondering if there was something I could have done that might have kept you in our lives.

I want you to know how painful it has been to see you in both our daughter and son, and not to be able to have them see you in themselves. Our daughter sees you in our son, and it's both painful and wonderful. As our son ages, he is reminding both us of your appearance and mannerisms. He likes opera and classical music just the way you did. He specifically loves Mozart as you did. Yes I know; I also wonder, what is the neurobiology of musical preference? His facial expressions are yours. He arrived unexpectedly one afternoon from college wearing glasses and looked so much like you that our daughter, my mother and I began to cry. He didn't understand.

This hurt is difficult to describe, and I am learning that it's never going to go away. It's part of our lives and to a large extent it holds tremendous sway and shapes our daily lives. When you left, you left a blank space forever present, never to be filled in the specific way you would have filled it. We know it's there, and will be there until we no longer have a mind to remember you in.

The particular episodic minutiae of life's consciousness are infinitesimally innumerable and mounting up even as I pause to tell you about them. They are each precious, intricate pieces of a puzzle, like our son's first bike ride on the pier. Our daughter at five years old was staring so intently at the man at Toys "R" Us when he was assembling her new bike because she outgrew the one you had bought her. When I asked her not to stare she told me, "I can't help it; I am thinking of my Daddy." Since our son was a baby when you died, he didn't remember your voice. When he was a young boy, I played him a tape recording and later showed him the precious pieces of video; he cried because you were and are, unknowable, untouchable, and gone forever. Everything that is something of them in my life I want to share with you but haven't been able to. Here I will try to begin writing to you through AfterTalk about our children.

Love always, Wendy

The following is Wendy's article based on her experience of AfterTalk as a tool for processing her grief through writing. Although 22 years have passed since her husband's suicide, she uses AfterTalk to maintain life's ongoing conversation.

The religions that teach a life after death foster the concept that our loss is not permanent but temporary. We must wait, however, until we too are dead. AfterTalk encourages us to remain connected with those we still love by continuing to communicate with deceased loved ones through writing. Writing allows us to create space for our loved one to fill over time and in the future. We can look forward to sharing our lives in the present rather than separating or waiting until we die. Writing allows for more time and space for our deceased loved ones. Each day now and in the future that we write to them creates an extension of our relationship.

For people who we have lived with for decades of our own lives we can discover their thoughts and responses to our questions within ourselves because we have internalized them during our shared times together. By writing, memories can come back to us that we thought were lost so that we can re-experience our loved one again. There is enough integration of the person we loved that we can answer new questions posed to them because, as we write, what they would have said to us gets written down.

When I finish a session with my father where I began by wishing that I could ask his sage council about some issue regarding one of my children, I have a pretty good idea of what he would have said to me. It flows from writing to him. His thoughts begin to flow through me. I can write it as if it were a quote and be comforted as I read it back. Who are we but the sum of all our relationships and experiences? Who are our deceased loved ones but our memories of all that we have felt about, talked about, experienced together, conversations, shared relationships with others in a web of interactions and thoughts? I chose not to separate. I chose not to wrench out my father, brother, husband from my soul but instead to invite them to be with me and to continue to share my future with them alongside of me.

Concluding Thoughts

As this case indicates, AfterTalk can be a powerful tool of self-therapy or an adjunct to professional grief counseling. Its *Private Conversation* feature affords those grieving the opportunity to write to their deceased loved ones in a very private, secure place. Through its archiving, users can revisit their earlier writings at any time.

Through its *Therapist Portal*, professional grief counselors can manage the writing assignments of multiple clients in one convenient location as easily accessible to them as their webmail. This tool also facilitates the counselor's response to clients' writing assignments. In all, AfterTalk is a technologically advanced tool that offers grief counselors a welcoming, efficient way to strengthen constructive continuing bonds in grief therapy.

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Singing an Imaginal Dialogue

Yasmine A. Iliya

Clients for Whom the Technique is Appropriate

This technique is appropriate for adolescents and adults who are yearning to create or maintain a continuing bond with a deceased loved one. It would also be recommended for those seeking opportunities for closure with their loved one, such as asking an unresolved question or saying goodbye. Sufficient clinical skills and training are needed in order to safely contain the potentially high level of emotional intensity the technique may arouse. The method is contraindicated for young children and adults with poor reality testing, as these individuals may have difficulty with the abstract processing required to engage in an imaginary conversation with a deceased person.

Description

Recent theory and research suggest that establishing and maintaining a connection with the deceased is an increasingly important aspect of healthy mourning (Neimeyer, Baldwin, & Gillies, 2006). One popular Gestalt technique adapted to grief therapy for the purpose of helping mourners with this process is that of the “imaginal dialogue” (Shear, Frank, Houck, & Reynolds, 2005). In Shear et al.’s (2005) research with grieving adults, the directive was explained as follows:

the patient was asked to speak to the person who died and that the person could hear and respond. The patient was invited to talk with the loved one and then to take the role of the deceased and answer. The therapist guided this “conversation” (p. 2604).

The technique of *singing* the imaginal dialogue incorporates music therapy techniques and theories as a variation of the method. Music therapy uses musical interaction to achieve psychosocial outcomes. Interventions include active music-making by clients and therapists, listening to music, singing improvised and/or pre-composed songs, and verbal dialogue.

The technique is heavily influenced by Austin’s (2008) method of vocal psychotherapy. It consists of the client and therapist singing together while the therapist plays a continuous, repetitive, and simple two-chord harmonic structure on the piano. The essential vocal components of the intervention include repetition, singing in unison or harmony with the client, and

doubling (Austin, 2008). Doubling is a psychodramatic technique where the therapist becomes an extension of the client, using intuition to express what the client might wish, but is presently unable, to say. The client and clinician both actively sing words, phrases, and melodies, sometimes together in unison or harmony, other times in repetition of one another. The clinician may want to make efforts to match the clients not only in emotional quality, but also in volume, timbre, and pitch of voice.

Throughout the imaginal dialogue, clients are asked to focus on creating a sense of connection with the deceased person, and to sing directly to him or her, imagining that he or she could hear them. While they sing, they can face an empty chair that is representative of the deceased. Clients are then invited to switch chairs and respond to themselves from the role of the deceased person, and can continue switching roles as needed. Clients are encouraged to freely vocalize whatever thoughts and images come to mind. The method is completely improvisational; music, words, and phrases are not planned or pre-composed. Depending on the circumstances of the loss, clients may find it helpful to ask advice or questions of the deceased and/or exchange apologies with the deceased. If the loss was sudden or the relationship was complicated, clients may find it helpful to say goodbye to the deceased. It can also be beneficial to express feelings of anger, guilt, sadness, and shame, especially regarding unresolved issues, survival guilt, and moving on from the loss. For example, a widow may feel guilty about engaging in romantic relationships with other people after her husband died, and may find it helpful to have an imaginary conversation with him to share her questions and feelings.

The intervention typically ends organically when clients stop singing. After singing, it is important to verbally process the experience with the client in attempt to make sense of uncovered emotional reactions and insights. Grounding exercises (i.e., deep breathing) can also be used to help clients transition from the intervention to the present moment, and to aid in concluding the session feeling emotionally stable.

Case Illustration

Manu was a 46-year-old immigrant from the Philippines whose younger sister, Catherine, had died from liver failure one year earlier. Already missing his family and grieving so many miles away from them, Manu was also overcome with guilt that he had not been able to bring Catherine to the United States for curative medical treatment. He believed that proper treatment could have saved her life, and that he was therefore responsible for her ultimate demise. His grief was also made complicated by the fact that he hadn't seen Catherine for many years prior to her death, and felt he never had a chance to say a proper "goodbye."

Over 10 individual music therapy sessions, Manu and I sang numerous imaginal dialogues to his sister. Early on in treatment, Manu expressed his guilt and remorse at not being able to have helped her. Below are lyrics he sang from the role of his deceased sister, where he expressed her desperate pleading for his help:

Manu, please help me; I'm so sick; Nobody could help me; Please; I want to go there; For my sickness; And suffering; Please help me; Please help me; I'm dying, Manu; Please help me; Please help me.

I supported Manu throughout this imaginal dialogue by singing with him continuously. I echoed his words and joined in on key phrases (i.e., "please help me") in harmony and unison. Over the course of treatment, Manu gradually accepted that there was nothing he could have done to save his sister. In our penultimate session, Manu said goodbye to

his sister, and started establishing a continuing bond with her as he gradually began to reinvest in his life. It was clear that he gained an acceptance of the loss, as well. Below are lyrics from that session's imaginal dialogue, where he achieved a sense of closure and also established the continuation of their relationship:

Catherine, thinking about you; Saying goodbye; It's not easy; But if it comes from your heart; It is easy to be done; Catherine, Catherine; Hold my hands; As we travel around the world; Singing, and dancing; Catherine; You smile at me; And you told me; It's time to move on, my brother; Stand up, with compassion; Stand up, with reality; I'm your sister, forever; Catherine, I'm your brother; Forever; Catherine, I love you; I love you, forever; Goodbye, Catherine; Goodbye forever; I love you forever; Goodbye, forever.

He cried throughout his singing, and we echoed each other in repeating the last phrases for several minutes. In our last session, Manu expressed that singing the imaginal dialogue allowed him to "bond" with his sister, again. Furthermore, he noticed that establishing the continuing bond allowed him to begin enjoying life for the first time since her passing. As he expressed, "I think my sister would say to me, 'Go on, Manu, go on.'"

Concluding Thoughts

The method of singing an imaginal dialogue has been qualitatively and quantitatively researched, and results are promising (Iliya, 2015). Participants found the method to be helpful in accessing, processing, and resolving feelings and issues surrounding their grief. Participants also found that adding music and singing to the imaginal dialogue made it more emotional, tolerable, and spontaneous than exclusively speaking the conversation.

Variations of the method can include bringing an object that represents the deceased loved one to place in the empty chair. Other harmonic instruments, such as the guitar, hammer dulcimer, harp, and xylophone, could also be used. Non-Western instruments and chord progressions could also be used to make the intervention more culturally sensitive and diverse. The method could also be used in a group context. There may be potential benefits of witnessing a group member sing an imaginal dialogue with a deceased loved one, as well as being witnessed by a group while doing so. In conclusion, this musical variation of the imaginal dialogue is a useful treatment intervention to help bereft individuals establish continuing bonds so crucial in healing from loss.

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Spontaneous Memorialization

Janna A. Henning

Clients for Whom the Technique is Appropriate

Engaging in a form of spontaneous memorialization for a deceased loved one can serve as an empowering act of resistance against community reactions that have felt restrictive or shaming. Furthermore, such public commemoration can provide opportunities for creativity and self-expression in the grief process, reframing the loss, restoring the bond with the deceased, seeking public validation of the loss, and facilitating connection with other survivors or communities of interest. When the loss is of an intimate other, however, additional therapeutic work is often necessary to help survivors accommodate the circumstances of the death and address possible unfinished business with the deceased.

Description

Public memorials play key roles in forming and highlighting perceptions and articulating narratives about identity, social order, and particular people and historical events. They also provide a vehicle to collect, store, and contain emotions and feelings about events or persons, as well as an opportunity to voice a protest against culturally sanctioned attitudes or policies (Breen & O'Connor, 2009; Doss, 2010). In the last few decades, memorials have evolved in response to advances in technology as well as changes in cultural expectations about emotional expression, satisfaction with “official” memorialization, and views about causality, blame, responsibility, and authority. Groups and individuals have increasingly turned to forms of *spontaneous memorialization*, such as informal rituals and customized shrines for deceased individuals within public spaces, to assist in grieving unpredictable, violent deaths (Santino, 2006). Spontaneous memorials invite active public participation, in that mourners leave commemorative items at the site of death or the home of the deceased, or remove items from the site to keep as souvenirs. They also provide focal points for communion and communication between the living and the dead, and openly evoke death in the midst of day-to-day life; as Santino noted, “Instead of a family visiting a grave, the ‘grave’ comes to the family—that is, to the public. All of us” (p. 13). Examples of spontaneous memorials include the 15,000 tons of flowers and teddy bears left by admirers at the homes of Diana, “The People’s Princess,” the many tons of photos and commemorative objects that appeared onsite within hours of the

World Trade Center tragedy, and *highway memorials*, or shrines installed at the site of traffic fatalities. These memorials, particularly in cases of tragic or untimely death, serve two functions; as *performative commemoratives*, they highlight a social problem (e.g., unsafe highway conditions) and call for change, but also reflect on and honor the unique characteristics of the deceased (Santino, 2006).

Ghost Bikes are a recent evolution in spontaneous memorialization. In 2002, after witnessing a car hit a bicyclist, Patrick Van Der Tuin smashed a bike with a sledgehammer to convey the violence of the collision, spray-painted it white, and installed it at the scene of the crash. Since then, in 22 nations and 37 US cities, memorial bicycles have been painted starkly white, decorated, and customized to honor and communicate with the deceased, and installed at the place where the death occurred (<http://www.ghostbikes.org/>). Their presence may invoke conflicts between competing agendas in gentrifying communities, bicycle vs. motorist cultures, and local laws and policies, but they function in both public and private arenas by facilitating the mourning of the bereaved while including passers-by in their call for increased motorist attention to road safety.

When a loved one has been killed on a bicycle, survivors may experience a wide range of emotions such as anger, frustration, anxiety, horror, and grief. These reactions may be ignored or invalidated by loved ones who feel uncomfortable or vulnerable when confronted by the unexpected and traumatizing nature of the loss, exacerbated by public reactions, and perhaps complicated by legal proceedings or media attention. Although the body of published research on the impact of rituals or memorials on the grieving process is very small, and there is even less published research on the impact of spontaneous memorialization on grieving, the fact that people all over the world have chosen to engage in these forms of memorialization attests to their healing power. A therapist can support a bereaved client in working through complicated grief reactions and perhaps achieving a sense of closure through the process of creating and installing a memorial. This process is described in the case study.

Case Illustration

In 1989 my partner, Patrick Thomas Stack, was struck and killed by a delivery truck as he pedaled home at the end of his shift as a bike messenger. Because at the time of his death he had been somewhat estranged from his family, who were recent Irish immigrants with a strong connection to the Catholic faith, his funeral included many elements and traditions that he would not have wanted, and the eulogy included overt criticism of him as a person. I was excluded from planning and discussion about his funeral, and was not allowed to keep any of his mementoes or belongings. He was then buried in a lonely spot in a suburban cemetery, far from the vibrant urban community he loved; his grave shows little evidence that it has been tended or cared for. My reactions in the first few years after Patrick's death included grief, symptoms of PTSD, and enduring changes in my beliefs about meaning and predictability, as well as disconnection from well-meaning friends and family who frequently expressed their desire for me to "get back to normal" and move on from the death as if it had not occurred. Over time my symptoms became less acute; yet, decades later, whenever I thought of Patrick I found myself pushing away the still-painful and unresolved aspects of this loss.

In 2010 I first spotted a ghost bike, and was fascinated by the phenomenon. I asked my research assistant, Marc Cottrell, to help me document Chicago ghost bikes. As Marc and I progressed with the project, he casually asked me when I was "finally going to get around to doing one" for Patrick. It had seemed too complex and daunting a project to attempt alone, but together we researched the news archives to identify the precise

location of Patrick's death and consulted with members of the local bike community. We discussed the potential reactions of the people who lived near the site of his death, and speculated about how to respond to negative reactions from them or my own family and friends. We purchased a used bike, sanding equipment, white paint, and a heavy chain. We conducted a brief ritual to bless the bike and thank it for its willingness to give up its useful life in order to commemorate Patrick, and to prepare ourselves for the work we were about to do. We then sanded the surface of the existing paint job, and applied three heavy coats of white paint over the entire surface of the bike over several days. On the second day we had to pause in our work to attend the funeral of another student, Rick, who had been killed in a drive-by shooting just days before we began transforming the bike. As we subsequently resumed painting, the meticulousness of the work seemed to provide a much-needed focus and outlet for the grief I felt about Rick's death. On the fourth day we decorated the bike with messages from me and my cats to Patrick, and covered it with silk ivy vines, orange chrysanthemums, and pink roses, stickers to represent his Irish heritage and St. Patrick's Day, symbols of his passionate interests in theater, astrology, and history, and an assortment of angels and white doves; I stitched a sparkling rhinestone "biker" cross pendant to the handlebars. Finally, we affixed the stenciled placard announcing his name and birth and death dates. On a late Sunday evening we escorted the bike by train to the place of Patrick's death, walked it to its new home, and chained and locked it in place (Figure 45.1).

I suspected that the bike might be removed after a few weeks (as happens with many ghost bikes), but it has remained in place for 3 years. During that time it has facilitated the maintenance of continuing bonds with those who knew Patrick, and the development of new bonds with those who never knew him but are inspired by

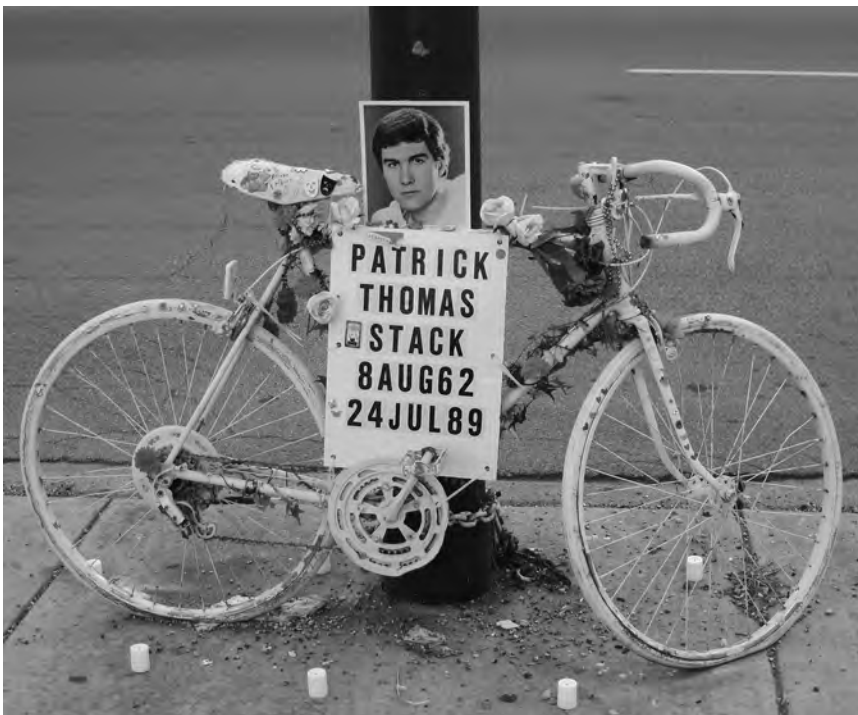


Figure 45.1 Patrick's ghost bike

his life and qualities, and by the devotion I show in maintaining the bike. I decorate it on holidays, and can see it through the windows of the train I ride to work each day. I have visited it with my family and friends; family members who knew him write notes to him on its painted seat, and others learn about him by looking at the bike and asking questions. I had wondered whether neighborhood residents would have negative reactions to this visual reminder of death in their midst; unlike the distance from death that is permitted by a grave marker in a cemetery, a ghost bike is a reminder that someone actually lost his life in this very space. However, it can also be viewed as an opportunity to reflect on the preciousness and brevity of life. On each visit, passers-by approach me with questions or comments; some have said that they pray for Patrick and his loved ones each time they pass. A homeless man shared that he communicates daily with Patrick, who “reminds him to stay sober and be good.” Two young children on a walk with their mother asked many questions about Patrick and how he died, and whether “lots of people die on bicycles.” I talked with them about safety, and bikes, cars, and pedestrians sharing the road; before they left the youngest girl pulled a Hello Kitty sticker out of her purse to more securely affix Patrick’s photo to the light pole. Recently, a neighbor attached a note to the bike: “I’ve watched dozens of people stopping at this memorial to read, look, pray, and pay their respects. Thank you for sharing your loved one with us. He is now an angel in heaven, whose name we know.”

Through my work on Patrick’s bike I have also connected with the Chicago bike community, particularly through the Ride of Silence (ROS). The ROS is a silent, slow-paced ride past each ghost bike, held each year to honor the dead and raise awareness about road safety; the riders also pause to clean and decorate each bike. I now participate each year in the ROS as the “representative” of Patrick’s bike; judging from the comments from bicyclists who offer condolences, it seems as if my presence and continued maintenance of the bike perhaps comforts them and offers hope that if they happen to be killed on a bicycle they will also still be remembered, loved, and mourned.

The process of creating the spontaneous memorial for Patrick, as well as my ongoing interactions with the bike and the communities it affects, has been deeply healing. The bike commemorates this intelligent, funny, creative, caring, loyal, passionate man, ensures that he will continue to be remembered and loved, and allows him to influence and inspire those who never knew him. Finally, the ongoing responses of the neighbors, my friends and family, and the bike community have contributed to a sense that this loss has been fully witnessed and validated. Although I actually perhaps grieve more openly now than before we created the bike, it feels more healing and satisfying, and I believe that it brings him joy to know that he is remembered through the efforts of a person who loved him so much.

Concluding Thoughts

Published research about the impact of spontaneous memorialization on the grieving process is extremely sparse. However, as I discovered through personal experience, participation in a form of spontaneous memorialization can assist survivors who are bereaved through sudden, violent death to express grief or other emotions, construct more adaptive beliefs about the meaning of the death, and formulate suggestions for social or legal change that may prevent such tragedies in the future so that the death will not be “in vain.” This process may be particularly useful as a healing opportunity for grieving when there has been a traditional funeral or forms of memorialization that have been traumatizing or disenfranchising for the survivor, or when there are conflicting or adversarial views about the death within the larger community.

Spontaneous memorialization may also provide a focal point for ongoing and communal mourning, and may include younger generations, people who were not able to participate in the formal funeral, or members of represented groups (e.g., bicyclists) who may not have known the deceased but still wish to grieve him or her as a fellow community member. This ongoing interaction between the memorial, the survivors, and the represented communities may facilitate transformed relationships or the creation of new relational bonds.

To use this intervention the therapist can help the client identify aspects of the loss that remain unhealed, assist in selecting appropriate symbols and rituals, and support the client in choosing whether and to what degree others should be involved. The therapist may also assist the client in planning each stage of the preparation and installation of the memorial, as well as any pre- or post-installation rituals the client may wish to conduct. This process may also facilitate an opportunity to connect with and be recognized by survivors of similar losses or others with shared interests; if desired, the client could be invited to research whether such a group exists and wishes to participate in the client's memorialization efforts. In addition, Neimeyer and Thompson (2014) have developed questions to facilitate reconstruction of the continuing bond that can be modified for a memorialization process. For example, the therapist may ask about the aspects of the relationship with the deceased that the client wishes to honor and sustain, joyful memories or special qualities of the deceased that invite celebration or commemoration, or painful memories that the client may wish to address or resolve in some way. The therapist may also ask the client about messages he or she may wish to convey about needed legal or societal changes highlighted by the client's death, or important lessons the death has taught the client. Finally, the therapist may want to help the client to anticipate potential community objections to spontaneous memorialization; for example, spontaneous memorials have been viewed by some as vulgar, tacky, morbid, or a health hazard (Doss, 2010). Because they are unavoidably visible in public spaces, some perceive them as a violation of rights with respect to use of public space, and some object to the persistent reminder of death in the midst of life that they represent. The therapist may then wish to encourage the client to consider public reactions that may occur, and strategize possible responses.

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Clients for Whom the Technique is Appropriate

Adolescents and adults who are comfortable sharing and expressing their feelings through social media and other technology will find this technique useful as a means of maintaining a connection to a deceased loved one. This technique is not recommended for anyone who is uncomfortable with the potentially public expression of grief online. Additionally, younger children and preadolescents may not have the knowledge necessary for creating a memorial but they may work with an adult to contribute to one.

Description

In today's digital world many people are active participants in some form of social media. People use various social media websites to express their feelings and opinions, keep in contact with friends and family, seek out new people who have a shared interest, and also to ask questions and gain information. These websites can help a person who feels isolated, either geographically or emotionally, make connections and share common experiences. Therefore, it should not be surprising that many people use the Internet and its many websites as a tool for expressing their grief of a loved one. There have been websites that focus on grief and online memorial pages since the Internet has been in widespread use. Some of the first grief-focused websites and memorial pages were started in the 1990s.

An online memorial page provides friends and families who may be scattered across the world a common place they can visit to share photos and memories, as well as provide support to each other and most importantly share their grief. Social networking has allowed people to share their thoughts and feelings with a broader audience, changing an act that some people may consider deeply private into one performed in the public realm on the Internet. It provides another way for people to maintain their contact with a deceased loved one (Walter, Hourizi, Moncur, & Pitsillides, 2011). These websites may serve as a place to share or a place to pay tribute. Some people create sites in an attempt to ensure that the life of the departed will be publicly remembered.

There are several ways to create an online website. A person may choose to develop his or her own independent website or use one of the many customized memorial sites (e.g.,

ForeverMissed.com, Legacy.com, LifeStory.com, and Tributes.com). Additionally, if the deceased had a Facebook account, that can also be transformed into a memorial page. Most people choose to use an established memorial site, which can be easily located through a web search for “online memorial sites.” Some important factors to consider in choosing a site that is most appropriate for a person’s needs include:

- *Terms and conditions.* This should provide information regarding the site’s approach and basic rules of use. It is important to establish whether the site is supportive of one’s beliefs and provides the services one is looking for in a memorial page.
- *Cost.* Many sites charge a fee to keep the website running. Some sites charge a sponsorship fee along with an annual fee for maintenance while others offer a more expensive one time “lifetime” option. Some sites are free but display advertisements on the memorial page. There are many options available to fit most budgets and some people have created a fund to which donors can contribute to in order to help with the cost of site maintenance.
- *Accessibility.* This will determine who has access to the site and what content can be shared. Most sites have settings that allow a person to manage what is posted. Additionally, some sites can only be accessed through a social networking site such as Facebook while other sites may require people to register with the site to receive access. Some people who may not be comfortable with the registration or who choose not to use Facebook may not have access to some memorial sites. Additionally, it is important to consider who can post to the site and if posts can be removed. Unfortunately, there is a category of people known as “trolls” who visit websites and leave negative and often hurtful comments. Users should consider whether the memorial site offers protections against misuse or negative posts as well as the ability to remove them.
- *Privacy.* When creating a site it is important to consider who is able to view it. Some websites allow users to control who is able to view the sites through an invitation process while others can be accessed by the general public. It is also important to consider how loved ones will be notified of the site or the ability of users to find it through search engines.
- *Bells and whistles.* A memorial site can be as simple as a description of the life of the departed or can include a variety of functions and features such as pictures, videos, music, guest books, and even the opportunity to light a virtual candle.

Another free alternative if the deceased person has a Facebook page is to provide proof of death and have his or her page “memorialized.” Doing so will remove sensitive information and stop notifications while still allowing Facebook “friends” to post condolences and messages. However, once a page is “memorialized” it is essentially closed to new people who were not previously Facebook “friends” with the deceased. As a result it limits access to the site and offers no way to make any other changes to the site, such as removing offensive or inappropriate posts.

Depending on the method of creation (i.e., private website vs. memorial-specific site vs. Facebook), development of an online memorial could be quick and simple or a significant undertaking. An online memorial provides a common virtual place that loved ones can visit at any time no matter how near or far away they may live. Online memorials provide the opportunity to share memories, pictures, and condolences as well as to share the story of the life of the deceased. Visitors to the site can return at any time, mark special anniversaries, and feel a sense of community with others who share the loss and perhaps comfort and support each other. Some sites even include additional information and resources to help people find grief support groups or grief therapy practitioners.

Case Illustration

Catherine is a 16-year-old sophomore in high school. Approximately six months ago, Catherine's best friend Anne was killed in an automobile accident. Four months after her friend's death, Catherine's parents sought treatment for her due to concerns that she was continuing to cry daily, had withdrawn from friends and family, had lost weight, and was struggling with schoolwork. During the course of treatment, Catherine expressed frustration that others were "moving on" and forgetting about Anne. She was angry with her other friends who were reluctant to talk about Anne and was particularly upset by a teacher who suggested that it was "time to get over it." Catherine reported that her greatest fear was that she would forget Anne and reported that she spent many hours in her room going through a scrapbook they had created together. She stated that she felt that Anne was "slipping further and further away." One of the few people who Catherine still felt a connection to was Anne's mother and on two occasions she had stopped by Anne's house to visit and share memories of Anne with her.

One day Catherine arrived to the session visibly shaking and in tears as she explained that the school had removed a makeshift memorial to Anne in front of her locker. She expressed her fear that Anne was "being erased from everyone's memories." I suggested that perhaps Catherine could create a more permanent memorial for Anne online. We looked at different memorial sites and also explored the option of memorializing Anne's Facebook page. I recommended that before Catherine begin creating a memorial, she should contact Anne's mother to get her approval and allow her to participate.

Catherine and Anne's mother worked together to create a memorial on a specified memorial website. They included pictures, stories, and even some of Anne's favorite songs. Anne's mother had offered to pay a onetime fee for a permanent display. Catherine described how much she enjoyed creating the memorial page and sharing memories with Anne's mother. She expressed happiness at the ability to keep her friend's memory "alive online forever!" At the next session Catherine described how much she enjoyed reading stories and condolence wishes from people who knew Anne in many different ways. She was surprised by how many people visited the site. The creation of the online memorial was instrumental in allaying Catherine's fears of forgetting her best friend. It also gave her back a sense of purpose and motivated her to start reconnecting with peers.

Concluding Thoughts

The creation of an online memorial may seem like a form of expression favored by and suited to teenagers and young adults. However, a quick visit to some of the most popular sites will demonstrate that these memorials are being created and visited by people of all ages. As illustrated in the case example, if someone who is not a relative of the deceased initiates the site, it is wise to contact family members for permission as well as with the invitation to participate in its construction. This is particularly relevant when the memorial is for a child, teenager, or young adult, as parents may object to certain photographs, stories, or music selections.

One of the most powerful benefits of the creation of an online memorial is to provide a space in which anyone, anywhere, who has computer access can share their memories, stories, photographs, and grief. Carroll and Landry (2010) suggested that online memorials

could enable or empower individuals who feel marginalized by more traditional forms of memorialization. Many people may decry the dangers of our digital society, but online memorials serve as an example of the myriad ways the Internet can keep people connected, even in their loss.

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Part IX

Re-envisioning the Loss

Dignity Portraiture

Nancy Gershman and Kat Safavi

Clients for Whom the Technique is Appropriate

Families of patients receiving hospice care, ready to begin the journey as personal historians embarking on a time-critical mission, can embrace this focusing process and the resulting transformative artifact that visualizes preferred stories. Patients may also take the lead recalling enlivening memories or be prompted to make corrections. While helpful for parents or children processing anticipatory grief to some degree, dignity portraiture occasionally encounters resistance from individuals or couples who feel a memory review depletes precious time from micro-planning in the moment, or hastens death, the ultimate separation.

Description

Processing feelings of powerlessness, sensing dread, and becoming a shadow of one's former self are rites of passage not only for patients at end of life, but for family members as well. To reclaim proof of love and loving acts, families can partake in dignity portraiture interviews, which explore the "meaning, contribution or purpose of their loved one's life" (Chochinov, 2012). When conducted by a memory artist (part digital artist, part oral historian), this interview portion enriches the quality of life around the deathbed by cataloging nearly forgotten events once associated with great joy. The resulting legacy product is an optimized portrait of the deceased composed of family photos, digitally recontextualized to appear as if they spring from these events, whether real, embellished, or imagined.

This vivid facsimile of an experience created through digital photo manipulation is designed to feel as real for the viewer as any construct formed by the limbic brain. Research shows that the "emotional brain doesn't appear to distinguish between imagined and physically-enacted experiences" and such experiences are also susceptible to an override by new learning or imagination (Kreiman, Koch, & Fried, 2000). The memory artist harnesses this phenomenon in order to imbue the viewer with a sense of ownership in generating positive memories.

The implication is that the preferred story fabricated in consensus with patients and their families overlays memories of the deceased typically associated with grief and loss (Freedman & Combs, 1996). By the very task-oriented nature of the process (storytelling, photo collection, brainstorming), the emotional mind embraces the illusion of certainty at a very uncertain time;

that is, end of life. The feedback loop elicited by anticipatory grief (i.e., reflecting back and acknowledging newly shared memory), appears to reframe negative feelings typically associated with loss: namely loneliness, abandonment, rejection, and regret.

Unless a patient is actively dying, any time is appropriate for dignity portraiture, as time is elapsing. The presence of visitors is preferred, as they are typically the archivists of sensory-rich memories and photographs, or if the patient is semi-alert, their tag-teaming with the memory artist becomes indispensable. Detailed questions about passionately held views (re: birthplace, profession, faith tradition) help the memory artist take the group's religious, spiritual, cultural, and socioeconomic temperature. Laughter, a wink, or a sarcastic snort can be a sign of an emotionally charged story positively affecting the cognitive mind. An affinity for humor and irony ensures more hormones and neuromodulatory chemicals are released into the brain, improving one's emotional state. Similarly, details conveying pleasing sounds, sights, smells, tastes, and textures are attractive to the emotional mind.

Also keenly observed is who will be most impacted by the loss, suggesting the portrait's "audience of one." If a solitary visitor keeps daily vigils with a non-alert patient, questions such as "What's your wife always reminding you about?" probe for loving admonishments (e.g., the wife who nudges her husband to use hand cream or else his "hands will get ashy"). Even if photographs are unavailable, objects can artfully stand in for the deceased, such as that tube of hand cream.

Settling on an approved direction, the artist connects the seemingly unconnected to produce a bounty of meaningful interpretations. The digital product is infinitely flexible, morphing from a framed print on the hospice nightstand to a memorial service poster to a screensaver on the home computer or smart phone. The recipient can even request a confidential modification after the loved one's death, as a peaceful means of reckoning with a truth not previously addressed.

Case Illustration

Social Worker

At age 26, Alia was processing the anticipated loss of her mother, diagnosed with cancer (Figure 47.1). Alia described a conflicted relationship with her mother, Bella, identifying the cause as her mother's inability to protect her from abuse she experienced by trusted adults as a young child in Trinidad. Alia believed that cultural attitudes caused her mother to minimize the pain she experienced. A second cause for separation appeared to be her family's deep relationship with their faith community. Although Alia was a practicing Jehovah's Witness, along with her mother, sister Johanna, and Aunt Gabby, she disconnected from church and family when she began to feel stigmatized for her diagnosis of bipolar depression.

When a failing Bella was admitted to hospice, Alia began to rebuild their relationship with deep loyalty, keeping vigil at bedside. Though dismissed as Bella's healthcare agent in favor of Johanna and Gabby, Alia adopted coping skills to further de-escalate conflict with family members who relied on God for decision-making, praying for Bella's unlikely recovery.

Memory Artist

At this time, I introduced myself as "the memory artist who makes pictures of happy memories," holding up a sample dignity portrait for Bella at eye level. Alert and oriented but noncommunicative, Bella's responses were imperceptible (although Alia was sure



Figure 47.1 Alia and Bella

that my asking Alia about creative decisions made her mother feel “My daughter will be ok”). Alia repeated my questions, and answered for Bella about Buccoo Reef and flowers in her native Trinidad; her life in Coney Island; her obsession with apples (after a deceased half sister named Apple); and her long-standing desire to be a flight attendant. Later, Alia was honored to discover that her mother shared this secret desire with her and not with Aunt Gabby.

Two days later, putting aside ill feelings in the family for the greater good, Gabby provided needed photos of Bella, Gabby, and Alia for a scenario, as I located photos from Caribbean Airlines, Tobago, and apple earrings, and composed a dignity portrait that cast the three of them as flight attendants (Figure 47.2). Seeing Bella’s preferred story brought to life, Alia later recalled: “Anyone can take a photo, but this was a condensed version of a life, another moment in time, on another level.” Months later she acknowledged that the process was helping her realize “Mom will not be there one day,” and “that her life meant something.”

After Bella died, Alia confessed that she was uncomfortable seeing her aunt’s face in the dignity portrait, and asked if I could remove it—which I did, repositioning the hummingbird to mask what lay underneath (Figure 47.3). Alia also chose not to attend a Jehovah’s Witness memorial for her mother, instead saying that the modified image would serve as her own way of memorializing Mom “with no arguing, no drama.”



Figure 47.2 The original dignity portrait of Alia, Bella, and Gabby as flight attendants



Figure 47.3 The retouched dignity portrait

Social Worker

Five months later, Alia told me, “Honestly, when I went through the interview with Nancy, maybe I wouldn’t have even remembered Mom’s dream about flying if it wasn’t for the questions she asked. The portrait makes me think about the dreams my mom had and consider it for myself.” It spurred her to think, “It’s going to happen; it’s inevitable: We all live. So what are we going to do with this life? I want to make her proud of me.”

Alia attended group therapy twice a week with others contending with grief-related depression. The dignity portrait ultimately found a home on Alia’s phone, on her computer, and in the living room with other pictures of her mother. Planning on returning to school, Alia wistfully added, “I can actually become a flight attendant; I’m seriously considering that. It would be my way of being closer to her.” If and when she had a family of her own, Alia added, “It will be good to introduce Mom’s portrait to somebody who didn’t know her.”

A form of re-parenting through art, the dignity portrait subsequently moved Alia into a space of having felt loved, returning an opportunity for mother and daughter to mend their relationship.

Concluding Thoughts

Just as hospice care is outside one’s typical experience, so is dignity portraiture, which gives this process and product its edge. It succeeds as a focusing agent because it is led by a memory artist who “keeps it real” with playful provocations and “experiences that trigger . . . curiosity and the desire to know more” (Armstrong, 2013). As a strategic intervention, it sparks families to mine memory banks for high points; revisit meaningful photos; interpret and reinterpret the idiosyncratic elements in this evolving portrait of their loved one, and share its narrative with others.

If a creative intervention means diverting time and energy away from the patient, families in a hospice setting will rarely invest in an activity they do not think worthwhile. But with dignity portraiture, reflecting back with someone outside the family brings an energy to the storytelling that speaking with those who already know does not. Patient and family are valued and heard by a witness to history—their history—restoring dignity to all.

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Drawing Images of Violent Death

Fanny Correa

Clients for Whom the Technique is Appropriate

This technique of direct imaginal exposure to death imagery through directed drawing can be used with adults, adolescents, and children experiencing intrusive images surrounding the sudden violent death of a loved one. It is important to reinforce resilience and restore positive nontraumatic images of the deceased with pictures and/or stories before exposure work with the reenactment imagery. Premature exposure to overwhelming imagery may otherwise be met with avoidance and may elicit unbearable distress. Depicting scenes of the death also may be less relevant in cases of nontraumatic loss.

Description

Grief following a sudden violent death is meaningless and beyond words. The reenactment of the dying moment may become the center of the surviving family's universe. In this quest for meaning, they are tormented with recreating the last moments of their loved one's life. How quickly did they die, and did they suffer? Every imaginable scenario is played, the script written and rewritten as the investigation unfolds. Assumptions are made by all the players in this script (the criminal justice system, the medical examiner, and any witnesses) in an attempt to make sense and build on a meaningless story. The bereaved, as helpless witnesses, are left feeling frightened and alone. What story do they tell? The horror of their thoughts—who do they share this with? Will this story also frighten the listener?

One of the remarkable ways restorative retelling (Rynearson & Correa, 2016; Rynearson, Johnson, & Correa, 2005, 2016) can help is by exposing the bereaved to these images of reenactment. The thought of drawing the images of dying can be terrifying to the client and unsettling to the therapist, whose nature is to relieve the suffering. However, the restorative retelling model helps process grief after violent death precisely because it supports the client in integrating this frightening reality. Initial work focuses on stabilization and exploring and augmenting client strengths, including their faith, support systems, and self-calming skills. The model introduces the living memory of the deceased through commemorative sessions. The sequence of sessions was designed to help restore resilience and prepare the client for the difficult work of retelling the violent death and sharing the intrusive death image.

Many clients have shared a sense of relief, an unburdening of sorts or purging of these secret thoughts and images associated with the death (Baddeley et al., 2014). To have some

sense of control over this moment and to be able to shout out loud and share what they would want their loved one to know at that moment may be a healing and powerful experience. This drawing exercise also invites the imaginary support and advice of the deceased by asking, “How could your loved one help you with these thoughts and images? What would he or she say to you?”

It is through the process of sharing the images that the intensity of the intrusive thoughts can begin to diminish.

Case Example

Maria found her teenage daughter after her suicide and so, tragically, she did not need to wait for any reports or stories to describe her daughter’s death or the scene. She was there, and the image of her death by self-inflicted gunshot was imprinted in her thoughts. Individual therapy, oriented around a slow-motion restorative retelling of what she had witnessed, included a simple line drawing in her own hand of the death scene as she encountered it. Initially reluctant to give visible expression to the imagery that had to that point lived only in her mind, Maria admitted,

The thought of drawing the death scene sounded horrific at first. How can you ask me to do this? But I am so glad I was able to do this with your encouragement. It’s like something switched inside of me, similar to on/off light switch. I don’t know why, but it helped calm my mind.

Prompting her to talk about her drawing gave her a chance to embrace and comfort her daughter, as she tearfully accepted the invitation to depict her own presence in the scene in a way that supported her child. “What would you want to say to your daughter now?” her therapist asked. In this symbolic manner, she was able once again to hold her daughter, to tell her she loved her, to tell her how much she missed her, and how sorry she was that they had sometimes fought. Engaging the story, the therapist continued, “How could your daughter help you with your thoughts and images, what would she say to you?” Immediately her reply was “Mom, it was fast, it didn’t hurt, it wasn’t your fault . . . please don’t cry. I am no longer suffering. I will always be with you in spirit.”

In a follow-up session, the client shared that through the process of drawing she was able to transcend the actual scene, and that her image of her daughter’s dying was now of her drawing, a safer image she could tolerate and, an image she often caressed and kissed.

Concluding Thoughts

Clinicians interested in this technique can guide their clients in drawing those intrusive thoughts or images, and then sensitively ask about their meanings in a way that invites clients to imagine a caring or empowering role for themselves in a scene that previously denied them that. There may be times the images will not be about the death scene. Some drawings may depict other scenes associated with the death—an ambulance, a phone ringing, a death notification, or the location where the death occurred. It is the opportunity for the dialogue and not being alone with the images that is so important.

Clients may be asked to draw the images they play over and over in their mind, and to share the drawing with the therapist or in a group therapy setting, with other members. Prompting questions might include:

- What do you imagine your loved one was thinking and feeling?
- Where would you place yourself in this drawing?
- What would you say to your loved one if you could be there? If your loved one were here with us today, how would he help you with these thoughts or images?
- How would she want you to remember her?
- Is this the first time you've shared this with anyone?
- What was this like for you?

In a group setting after everyone has shared their drawing the therapist could ask, "What was it like for you to share this with the group? As a group member, what was it like for you to hear these stories?"

As a clinician, it is important to allow time for this exercise. The drawings are not completed with the intent to analyze them but rather to share and not be alone with these images of the dying and associated intrusive thoughts. I am empowered in my therapeutic work with this technique and invite clinicians working with sudden violent death to consider learning more about it.

The restorative retelling model was developed by Dr. Edward K. Rynearson, founder and Medical Director of Separation and Loss Services, Virginia Mason University, and it continues to attract a promising evidence base for its efficacy (Rheingold et al., 2015; Saindon et al., 2014).

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49

The Dual Rose

Amy Y. M. Chow and Kurtée S. M. Chu

Clients for Whom the Technique is Appropriate

This technique is appropriate for bereaved persons who want to remember the deceased but who are preoccupied with bad memories. They struggle with a conflict between tolerating the pain in remembering the deceased and setting aside those memories, which is perceived to be hard-hearted. This technique has been used to work with many bereaved adults, including those with intellectual disabilities, feasibly and effectively. It is more appropriate in group settings, to encourage communication between members, but is also applicable one-on-one. It is contraindicated when the bereaved are allergic to flowers, in particular roses. Those who have hemophilia or any other forms of blood-clotting problems should avoid this technique, as on some occasions, the hands of the users might be scraped.

Description

By definition, the death of a loved one physically separates the bereaved from the deceased. In response, bereaved persons usually have strong yearning and longing for the loved one. Yet after repeated failures to reconnect with the deceased physically, most mourners eventually turn to reconnection through inner representations, as through memories. Preoccupation with thoughts and recollections of the deceased are common reactions to bereavement. As in the *DSM-5* (American Psychiatric Association, 2013), such preoccupation with the deceased and difficulty with positive reminiscence about them are identified as symptoms of potential disorder. Similarly, MacCallum and Bryant (2013) proposed that persons with prolonged grief are more likely to have overly general memories and difficulties retrieving a specific positive memory from the past, even if loss-related memories remain fully accessible. In clinical contexts of working with bereaved persons, it is not uncommon to hear that “I did not treat him well!” “Whenever I close my eyes, I only see his bony face in his death bed, with helplessness in his eyes,” or “I keep asking myself, ‘Why was he so cruel to me?’ He took his life. Did he think about me when he did it?”

Most bereaved persons understand that these cognitions are unhelpful or even hazardous to their health. On the other hand, these cognitions seem to be fixated as well as intrusive, and letting go of them appears to be disloyal to the deceased. As a result, the only choice seems to be to hold on to these hurtful memories or thoughts, leaving the bereaved in emotional agony.

The Dual Rose is an experiential exercise meant to parallel and represent the dilemma the bereaved face. This exercise uses a cut rose with the thorns and withered outer petals attached, the latter surrounding an intact inner bud. The rose symbolizes memories of the deceased, which have both an ugly and thorny side as well as a lovely and fragrant side. The bereaved are asked to hold the rose in their hands and look at the withered petals, simply experiencing the reactions in their body and mind. They are further asked to link these reactions with their life experiences. When negative emotions grow strong, clients are guided to break off the thorny leaves and spines of the rose one by one, imagining each to be a memory they find hurtful. Similarly, the withered petals are removed, each symbolizing another, perhaps less troubling memory, which nonetheless gets in the way of recalling the best parts of the relationship. The thorns and petals are placed into an attractive dish or bowl filled with water. After this “plastic surgery” for the rose, clients are asked to hold the rose again and to carefully inspect its beautiful inner petals and smell its fragrance. Though the thorn and withered petals symbolize the bad memories, they are asked to gaze at the water basin and cultivate a new perspective on these elements of the relationship. Often, even these will then appear to have their own beauty (Figures 49.1 and 49.2).



Figure 49.1 The Dual Rose: Removing thorny and withered parts of the rose to reveal its inner beauty



Figure 49.2 The Dual Rose: The water basin with thorns and petals

Case Illustration

Annie's husband died in his sleep from a heart attack several months before she sought services in the bereavement support center. She was sharing the bed with him and was awakened by his shout in the middle of the night. She then saw the face of her husband in agony and within seconds he lost his consciousness. She at first was shocked into inaction, but eventually managed to call the emergency line for help. An ambulance arrived in 15 minutes, but that seemed to be an eternity for her. The medics attempted CPR on her husband, but were unsuccessful in resuscitating him. Together with her husband, Annie was taken to the hospital where she received the bad news of his death after 20 minutes of further resuscitation efforts.

When I first met Annie, she was preoccupied with thoughts of her husband, in particular the final image of his helpless face in their bed. She kept asking, "He was asking me for help. Why was I so stupid and unable to save him?" She sought psychotherapy for her traumatic symptoms, but this intrusive memory could not be eliminated by the prolonged exposure intervention. She kept sharing all the bad memories with her husband, including the recent quarrels they had as well as the exhausted look of her husband after work. Annie considered all these as signs of help seeking, which she had mindlessly ignored. In consequence, she was immersed in self-blame for her insensitivity to him.

I then invited Annie to perform the Dual Rose experiential exercise. Without a second thought, she agreed enthusiastically, and shared that "He sent me roses all the time!" I asked her to hold the stem of the raw rose in her hands. Immediately, she felt the pain and said, "Ouch! There are thorns. Why are you asking me to hold this rose?" I nodded my head and followed with a question, "Yes, why am I asking you to 'hold on'? Can

you guess?” She furrowed her brow in thought, but appeared unable to find an answer. I then suggested that she simply feel her reactions in holding this rose, and to connect this feeling with her daily life experience. Her eyes reddened and tears fell. Finally, she muttered softly, “I can’t let him go!” At that moment, I asked, “Is it necessary to continue to hold the thorns to keep him?” With dawning insight she asked, “Can I keep the rose but take away the thorns?” I immediately responded affirmatively, “It is really your choice!” I invited her to pluck the thorns and the withered petals and release them into the basin of water. Doing so, she commented that, “Now, it looks better and can be held comfortably.” I suggested that she gaze at the rose and smell its fragrance. She responded with a smile, “That’s a smell that I have forgotten for quite some time. I still recall the first time he sent me roses . . .” and followed this by a train of positive and sweet memories with her husband. Continuing, she noted, “If I don’t take away the withered petals, I will never realize the inner beauty of the rose. How stupid am I in holding onto the negative memories that are hurtful to both myself and my relationship with my husband!” Before leaving, Annie took a look at the water basin that held the withered petals and thorns. She then added, “Probably, if these are taken away and being viewed from another perspective, they might not be too bad.” She held the thornless rose in her hands and left with a smile.

Concluding Thoughts

Most counseling approaches use verbal communication as the only tool. But bereaved persons who are overwhelmed with disturbing memories or thoughts might not be able to process all the messages in a therapeutic dialogue. Experiential exercises therefore can help to center bereaved clients in fundamental sensations such as touch, smell, and vision. They also engage bereaved people’s own capacity for self-healing, as the insights are generated within themselves, with the therapist as a facilitator.

The use of simple materials, like roses in this case, that exist in the environment of the bereaved can have added value. Whenever they see or smell a rose, the message of “letting go of the thorns” and “having a choice” will re-appear in their mind, generalizing the effect of therapy beyond the counseling room. This exercise has greater impact when used in a group setting, as the messages will be reinforced among members.

For those who lost their loved ones through sudden or traumatic circumstances, it is not uncommon to find intrusive memories around the death. Though there are psychological approaches that can help to reduce general traumatic imagery, the situation for those bereaved by traumatic death is more complicated. On the one hand, they find the intrusion genuinely anguishing. Yet on the other hand, they believe they have to hold onto the memory of the deceased as a sign of loyalty. The ability to differentiate good and bad memories of the deceased is often weakened in the bereavement process. Thus general techniques for mitigating traumatic symptoms often fail with circumstances of traumatic death. Very often, it is actually the choice of the bereaved persons to hold tight to such memories. The Dual Rose exercise helps the bereaved to visualize the differentiation of good and bad memories and recognize their autonomy to choose. In some cases, they choose to keep some bad memories of the deceased as a reminder of lessons learned in this experience. Provided they also have access to good memories, the inclusion of some bad memories is fine.

A colleague once asked me about the consequence of witnessing the inevitable withering of the “beautified” rose when the client carries it home. In my experience, most bereaved persons who observe the rose’s eventual deterioration shared their awareness of impermanence of all things, providing further food for thought. Tracy, an exceptional client, proposed another

direction. She worried about the withering of the rose, and therefore put it into a desiccator to preserve its shape and color. She then framed it in a 3-D photo frame, which she placed on the wall of her bedroom. It was a wonderful metaphoric representation of framing the good memories and placing them specifically in the bedroom! Our bereaved clients are sometimes more creative than we imagine, using our ritual interventions in ways that carry unique personal meaning.

“A rose is a rose is a rose!”

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Photographing Relationships for Remembering

Judy Weiser

Clients for Whom the Technique is Appropriate

Actively planning photos together with loved ones about to die can be very helpful in preparing for, and sharing, anticipatory grief—not only for the survivors being “left behind” but also for the dying person. However, doing so may be inappropriate when the relationship was characterized by severe ambivalence, oppression, or abuse, or when the press to memorialize the relationship may mask hard feelings.

Description

Planning and taking new snapshots of oneself together *with* the person who is dying not only provides survivors with comfort after that person is gone, but also while viewing, discussing, and enjoying these with that person before the death. Shared moments with the photos let families or friends revisit their good times together and explore and discuss what this bond has meant to them in terms of the meaning and value of life.

These kinds of photos also comfort dying people with needed reassurance against the fear of being forgotten. They can see for themselves inarguable proof that they are loved, that their life has mattered to others, and that they will be missed and will continue to be remembered. Actively participating in the creation of photos of themselves with loved ones gives them a way to have some control over what part of themselves they want to “leave behind.”

The benefit of this activity is found not just in the photographic results, but also in the sharing of time during and after this mutually enjoyable activity while planning, creating, viewing, and later discussing the results.

Although such photo-taking activity can be planned in advance, it is nevertheless only lightly structured, and can happen “on the spur of the moment” in any spontaneous camera-ready instant, as it does not take much time to click a shutter. People can simply arrange to have a third person take photos of them together with a loved one, or even take “selfies” with camera phones in hand (or on tripods). Even if the dying person feels he or she does not look “proper” for a photograph, representations of them can be used, for example their hand joined with another’s could easily suffice.

All that needs to happen is for those who are dying to ask loved ones to pose together with them in a photo and/or for the loved one to ask for a photo taken together with the person who

is dying. This can be done as an open-ended (“anything goes”) assignment or by using some of the suggestions given below to help get the process started (after which it usually evolves without further guidance).

The photos can be done all at one time or spread over days, weeks, or even months (if months remain). They can focus on only faces, entire bodies, and/or with additional props. If it is easy for the dying person to move around, these can be done in various special places they have been together with their loved one; just about anything in any place at any time can produce strong and delightful memories.

No photographic ability is needed and simple cell phone cameras are sufficient. The goal is to capture time together and not just the dying person alone, and in a variety of moods that capture the remembered moments (i.e., “funny” is also fine).

The remaining step in using this technique consists of viewing and discussing (and sharing with others, if desired) the photos that both parties feel really captured their bond. If desired, a deeper probing can take place by asking additional questions (such as those suggested below), but this is not required.

If it is difficult to begin, then the two can just take photos that (a) recreate each person’s memory of their earliest encounter, (b) show them at their best and worst times together, (c) depict their most serious or silly moments, (d) tell the story of their relationship as it grew, (e) situate them in places (or with items) of special significance to them, and so forth.

If it seems a bit awkward to begin talking about the photos later, this conversation can be prompted by questions such as “How do you think we might title this photo of the two of us?” “What would it say to us if it could speak?” “What do we each think of when we see this?” “What sorts of feelings does it contain?” “What kind of memories does it trigger in us?” “What does it show us of our special connection?” “Is there anything in it that we might want to change to make a new photo even better?” “Is there anything missing in it that we might want to add when taking a new one?”

If desired, this process can be taken deeper by taking photos (or talking about) topics such as “What will I miss most about you or about us?” “What do you want me to know about us?” “How has our relationship affected both of us?” “What has it meant to us?”

Case Illustration

On my first visit with my new husband, Martin, to his family far away, I met most of his relatives. Martin’s mother and father were in good health, and his grandmother Betty, who lived with them, was 85 and also seemed in good spirits, but her body was frail and his mother told us that Betty had a bad heart and could “go” at any time (though no one had told her this, as they saw no reason to depress her). Martin was Betty’s favorite grandchild and she made sure to tell me this at least once daily; they had a strong and loving bond.

Because Martin had long been the “family photographer,” he took lots of pictures of all his relatives during our visit—both individually and in groupings, but rarely included himself unless a picture of the entire family was taken by an outsider like me. He told me that it was most important to him to get photos of all the others, as we lived so far away and could only see them every year or so—and that he particularly wanted to make sure to get several of Betty, due to her poor health.

After accidentally encountering them several times alone together deep in conversation (and love), I began to snap photos of the two of them together whenever I could, as there seemed to me to be a special energy between them that I had rarely seen Martin

express other than with me. He didn't like this at first, reminding me that he "didn't photograph well," but I told him it was their relationship I was trying to capture, not him or her specifically. He said if I could keep doing this but he didn't really want to look at himself in the photos.

A few weeks after we returned home, we learned that Betty had passed away peacefully in her sleep—and my husband was in deep distress. He kept looking at the photos he had taken of her and took pleasure in seeing her happy there. But, he said, those photos were a bit "empty" to him and he could not figure out why. I told him that to me, those were photos of her, and that what I had really treasured were the photos I had taken of the two of them, together—and asked him to let me at least show him my favorite one of those I took.

He agreed, and I brought him the one shown in Figure 50.1. For me, the love between them was strongly evident in the shot, and her love and pride in him being there with her that day showed in her eyes and smile. That they adored each other seemed obvious to me, and I hoped it would to him, also.

He looked at it in silence for a long time, and then began to sob, telling me that he missed her very much, but that he hadn't realized how much he would miss their "together times" that I had captured in that photograph. He told me, "When I see that photo of the two of us together, I know our relationship is still alive, even if she isn't, and that just brings me so much relief from the pain of losing her. But it's not just her that I miss—I miss US, too!"



Figure 50.1 Betty and Martin. Copyright Judy Weiser

Concluding Thoughts

People often want to take photos of a person who is dying, but find later that it is more important for them to have taken and kept photos of themselves *with* that person, because their opportunity to share more experiences together has also ended and thus must also be grieved. I therefore encourage people to plan, create, and discuss photographs of themselves with a loved one who is dying, which can also be useful for the dying person.

Finally, although this activity is especially useful with grief and anticipatory grief work, *it can be just as valuable in everyday life*. I strongly recommend that people not only take lots of photos of their loved ones, but also take lots of themselves together *with* those loved ones, as we never ever know what twist of fate might remove them from our lives suddenly and unexpectedly. Preserving images of togetherness, while there is still time, helps preserve that precious bond.

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51

Healing Flowers

Lara Krawchuk and Terry Sturmer

Clients for Whom this Technique is Appropriate

Clients of any age who are experiencing significant relationship losses can profit from this technique. Healing Flowers can be used with a group, family unit, or individual clients. A strong therapeutic alliance and some prior exploration of the impact of their tangible and intangible losses is strongly recommended before embarking on this technique, as powerful emotions may be elicited, and exploring the potential for growth may fall flat if done before the pain of losses have been deeply honored.

Description

Relationship endings bring about a host of living and ambiguous losses that are frequently underrecognized or ignored (Attig, 2004). Ambiguous loss occurs after a break-up when a former romantic partner is physically absent, but psychology present (Boss, 2010). Former connections may be severed in some ways, but necessarily sustained in others, particularly when children need to be co-parented. In addition, a slew of expected and unexpected concrete losses, including role changes, financial strains, loss of home, and altered friendships can add to the profound loss burden borne by individuals and grieving family systems. Sadly, few formal rituals exist to support families in grieving significant losses. Expressive arts can foster healing from loss, by facilitating meaning-making and revising the attachment to the person after the ambiguous loss of a break-up (Boss, 2010; Thompson & Neimeyer, 2014).

Healing Flowers was developed to support recovery from relational loss. In this simple yet powerful technique clients create two tissue-paper flowers. Flower 1 represents the most important people, places and things that filled the client's life while still in the relationship. Flower 2 represents their current situation, including a representation of how the relationship with the former partner and other significant objects has shifted. Together client and clinician compare and contrast both flowers to understand the unique meaning of the many losses and explore the reconstruction of a life post break-up and the posttraumatic growth that is possible (Bowman, 1999).

Case Illustration

Allison is a 35-year-old woman who came to see me (LK) related to a long history of devastating losses and few reliable familial supports. She and her husband shared a home and three dogs. After 9 years of marriage, they had reluctantly made the painful decision to divorce after it became clear that their goals and interests in life were incompatible. Though Allison considered her husband a dear friend, she no longer wanted to stay married. The two went through an amicable mediation experience and eventually papers were signed. As the divorce decree became imminent, Allison began to experience significant grief and anxiety related to her fear that she was losing “everything” and would be incapable of building a meaningful life for herself in which she could thrive. After processing her grief for many months we agreed to try Healing Flowers to honor the depth of her losses and the real possibility that she could build something different yet beautiful for herself going forward.

To create the flowers I offered Allison two pre-made packets of squares (approximately 5 × 5 inches) of different colored tissue paper, a small decorative glass “stone” (typically used in the bottom of a fish tank), and a small rubber band. Each packet was identical and contained 12 different paper colors. I told Allison that the small stone represented her and that she should select a tissue paper color to represent her husband. She chose light blue because she felt it represented his calming influence for her. I asked Allison to select other colors to represent the people, places, and/or things that were important to her through her married life. I suggest that clients select up to 10 colors for this exercise to keep the size of the flower manageable. Allison chose yellow to represent her dogs, purple for her work, red for her friends, white for her father and sisters, green for her home, turquoise for her professional helpers, and orange for travel. I asked her to place the sheets of paper in order from most important or present in her life (while married) to least. She placed her husband, dogs, friends, home, work, professional helpers, family of origin, and travel (Figure 51.1).

She told me that she chose white to represent her family of origin because she needed them so much, but that they were almost invisible. She cried as she reported that it made her very sad that they were less important to her than her professional helpers who she felt she could better count on for support. She cried as she recognized the very important place her husband had held in her life and also the deep pain of knowing she would lose the home they bought together and that she could only take one beloved dog with her. I wrote down a simple “reminder” ledger reflecting Allison’s color choices matched with the significant people, places, and things from her life. Mostly, I listened deeply, expressed my understanding and support, and allowed her the space to work through her memories and acknowledge the depth of her losses. Gradually, Allison crafted the flower by layering colored squares of tissue paper around the glass stone. She carefully placed colors representing her closest relationships nearest the stone representing herself. After all the chosen colors were used Allison secured them with a rubber band wrapped around the colored stone at the base of the flower. She smiled deeply as she carefully examined the flower representing the beauty she attributed to her life throughout her marriage despite its many challenges.

After allowing time for Allison to process her “old life,” I suggested she create a second flower to represent her life after the divorce. She hesitated. This was so hard! I gently



Figure 51.1 Allison's initial selection of papers to represent her life before her divorce

encouraged her to try this and see what came from it. I told her she could re-order or alter the tissue paper in any way she needed to reflect her current life. I also encouraged her to add new colors to represent any additions to her important people list. She sighed deeply, referred to the “reminder” ledger to help recall her color choices, and got started. Allison looked at her chosen colors and added hot pink for her favorite dance class and brown for her meditation group. With tears in her eyes she got to work gently placing the tissue paper in an order reflecting the new state of her life. She ripped her yellow paper (representing her dogs) in half to represent the splitting up of her canine family. She placed the sheet representing the dog she would keep next to her and the other half further out from her self stone and next to her soon-to-be ex-husband in the flower. She

crumpled and ripped her white paper (representing family of origin) to acknowledge her painful realization that they had failed to support her through this arduous divorce journey, but that she could not pretend they meant nothing to her. She folded the white sheet until it was small and folded it behind one of the papers near to her center—close to her core, but small and tucked out of view. She next moved her friends, helpers, and healing groups closer to her center stone. She removed the green paper (representing home) to show her need to move out after the divorce. Finally, she hesitated several times as she decided where to put her soon-to-be ex-husband. How did he fit in her life now? Where did she want him? Eventually she crumpled the light blue paper and then placed him in her new flower after friends, her favorite dog, and professional helpers. She shared that while he was still an important part of her life as a friend, she could no longer have him next to her very center.

Allison wrapped and rubber banded the base of her flower, then looked at her two flowers side by side (Figure 51.2). Tears dripped from her nose. A wistful smile played on her lips. We sat in silence for a moment as she looked at and touched her creations. Finally I asked what she saw, what she felt. She looked at me and quietly shared that she could see beauty there in the flowers. She saw the colors of her old life and some new ones as well. She saw that her husband was still there, but that there was room for new people at her center. She said it still broke her heart to move out of her home and split up her doggies, but that she was thinking she might adopt a new puppy she would raise on her own and help keep her company. She saw that beauty and pain could coexist and this was a comfort she would hold near when the pain of her losses felt overwhelming.



Figure 51.2 Allison's pre- and post-divorce flowers, held side by side

Concluding Thoughts

When losses are ambiguous and disenfranchised it can be helpful to create something tangible to honor grief and offer a glimmer of the beauty that still exists despite the pain. In Allison's case, it was powerful to validate her pain and explore the meaning of her losses while offering a visible reminder of her potential for growth, at a time when she felt unsure and vulnerable. Though she needed a bit of encouragement to take the risk to re-order her flower, she found that once she got started, beauty and growth were within her grasp. She also symbolically revised her attachment to her family of origin who had been unable or unwilling to support her grief journey through the process of her divorce. Finally, her second flower provided a reminder that her ex-husband could remain a visible presence though the terms of their relationship have been drastically altered. It was heartening to see that while discussing the meaning of her flowers with me she came up with another good idea (adopting a puppy) for further enriching her life after the divorce and move. We explored the idea of creating a third flower in a few months to explore the ways in which she grew again after the divorce finalized and she moved into her new home. Allison liked the idea of creating a vase to hold her flowers and bear witness to her loss and growth over the course of her marital relationship.

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Part X

Mobilizing Systems

Expanding the System

An Hooghe and Lieven Migerode

Clients for Whom the Technique is Appropriate

Inviting significant others to join in grief therapy might be especially important for all bereaved who feel estranged from their natural support network. Bereaved individuals who feel connected with others in their common loss might have the need for more intimacy in their grieving, requesting an individual therapy.

Description

Most grief therapy assumes an individual approach, giving the bereaved the chance to build a therapeutic relationship with the therapist, to tell the story of the loss, and to search for meaning in the experience and in their changed lives. However, theory (Hooghe & Neimeyer, 2012), research (Burke et al., 2010), and clinical practice all suggest the importance of the broader natural support system. Most grieving is done in context, as significant others are grieving the same loss from a different position. Moreover, grief both influences and is influenced by significant relationships (Hayslip & Page, 2013; Hooghe, Neimeyer, & Rober, 2012; Stroebe, Schut, & Finkenauer, 2013). However, many bereaved clients feel lonely, unsupported, and even isolated from their family and social context. Accordingly, a family or contextual approach to therapy would be a logical course to follow. Why then is it not the most common practice to invite other family members or people from the natural support system to create or enhance support for the bereaved person who requests psychotherapy? In this chapter we consider two possible challenges to expanding the system in grief therapy, consisting of hesitations residing in the therapist and those residing in the client.

Hesitations Residing in the Therapist

First, many therapists feel insufficiently equipped with systemic techniques or competencies to orchestrate a conversation with several people at the same time. How can one give enough attention to all those who are present in a short amount of time? What should I do when they do not agree (or fight) with each other, or have very different experiences or ways to deal with the loss? However, it is worth noting that inviting others to join the therapy does not

automatically mean the same as marital or family therapy. Much can be accomplished simply by following the straightforward procedures illustrated below.

Second, the conceptualization of grief as a systemic process as well as an individual one is not well developed in the bereavement literature (Stroebe et al., 2013), so that it might not occur to the therapist to invite the participation of the larger system in the therapy. However, we believe strongly that relevant others benefit from inclusion, as does the client initially requesting services. Broadening the system in this way both reveals how one person's grief influences that of the others, and opens possibilities for evolution of the family's stories of the loss while listening to similarities and differences in their grieving.

Hesitations Residing in the Client

A second challenge to expanding the system arises from hesitations residing in the clients themselves. In many cultures, bereaved clients request an individual session. Often they feel stuck in their grief, and disengaged from the people around them, not having others with whom to share their deep desolation. Ironically, under these conditions the clinician's suggestion to invite others at the outset of therapy often encounters client resistance: "My husband doesn't need therapy, he feels fine," "I don't want to burden my children with my grief," or "There is nobody who understands the way I feel." Further in the therapy process, inviting others to join often becomes even more challenging: "I feel very much understood by you. Why would I want to jeopardize that?" or "My family members don't know that I've been seeing you for a while now," or still more problematically, "Since I started this therapy, the lack of empathic support from my family members feels even more obvious to me, and is getting worse." This escalating reluctance is one reason we routinely invite family members to the first session, countering iatrogenic distancing in the natural context. In fact, we could legitimately wonder if those bereaved who call for an individual session, expressing their loneliness in grief and the disengagement from others, might particularly benefit from joint sessions that expand their natural support system. Moreover, given the fact that we as therapists are only temporarily present in the lives of our clients, and that we cannot be physically present to support them in their daily lives, we need to seek ways for their natural context to become more supportive.

Inviting Others to the First Session

In our experience, the request to involve others is preferably made in the first contact, usually the telephone call in which a first appointment is requested. Inquiring about the caller's support network, the therapist immediately gets an idea of the presence or absence of such support. However, simply inviting others to come rarely is persuasive enough to overcome the client's prevailing hesitations. We therefore find it helpful to ask if they could ask someone who they feel loved by to come along for the first session, to help us as therapists to better understand the concerns they have, and to have a dialogue about what might be needed to provide help best fitting their concerns. This approach, inviting others to help the therapist to better understand, fits with the limited mandate given to us at that point.

A First Session with a Client and an Invited Other

Seeing the bereaved for the first time accompanied by others, who usually have been close to this person for a long time, and have witnessed the grieving process since the loss (or even during the time of illness), is extremely helpful for the therapist. In this first session, the therapist usually gets a good notion of the complexities related to the grief story, embedded in its own family and social context. In this first session we want to explore the concerns of everyone, and formulate, in dialogue, possible goals and ways to help. Nevertheless, in our experience it is

very important to remain aware of the limited mandate that is usually present and the fact that we are the ones who invited the others to this session.

In beginning an initial session, it is important to welcome both or all participants, especially those who came at the therapist's request, without assuming that they came because they too need help. Not doing this often creates a trap, in which the couple or family resist the presumption that they need therapy, or that their marriage or family relations require professional help.

Finally, exploring all participants' hesitations related to talking about grief, or the good reasons people have not to talk about the loss, is very important to understand the dynamic of talking/not talking in an intimate relationship (Hooghe, Neimeyer, & Rober, 2011). Especially in the case of couples therapy, exploring differences between the two partners and accepting both their needs opens room to talk about the struggle and pain resulting from the difference.

Case Illustration

One morning, Carla called me (AH) with a request for therapy. I asked her if she could tell me in a few sentences why she was looking for therapy. She said that she lost her baby 5 years ago during labor, and that she felt stuck in her grief. I asked her if she was still in a relationship with the father of this baby. "Yes, but he doesn't understand my grief . . . and he doesn't need therapy himself . . . it feels as if he doesn't care." I asked her if she thought she could invite someone who she felt supported by for this first session, to help me, as therapist, to better understand her concerns and the help she needed. She was thoughtfully silent for a while and then she responded, "Okay, then that needs to be my husband. There is no one else." She repeated that her husband did not have a need for therapy, but maybe he would be willing to come along this first time.

As I listened to Carla, even these few sentences on the phone brought to light her experience of feeling unsupported in her marital relationship and the apparent scarcity of supportive others. Nevertheless, I realized that neither Carla nor this couple had requested marital therapy, and that the only mandate I had was the one they would give me. In such a telephone conversation, we find it even more pivotal to involve others and look for possibilities within the natural support system, avoiding the client's development of dependency on me for all support. Furthermore, from a systemic approach, it is possible that the lack of support Carla experienced could be connected to the way her husband also grieves the loss of his child, and to the way their grieving influences each other mutually. The following excerpt from the first session with Carla and Tom illustrates this stance.

An (therapist): Welcome to you both. I'm glad you (nodding to Tom) came along. Your wife, Carla, had called me. At first (looking to Carla), your request was to come alone. And it was me who asked for you (Tom) to come along. I asked you to join us from the perspective that you might help us, or me, to better understand why Carla took the initiative to call me. Probably the people around you (to Carla) know you best, or might be best suited to help reflect on where you come from, and where we would need to go, or where you feel stuck. So that is why I asked you (Tom) to come along. This is something I usually ask people, to bring others along.

Carla (laughing): If you want me to bring more people . . .

An: Well, some people bring their mother or sisters, or . . .

Carla: My mother wouldn't be the right person to come along. She would even cry more than me.

In this first session, Tom went on to emphasize that he did not need any professional help. He continued with his life, and tried to cope with the loss in his own way. Talking about the loss made him feel worse, and, moreover, he did not know what he could say to make it better for himself or his wife. I further explored his feeling of incapacity to support Carla. He wanted to help her to “go on” and enjoy their relationship as they used to do. Not talking about the pain seemed to be his way to protect their marital life. In contrast, Carla wanted to strengthen their connection by talking about their emotions. She needed Tom in these conversations, or in the sharing of her grief, because she felt that her husband was the only one who truly understood the emptiness she felt. Now, 5 years after the loss, there seemed to be no one else to share her story. We talked about how they differed, and how they both seemed to need each other in their own way.

Near the end of the session we talked about Carla’s need for help, and how they both understood this request. Tom said he felt very thankful to be invited for this conversation, as he finally could explain his own view on the need for help for Carla. Again, he stressed the fact that he did not need any professional help, but that he was willing to participate in future sessions, when that would be requested by his wife or me. If he could be helpful to her and their relationship, he was willing to join her, and listen.

Concluding Thoughts

From a systemic perspective, the advantage of inviting significant others when a request for grief therapy is made seems self-evident. However, reluctance to include others often arises. These hesitations are important to take into account for a better understanding of the relational context of bereavement (Hooghe et al., 2011). More research is needed to grasp the interactive dynamics involved in grieving within the couple or family relationship. Phrasing the invitation to participate in therapy in terms acceptable to all participants opens the door for such research as well as practical intervention.

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The Bereaved Sibling Interview

Alba Payàs

Clients for Whom the Technique is Appropriate

Parents who have lost a child and have surviving children who present behavioral and emotional difficulties can benefit from this interview structure. The technique is not to be used too early in the therapeutic process, either for very recently bereaved parents or for those who exhibit overwhelming emotional responses due to a highly traumatic death. The interview requires a strong therapeutic alliance that can withstand the possible emotions that can arise, and a contract for ongoing therapy, so that it can be complemented with other intrapsychic, interpersonal, and psychoeducational interventions.

Description

The death of a child is a devastating experience for a family. Parents often feel overwhelmed and struggle to manage their pain. Secondary emotions such as anger, fear, and uncontrolled sadness may appear, leading the parents to react and displace those emotions to the surviving siblings in the form of irritation, overprotection, or turning to them for comfort. Parents may also become very busy to reduce their anxiety, or minimize contact with surviving children, in order to protect themselves from the pain of possible further losses. All such reactions are commonly identified when working with bereaved parents, and represent unconscious efforts to protect themselves from the pain of the loss they have experienced. Yet these same protective strategies can have a devastating effect on other family members, especially on surviving children and adolescents. Siblings have to face not only the absence of a brother or a sister, but also the partial loss of the parents who are no longer available to them. This loss constitutes a secondary or cumulative trauma that may harm them more than the primary loss (Payàs, 2010).

As a response to their parents' repeated failure to attend their needs, siblings often react with a range of emotions, behaviors, cognitions, and even somatic responses that form a pattern usually labeled as "disruptive." This pattern represents the natural survival reaction of the youngster to adapt to this secondary loss.

In therapy, parents commonly share their overreaction responses and may listen to the psychoeducational information that the therapist gives in form of advice, which they understand at a cognitive level. However, they frequently do not have the emotional capacity to follow it.

The Bereaved Sibling Interview (BSI) is a technique I developed, inspired by such intrapsychic methods as the *Father Interview*, the *Empty Chair*, *Script-cure*, and *Therapy of an Introjected Other*, which originate in different humanistic approaches and classically are used in Integrative Psychotherapy (Erskine & Moursund, 1997; McNeil, 1976; Payàs, 2010). The BSI aims to give to the parent an integrative understanding—including somatic and emotional dimensions of the experience—of the siblings' needs, and also clues about how to better respond to them.

When enacting the perspective of the adolescent, the parent temporarily sets aside his or her sense of self and assumes the character of the son or daughter, thereby making it available for inquiry. The client takes on the characteristics, beliefs, feelings, memories, hopes, fears, and needs of the child for the time of the interview. Instead of the therapist interpreting and pointing out the son or daughter's needs, the therapist facilitates the parent's subjective experience of the sibling's inner world. The parent must search for the answers to the therapist's questions using the cognitive, emotional, and even somatic frame of reference of the sibling. At the same time the therapist has to ensure that the parent is mindfully present also, and is not over-identified with the child, that he or she has a clear awareness that "I am not my child."

The interview may have to be repeated in order to have a complete overview of all the aspects of the family's dynamics that have been affected by the loss. The case example below includes only the aspects relevant to the particular family at a particular moment of their process. In preparing a BSI intervention the therapist may decide simply to deal with a particular behavior or dimension of the difficulty expressed, taking into account the level of insight, ego strength, time of the sessions, and other relevant variables for the couple or the individual. It is not a technique that can be improvised and it needs forethought and relevant training to determine areas to explore and which questions are likely to produce insight for the parents. The following represent the key steps of the BSI.

1. Explanation and Contracting

Because BSI sessions have to be scheduled with enough time for preparation, the interview itself, and closure, a 90-minute session is optimal. When working with both parents, the therapist may conduct both interviews (father and mother role-playing the same child) in the same session. Preparation includes an introduction to the technique, its aims, and how it works. The parent has to accept and assume the role of the teenager and maintain it during the entire interview, which may vary between 20 and 50 minutes.

2. Role-Playing the Child

The therapist encourages parents to set aside their own perspective and take the daughter or son's subjective experience, inviting them to feel, move, think, and talk as the sibling. In doing so the parent will be able to more fully connect with the youngster's personal characteristics: ways of feeling, thinking, experiencing. The therapist invites the parent to "be" the adolescent, not to "pretend." This intersubjective experience between the parent and child is induced by the therapist's language: using a tone adapted to the child's developmental stage, repeating his or her name frequently, and signaling the emotional, somatic reactions and gestures that clearly belong to the child. Although the parent usually starts with a sense that playing the role is artificial, very soon "the child" is psychologically present in the room.

3. The Interview

The questions selected by the therapist will depend on the age of the child, the difficulty that is being addressed, and the material that may appear during the interview. The therapist must

keep in mind that the aim of BSI is to allow the parent to understand, discover and acknowledge the etiology and adaptive function of the child's disruptive thoughts, behaviors, or emotions. Its aim is not to treat the enacted youngster. The constant validation and respectful nonjudgmental inquiry of the therapist to both parent and enacted sibling will become a model for the parent in future transactions with the child.

4. Closing

The therapist must ensure that the parent can de-role appropriately and reconnect with him- or herself for closure of the interview. Using a change of chair, encouraging a change of posture, addressing the parent by his or her name, and altering one's tone of voice are strategies that help the parent regain self-contact. The implicit confrontation underlying BSI can evoke emotional reactions that the therapist must explore and support in closing. Talking about the experience, inquiring about what parents have learned that was unknown to them previously, and what course of action should be taken to meet the child's needs all need to be addressed. The closure of the session does not involve prompting a further conversation between the sibling and the parents, or direct inquiry with the child regarding "missing information." Instead, the rest of the session is to be directed toward a full integration of the material revealed in the BSI.

Case Illustration

Manuel and Carmen lost their eldest son Javier a year ago after a struggle of 12 years with cancer. The experience had been traumatic as Javier had several recovery periods when hopes were raised, followed by relapses that led to the despair and exhaustion of the parents. They had three younger girls, and Cristina, 16, had been displaying outbursts of anger, overweight, loss of motivation for her studies, and signs of depression. The relationship with her mother was very difficult. This was the first BSI I used with this couple and was suggested at the seventh session. I began the BSI by addressing both parents in the transcript that follows.

Therapist (T): You were telling me how worried you are about your daughter, Cristina, since the death of her brother. In our previous sessions we've been talking about her difficulties, her constant outbursts of anger, her disruptive behavior, and how difficult it is for you to deal with her at home. We need to understand her subjective experience in order to help her better, and we have seen how difficult it is for you to deal with her reactions. Therefore, today I'd like to suggest an exercise that will help you to understand how your daughter is feeling at this present moment. Instead of discussing her behavior, we are going to try to explore it from within. It is an exercise about empathy, about being in her place, as we say, to walk in her shoes. You understand what I mean? I need your permission since it will involve the participation of you both. One of you will have to play Cristina's role. And I, as someone unknown to her, will ask questions about her experience, and you will try to respond as closely as possible to what she would think, say and feel.

Let's start with you, Carmen, since it seems it is on you that she is displacing all her difficult feelings. And you, Manuel, I'd ask you to silently watch and also be aware of your thoughts and feelings. Your presence is very important in the exercise because you will give support to us. I know this may be difficult for you and you may

feel the need to interrupt at certain moments but I encourage you to stay in silence, just observing and listening. When we are finished I am going to ask you about your experience, and you will be able to share your thoughts. Do you both agree?

After both parents give their agreement, I address the mother.

T: Let me ask you to stand up in silence for half a minute and try to feel as if you were in your daughter's body. You are going to be your daughter for 20–40 minutes and I need you to enter in her inner experience, feel her body, her emotions. Please take a moment to experience this. When you are ready, let me know.

Carmen says she is ready after a minute of silence.

T: Okay. Could I ask you to sit in that chair (pointing to another, different chair) and “be” her as much as possible. Please use her body posture as she would be seated, and I will have a dialogue with you being her, just as if I were interviewing her. I'll ask you to maintain her role until we have finished, and afterwards we will discuss what has happened.

The mother takes half a minute, and then sits down, half lying on the sofa, with her arms crossed with a defiant posture and look.

T: Now you are Cristina; you have her feelings, memories, hopes, and thoughts. Just take a few moments before I start with the interview. . . . (With a lively voice as if addressing a 16-year-old girl.) Hello Cristina! My name is Alba, and I'm your parents' therapist. I believe you've heard about me.

Mother (as daughter): Yes, I know. (With a face and tone conveying that she is deeply bored.)

T: Tell me about your life now. I am interested in knowing what are the good things and what are the difficult things.

M: Good things? Very few. Only my friend, Julia. The rest is shit. My mother especially. She is disgusting, always annoying and she wants dad to get angry at me (with very angry tone). I'm angry at everyone except Julia.

T (showing interest and curiosity): What is it that is so special about Julia?

M: I can tell her the truth about everything. I cannot talk about my issues with my mother because she tells everybody. She is always asking too many questions and she is always angry. With her I have to pretend, not with Julia.

T: When did all that start, Cristina? When did mom start being like this?

M: When I was 4 years old, Javier got ill. Mom was always having to take care of him.

T: How was your life at that age? What do you remember, Cristina?

M: Well, my parents used to travel for Javier's treatment and spend a lot of time away. I was left on my own with my grandparents. Then they would come back and leave again (with an angry voice).

- T:* How did you see them? Can you remember how they looked?
M: They were always sad, with a worried face, and preoccupied. They were always very busy.
T: So you were a 4-year-old girl, who sees father and mother always sad.
M: Yes, and then when Javier was better they were all happy and we could do things together. People came to our home and I could see them happy. But now? Nothing.
T: When Javier was doing better, your life as a little girl was better.
M: He used to protect me. We got along very well, and when he was ill again I was left alone with my grandmother. They were away for very long periods of time.
T: Tell me Cristina . . . how is life for a little girl that has a very ill brother and a father and mother that look very sad?
M: (After a few moments of silence, and still with an angry voice) I think they don't love me.
T: What makes you think that? How did you reach that conclusion, Cristina?
M: Because I see that Mom is angry with everyone, especially with me.
T: Oh, Cristina! It must be very hard to see mom like that all the time!
M: Well, I'm used to it. In fact I don't care at all, it makes no difference to me! (With a surrendering tone.) She says she is going to a meeting, but I believe she goes out with her friends. (With angry voice.) She is always back and forth.
T: So Cristina, you're telling me that when your mom is angry at everybody and she leaves home to be with her friends, you believe she doesn't love you?

Mother, as Cristina, is quiet for a moment, but relaxes her posture.

- T:* Tell me about your father, Cristina. How do you see him?
M: He's always working. Always. I don't know why he works so hard. I think he is very tired. Mom is always complaining about us to him, and then he gets very angry with me and screams at me, so I react badly and say terrible things.
T: You behave badly and say terrible things. Tell me. What other things happen to you when your dad is always working and looking tired, and your mom is angry?
M: Then I feel as if they don't love me. I wish I had another family because they don't love me (softens her voice).
T: And when you think that, what do you do, Cristina?
M: I go to see Julia and I cry, but not in front of Mom. Julia is the only one that understands me. My mother (angrily) is always scolding me.
T: How would you like your mom to be?
M: Loving. That she would care about the things I do well. She is always in a bad mood, and all she does is complain about me, telling me all the things I do wrong.
T: And then, Cristina, if your mom would change her attitude and would tell you positive things about you and be in a better mood, what would change within you?

M: I would be more happy, but she never says good things, Well, she does . . . (thinking for a few seconds) but I do not want to hear them.

T: You cannot hear them because you are too angry (softly but with a very affirmative tone).

Carmen, as her daughter, sits silently, taking this in.

T: I think, Cristina, that your anger is as big as your sadness (in a validating tone).

M: She doesn't understand me, but I am not happy with myself either. I don't like myself. I don't like anything about me. I don't like my hair, I've gained weight, I should go on a diet, all my friends are thin and I don't take care of my self.

T: And when you don't take care of yourself, it is a way to express what, Cristina?

M: That I am not happy and I will never be! (angry, sad tone). It's the truth. I feel they don't care about me . . . I don't know why I have to exist (lower voice and looking down).

Deep silence ensues as the therapist empathically repeats this statement, and then continues.

T: I am going to ask you an important question, Cristina. What would you need now from your parents so you could feel worth existing?

M: To feel that they love me, that I could be happy . . . (sad and silent). If one day I have kids I will make them feel happy! (with an angry tone again).

T (with a strong validating voice): Tell me what a mother has to do to make a child feel happy.

M: When a child says that she is sad, a mom doesn't need to tell her that there are many things to be happy about, or to give her a lecture. They don't pay any attention to me, they don't love me, I am not important for them. With Javier it was different. He made me feel important, and he really loved me.

T: How did he make you feel important?

M: He always listened to me. He helped me with my homework, and when he was doing his treatment we would always talk on Skype.

T: When he died how was that for you?

M: My mom was crying all the time, my dad running in one direction, my grandparents in the other (lower voice).

T: You were very sad. Did someone notice your sadness?

M: No. But I don't cry anymore. I try to keep my mind off it, otherwise I would cry a lot!

T: So, Cristina, there are many things you try to keep your mind off: the sad childhood you've had, having to spend long periods of time alone with your grandparents, the death of Javier, the pain of seeing your dad and mom sad and worried and preoccupied, feeling that you are not loved, asking yourself why you have to exist. So, instead of thinking about all those things, what you do is . . . ?

- M:* I get angry (without hesitation).
- T:* And when you're angry, you show it by?
- M:* By behaving badly, being rebellious and insulting. Especially toward my mom.
- T:* So, Cristina, you are a clever girl. Instead of feeling sadness for all that your family has gone through, you get angry, annoyed, and insult your mother.
- M:* I do it to hurt her, but the truth is I don't really believe the things I say.
- T:* Oh, Cristina, that is very interesting. You don't really believe the things you say. You just say them to have an effect on your parents.
- M:* Yes, precisely.
- T:* So when you are angry, what you are really trying to tell them is . . . ?
- M:* That you are pricks! I want you to pay attention to me! Then I hurt them, I hurt them badly.
- T:* I imagine, Cristina, that the harm you do to them is proportional to your despair because they do not give you the attention you need.

I then compassionately repeat the various ways Cristina lashes out and fails to take care of herself, and add, "What's a special way you have found to ask for what you need." Carmen, as her daughter, sighs audibly, and acknowledges that she does it until her mother ends up crying, and only then can she relax. I then continue.

- T:* Of course. You calm yourself, because finally you have had an impact on her and then it looks like now you are important to her. (Carmen is silent, thinking deeply.) And if, instead of asking for attention by showing your anger, you asked for it directly, what would you request from your mom, Cristina? It has to be something very specific, not an unrealistic change. Your mom cannot do a big change because she is not well since Javier's illness and death.
- M (after moments of silence):* That she would help me in my studies, not just telling me, "You have to study," but sitting down with me and helping me. Not just paying someone to help me do my homework but being there with me. Not being in a bad mood all the time and always away from home.
- T (interrupting):* Cristina, we have to think of something simple, not too many things because it will be too much for her, something very specific that you really believe she can do for you.
- M:* Well, that she would help me do my homework and study, my studies. That some days, maybe not every day, she could sit with me and just look at me without saying anything, she does not need to say anything, just watch me while I study.
- T:* And your father? If you could ask for a little change from your dad, what would you ask?
- M:* That he would pay more attention to me, that he would spend some time with me, just the two of us, doing something together, without my sisters.
- T:* It seems like an excellent idea, Cristina, doing something just the two of you.

M:	Yes! To be alone with him on a trip would be wonderful for me (with happy voice).
T:	Let's imagine for a moment that those changes occur. You go on a trip with your dad and your mom sits with you while you study. How do you feel?
M:	Happier. I would smile, I wouldn't be so angry.
T:	Well, Cristina, I really liked getting to know you better and listen to your thoughts. Is it okay with you if we stop here?
M:	Yes. I liked it too.

Having witnessed a shift in Carmen's body language as well as in the content and tone of her speech, I invite her to stand and "shake off" her daughter's role for a couple of minutes, and then return to her own chair. She does so, and sighs with emotion, as I wait patiently in silence. She opens the processing by noting, "I knew there was pain under her anger. I knew it, but now I could truly feel it." For the remainder of the session, we explore the many emotions and insights that follow for her and her husband, as each shows deeper compassion for their daughter, and a readiness to act upon this in tangible ways suggested by the interview.

Concluding Thoughts

The BSI elicits the bereavement coping script system (Payàs, 2010) of the child in all its dimensions: cognitive (I do not want to exist, I am not loved, my life is shit), emotional (disruptive anger, hidden pain, despair), behavioral (acting out, insulting, overreacting, acting rebellious), and somatic (defiant posture, neglecting self-care, not taking care, body tension). This coping system is reciprocally reinforced by the parent's bereavement experience and is the natural survival reaction the adolescent uses to manage the pain and give meaning to the original primary loss of the sibling and the wound inflicted by the secondary loss in the form of the empathic failure of the parents, as it is clearly revealed in the interview.

The careful selection of questions and orientation of the interview requires the therapist to be attuned to the needs of both parents and child. Its reparative strength arises from consistent inquiry and validation of the adolescent's experience. Instead of being judgmental, the therapist is interested in knowing and understanding the sibling's experience, thus providing parents with a reparative attitude that they can use as a future model. The parent gradually learns how to avoid criticism and to not overreact to provocation while at the same time gaining awareness that the child's responses are a consequence of their own difficulties in being fully available.

Repairing the wound is achieved through enhancing the parent's ability to contact the child's relational needs and find creative ways to appropriately respond to them. The BSI is a sophisticated intervention that can help the parents to find ways to manage the surviving children's coping difficulties with which they struggle and often feel hopeless.

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The Grief Spot

Laura L. Hinds

Clients for Whom the Technique is Appropriate

Adult partners who have lost a child and reside together can utilize the Grief Spot activity to support each other in meaningful and specific ways. This project is less useful in households where one member of the couple is acutely grieving and suffering from emotional dysregulation to a much greater extent than the other. This activity is contraindicated for partners who live in separate spaces or who have decided to dissolve their relationship.

Description

Despite the fact that a shared loss occurs simultaneously for a family, it is common for partners to manage their grief processes in discordant manners (Büchi et al., 2009). When these differences are misunderstood or invalidated, couples often find themselves facing deeper emotional wounds and the threat of the union being buried with the child. Research indicates that marital closeness can lessen the devastating impact of the loss of a child (Song et al., 2010). Use of the Grief Spot activity can assist couples to better understand their partner's emotional responses, take the other's expressions of grief less personally, and improve their ability to respond in a manner that feels supportive and loving, despite their own grief process.

The Grief Spot is represented by a physical container or box, or specified location within the shared living space of the couple. The box or space can be decorated with any pictures, sentiments, or any creative adornments that carry meaning for the couple in regards to the lost child. Ideally, it has designated spaces dedicated to each partner. Partners can leave notes, gifts, or tokens in each other's space to support the expressed needs of the partner pertaining to the loss. Both members of the couple should agree to check the Grief Spot at regular and expected intervals (e.g., every day, or every other day). This activity allows partners to communicate in a way that is not intrusive and respects one another's healing space, thereby avoiding painful misunderstandings or triggering of intense grief that they might otherwise endure when trying to verbalize their pain (Hooghe, Neimeyer, & Rober, 2011).

Case Illustration

Charisma and Franz, 28 and 27, were two young parents who had recently lost their first-born son, 7-month-old Kenny, in a suffocation incident. Historically, Charisma had been considered the more “emotional” one of the couple, as Franz’s German ancestry influenced his choices to minimize his emotional responses to challenging situations, especially regarding death. Always supportive of his wife, Franz historically had held the role of the emotional “rock” and “protector” of his wife and young family. When Kenny died, Franz questioned his ability, role, and efficacy as being “enough” in the face of his family’s overwhelming experience. This poignant doubt on his part was one focus of our work together.

Toward the middle of our work, Franz became more reticent, disengaged, and troubled. When I probed his demeanor he shared that he had been feeling “drained” and “empty.” Franz reported struggling to respond to the various manifestations of his wife’s needs; though her grief was progressing appropriately, she was still the major recipient of the family’s energy and comfort. This was further compounded by Charisma’s increasing need to stay physically connected to Kenny’s ashes. Despite her family’s religious beliefs in burial, and Franz’s cultural stance that preferred burial as well, Charisma had elected to have Kenny cremated and his ashes kept in a small urn shaped like a teddy bear. Two months after the loss, Charisma had begun carrying the ashes around the house with her while she did chores, sometimes even taking the ashes out of the house with her when she went on extended errands. Though she herself was not entirely comfortable with this process, Charisma had made peace with this behavior and our work focused on her maintaining an emotional connection with Kenny while lessening the need for a physical one.

Fatigued from caretaking and still emotionally raw himself, Franz reported having a visceral and negative reaction to Charisma’s behavior. He shared being resentful of her requests for cuddling and physical proximity at moments when she felt emotionally vulnerable. As a complement to the therapeutic work I did specifically with Franz, we decided to utilize the Grief Spot. A box was created where one side was dedicated to Charisma, the other to Franz. The couple agreed to check the box daily, on their own terms. Neither was allowed to speak to the other about the box and the potential notes, requests, or other items that they left within.

After I supported Charisma in better expressing her needs, she was able to draft a note to Franz expressing her gratitude for his care, her desire to support him, and a request for him to be patient with her need to carry Kenny’s ashes with her. She acknowledged his discomfort with both the decision for cremation and her physical connection with the ashes. Charisma acknowledged that Franz had preferred to have had their son interred and expressed how much she appreciated his generosity of spirit in allowing the cremation. She stated her hope that her need to be physically attached to Kenny’s ashes would lessen, and shared some successes she had already experienced in this vein. Charisma placed the note in Franz’s side of the Grief Spot.

Two days later, when Charisma went to check her side of the Grief Spot, she found a present from her husband. Franz had researched and secured a doll-sized infant carrying harness that perfectly fitted Kenny’s urn. Charisma was touched by this action and reported feeling understood, supported, and loved.

In our next session, Franz reported that he was also moved by the process. Having the request come in a nonconfrontational way and on his terms relieved a sense of

responsibility and “burden” that Franz had been carrying with increased difficulty. That the note included the thoughtful and thorough explanation, the validation of his experience, and commitment of his wife toward healing, further supported Franz in feeling valued and cared for in their relationship. He consequently found it easier to support Charisma’s experience and request for patience despite his own grief process.

Charisma and Franz continued to use the Grief Spot with great success. The exchange of notes requesting “quiet space” of one’s own, heightened attention during significant loss anniversaries, and general expressions of love helped this couple support each other.

Concluding Thoughts

When two partners experience the devastation of the loss of their child, differences in bereavement responses, cultural norms, and social expectations can result in discordant grief expressions and needs. These differences can cause additional strain between the partners and increase the burden on individuals already managing their own heartache and limited emotional resources (Büchi et al., 2009).

In my practice, using the Grief Spot as a designated place where couples can communicate their needs to one another has proved to be an invaluable resource. The Grief Spot provides a nonconfrontational way for couples to explicitly express both their specific personal needs and how those needs could best be met. Additionally, the fact that couples can check the box on their own terms (within the agreed-upon window) empowers each person to check in on the Grief Spot and their beloved’s needs when feeling emotionally prepared to do so, thus resulting in greater responsiveness to a partner’s need without the unintended pressure that might accompany a direct request. Ideally, parents can also use this process to further support their connection to the lost child, which is the common best-practice model for supporting bereaved parents (Davis, 2004).

By visiting the Grief Spot daily (or every other day), parents can honor their loss consistently and in a way that allows them to hold their grief while continuing to attend to other aspects of living. Parents have reported that this balance helps them manage the general feelings of guilt and responsibility that accompany this special type of grief. The use of the Grief Spot exercise can strengthen the emotional bond between grieving parents. A strong connection between parents has been identified as a factor for resiliency (Song et al., 2010). Clinicians can use the Grief Spot exercise to foster healthy management of this life-altering experience.

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Family Coat of Arms

Janet L. Bradley

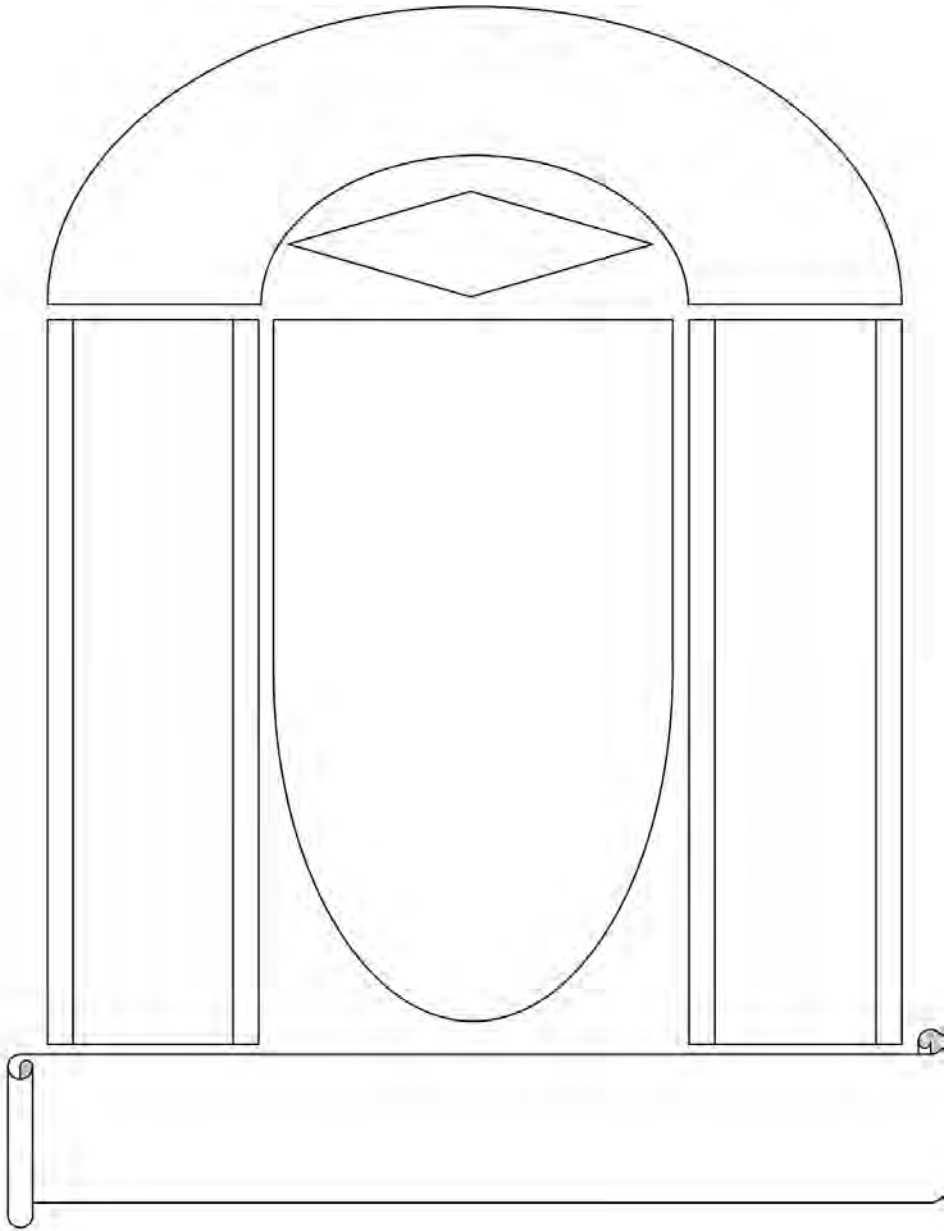
Clients for Whom the Technique is Appropriate

Families who have experienced the loss of a family member can benefit from creating a family coat of arms. This technique is used to elicit dialogue between grieving family members. Each member of the family is provided the opportunity to express grief-related loss while remembering and honoring the strengths of the family unit. The technique may be less appropriate for hostile and conflicted families for whom collaboration on such work is difficult.

Description

With the death of a loved one, families often question their resiliency. “How will we get through this? How will we survive?” Such a significant change in a family creates a shift in its balance where the family senses they will never be the same (Jeffreys, 2011). This fear challenges the identity of the family unit. It is important during this time of loss, grief, and confusion for a family to communicate concerns and feelings with one another. Grieving families can require an opportunity to express their positive and negative thoughts, concerns, and memories. A joint activity where the family can process and acknowledge their feelings together can often assist and make healing easier (Jeffreys, 2011). The coat of arms is a joint activity that encourages dialogue. It also provides an opportunity for the family to identify strengths, shared values, and beliefs. Each member is then reminded of the things that continue to make them a family and provide them with a basis for resiliency as they grieve.

This technique stems from the “coat of arms” often displayed on the shields of medieval knights, which were used as a means of protection during battle. The designs were created to uniquely identify the knight, his victories, and strengths. In the condition of family loss, the coat of arms is used to assist the family with conceptualizing and discussing their uniqueness, resiliency, and strengths as they encounter the grieving process. The clinician can create a blank format of a coat of arms or use the template provided (Figure 55.1). Each member is asked to include the following on their coat of arms: the family name, a motto and a symbol that represents the family, a drawing of a favorite family memory, and in each column a word that describes the family or a shared value. Upon completion, each member shares their coat of arms. If desired, all members could then collaboratively make one shield to represent the family.



FAMILY COAT OF ARMS TEMPLATE

Figure 55.1 Template for the Family Coat of Arms

Case Illustration

At age 44, Marilyn never anticipated being a single mom of two teenagers. Her husband of 20 years, Brad, had just recently died of pancreatic cancer. Erin, their daughter, was 18 years of age and a senior in high school. Daniel, their son, was 14 years of age and had just started high school when Brad died. Marilyn and Brad were married for 20 years. They met in college where they became the best of friends, enjoyed all forms of activities together, and developed a strong emotional bond. They married after completing graduate school. Prior to Brad's illness, which was diagnosed only eight months before his death, life for Marilyn, Brad, and their children was happy, successful, and joyful. In all aspects of their individual lives and as a family unit, they were thriving. Upon Brad's death, the atmosphere at home became tense, sad, and lonely. Their positive family interaction had ceased. When home, everyone went to their respective bedrooms. Conversation did not take place. Dinner was no longer "family time." Meals were eaten alone. Marilyn continued to work but spent most of the day worrying about how the family would manage without Brad. In the evenings, she retreated to her room in sadness, greeting only her loneliness and hopelessness. Erin and Daniel continued their routine of going to school but evidence of their grief was manifesting in other areas. Daniel, a consistent above-average student, was now receiving failing grades. Once described as friendly, happy, and "a joy to be around," Daniel had become gruff, blunt, and obstinate. Erin, with her ability to drive, created her own independence. She was rarely home. She consumed all of her time with after-school activities, dance, work, friends, and social activities.

Marilyn expressed her grief and worry in this way, "We are no longer a family. I don't think we can survive this. We don't talk. I miss Brad so much. I just want life to go back to the way it used to be." Daniel sat frozen, staring out the window in silence. Erin shared the latest news of her activities and reported, "Everything is fine. I don't know why we are here." Their presentation was that of three individuals. They did not demonstrate any emotional connection as a family. They appeared to have nothing in common. Each member was consumed in his or her own state of being with no regard or connection to the feelings of the others.

The family was encouraged to participate in the family coat of arms activity. Upon completion, each member shared their coat of arms while I facilitated deeper discussion between the members. As a result, each member demonstrated and experienced "active listening." They expressed their feelings about the past, their loss, and their worries about the present and the future. This exploration created an opportunity to talk, to reconnect, and also provided insight on current patterns of interaction. Through dialogue, they were reminded of their commonality, strengths, and resiliency in spite of their loss. They discovered, "We still are a family."

Concluding Thoughts

The use of a family coat of arms when working with grieving families supports the opinion that while some families can feel "shattered" due to stress, loss or traumatic events, families also can emerge "strengthened and more resourceful" (Goldenberg & Goldenberg, 2004). Captivating the family through this technique improves open expression between family members, which leads to emotional connection and deepens understanding. However, a clinician should be aware that not all families can give account to fond memories and describe "the good times." Recollections can surface memories of abuse, abandonment, betrayal, and trauma. These

memories are stored and are considered “unfinished business” that can compound grief and add to the intensity of the grief response. Clinicians must be prepared to attend to these experiences in order to fully serve the family (Jeffreys, 2011).

This technique has proven to be very beneficial when attempting to tap into the emotions and feelings of males. Relating the family coat of arms to medieval times, the adventures of knights, and their strengths can persuade males to participate and ease the stigma of talking about feelings around grief. This tool may not be appropriate for young children who have not yet developed the ability to express their ideas verbally or in writing. For young children, the instructions can be modified to an age-appropriate level. A child can be asked to include drawings that depict the family, his or her moods of happiness or sadness, favorite animal, a fun family activity, etc. This adaptation allows a younger child to contribute to both the activity and the discussion.

This technique is a suitable approach when working with diverse ethnicities and cultural backgrounds. The information obtained and the topics discussed through this technique are universal concepts experienced within all families. The family coat of arms will assist the clinician in learning more about the grieving family’s religion, spirituality, and culture, all of which impact the grief response.

With this technique, no matter the emotions or experiences depicted in the coat of arms, the goals of the therapy are being achieved. Each member is being provided the opportunity to speak. Each person is being supported in the realization of their feelings and interpretations while acquiring an understanding of others. No matter the concept or design, the discussion of a family coat of arms provides open communication, free expression and creates a sense of cohesiveness which can encourage and support a family’s resiliency during the grief process.

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Grief Etiquette Coaching

Doris Chambers Vaughans

Clients for Whom the Technique is Appropriate

Adults who are offering grief support to a bereft member of a group can benefit from distinguishing between post-bereavement support that is perceived by the bereaved as compassionate, caring, and helpful, as opposed to support efforts that are awkward and that leave the bereaved feeling unsupported. This technique can be used in diverse employment, church, school, and social organizational settings. However, grief etiquette coaching may prove insufficient for losses that are traumatic in nature, such as a shooting or suicide, necessitating professional therapy and systems-wide interventions.

Description

Most bereft people advance through bereavement without any residual problems (Parkes, 2011), yet reported normal (uncomplicated) grief symptom manifestations may include responses that are distressing, upsetting, painful, and even agonizing. Given this, the support provided by social networks can have significant positive effects for the bereaved, greatly enhancing their well-being and sense of being reintegrated into a caring community. In contrast, there are moments when well-intentioned words and actions further isolate the grieving person and fail to achieve their intended purpose. “Grief etiquette” is a term that describes individualized and culturally attuned social support gestures based on factual bereavement and grief knowledge that are perceived as both compassionate and meaningful for the bereaved. Additionally, grief etiquette can be a source of team-building and prevent bereavement-related problems in the workplace, school, organization, or other social group.

Grief etiquette coaching provides professionals and laypersons with insight and assessment skills helpful in providing individualized, meaningful, and compassionate social support to bereaved persons. The technique begins with basic knowledge of the cause of death and the bereaved person’s circumstances following the loss. From this body of knowledge, the coach can inform the group of expressions of support that are consistent with bereavement research as well as local practices. For example, it can include coaching the group on ways of being attentive to feelings and the importance of avoiding clichés that seem callous or hackneyed. Statements such as, “I can identify with your feeling of (name the feeling)” and “I am sorry” are more empathic than saying “I know how you feel.” Other grief etiquette coaching tips are to: be truly present with the bereaved, undistracted by other agendas; consider the value of rituals;

assist with meeting needs that were previously met by the deceased; empower the bereaved by offering to teach them new skills; set appropriate boundaries; and offer meaningful gestures for special days such as holidays, anniversaries, and birthdays. Dyregrov and Dyregrov (2008) identified three main criteria for good network support: (a) its being viewed as beneficial, (b) reciprocity between the bereaved and the network, and (c) sensitivity to the experiences of the bereaved.

Case Illustration

A supervisor at a social service agency called and requested help to address the needs of an employee who worked at the agency as a case manager. The employee, Amy, experienced the death of her spouse and her subsequent grief had negatively affected the work environment and the care of the clients. Eight months after her husband's death, Amy was not fulfilling her job responsibilities, which caused problems for other members of the team. Additionally, previously upbeat staff relations were stifled for fear of upsetting Amy. The supervisor reported staff morale was down and all attempts to support Amy had been met with resistance as she simply turned sullenly away. For example, when coworkers shared positive personal news or planned their monthly birthday outing, Amy's body language would quickly communicate anger and she would exit the room. Despite coworkers following her and offering many apologies for unintentionally hurting her; as well as making many requests for Amy to join the group for their birthday outings, Amy consistently and harshly accused her coworkers of "not caring" and of being "insensitive" to her loss. In the absence of effective ways to support Amy, the supervisor stated she would have to terminate her.

As the grief etiquette coach, my first intervention was to request information about Amy's loss in a meeting with her coworkers and managers on a day Amy was off work. Amy's husband had died due to a rare genetic liver disorder. The death occurred after a long hospitalization and was expected. According to the supervisor, prior to his death, Amy often declined after-hours outings with the staff, stating she only did things with her husband. Amy had no children but she had a dog that she used to talk about. She was previously a very good employee who was liked by her coworkers. The supervisor described the work environment as "like a family." Since her husband's death, however, Amy had become somber, displayed mood swings, and became upset when coworkers shared positive things about their own lives. She continually told her coworkers that they didn't understand because they had not lost their spouses.

After gathering information surrounding Amy's loss and responses to it in the workplace, I encouraged the group to consider changing their expressions of concern to statements of affirmation and validation. For example, rather than saying "I know how you feel," I coached them to say, "I can identify with your sense of feeling angry and cheated. I hear you when you say how lonely you are and I am so sorry you are experiencing this." Suggestions also included continuing to invite Amy to join them for a monthly birthday outing for coworkers despite her previous refusals. I also inquired if anyone could consider an outing that would be meaningful but not emotion laden for Amy, such as accompanying her to the dog park to walk her dog.

From her coworkers' perspective, I suggested that the team hold Amy accountable to complete her work, perhaps gently reminding her that her work was needed by a certain date to counter the mental fogging that often accompanies acute grief. Additionally, I emphasized that although it might feel uncaring, employees needed to return to their former spontaneous and positive way of communicating in the office. If Amy were to leave when coworkers naturally shared with one another a positive anecdote from their

lives, I suggested that they simply later acknowledge to Amy her quick exit, voice understanding, and suggest that she participate when she felt she could. I likewise emphasized to her supervisor that Amy needed to know that she was cared for but also that she was accountable for her job duties as well as any behaviors that conflicted specifically with stated office policies, such as passing on her responsibilities to others. I also suggested that the supervisor encourage her to take advantage of grief counseling through her Employee Assistance Program benefit or otherwise assist her to get counseling.

Amy's coworkers readily implemented these suggestions and began to use wording that was validating and unassuming. They stopped doing her work and offered strategies to help her keep up with due dates and validated her work contributions. They continued to invite her to the monthly birthday outing, which she eventually accepted. Additionally, they began sharing good news with each other again while acknowledging Amy's loss reactions. Gradually, she started engaging in dialogue and exited less often. One of her coworkers suggested they walk their dogs together to get her out of the house and exercising (both beneficial while grieving). Amy reached out for grief counseling as suggested by her supervisor. In the end, Amy felt supported by her supervisor and coworkers, changing the work environment back to one that was again "like family."

Concluding Thoughts

The challenges and obstacles encountered during bereavement can present significant life issues for the bereft person who perceives his or her social support network as inadequate. Wrzus, Hanel, Wagner, and Neyer (2013) defined social networks as close relationships with people who are directly involved in our lives, such as family, friends, coworkers, and members of our social organizations. Social relationships can be diverse and based on things such as religion, socioeconomic status, race, and other factors (Wrzus et al., 2013). With appropriate attention to the needs of the grieving individual and the culture of his or her group or workplace, the techniques of grief etiquette coaching can assist groups to provide compassionate, caring, and helpful support to members who are experiencing a difficult bereavement.

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Part XI

Facilitating Group Work

Facilitating Safety in Group Work

Simon Spence and Una Smale

Clients for Whom the Strategy is Appropriate

Bereaved participants in a facilitated support group benefit from the establishment of safety in the group process. This strategy is appropriate for adults, but the principles are applicable to all. Group work (and this approach to it) is less likely to be helpful for people who, for whatever reason, are unable to engage with group processes or significantly disrupt or inhibit the helpfulness of the group for other participants.

Description

As many writers have described (Schmid & O'Hara, 2013; Yalom & Leszcz, 2005), therapeutic groups have the potential to be frightening places. They can generate considerable anxiety, leading to a variety of distressing experiences for participants including feeling misunderstood, angry, rejected, isolated, and shamed. Grieving people are frequently already grappling with heightened levels of anxiety and vulnerability. Many may avoid group situations, and those who do not may approach them with even greater trepidation than is usual with other populations.

One response to this can be to facilitate bereavement support groups in ways that are highly structured and facilitator-led, which focus on more cognitive or task-oriented approaches, and which may minimize distress. Our approach (Spence & Smale, 2015), however, persists in the conviction that for many bereaved people, group work is most deeply beneficial when it creates space for mutual and honest experiencing and exploring of practical, cognitive, affective, existential, and spiritual issues, with compassion and acceptance, and without preconception or agenda. This encounter can constitute an important and healing part of the "grief work" that is central to most contemporary understandings of grieving.

Attempting to describe the processes of therapeutic psychological change, Carl Rogers proposed that "under certain conditions, involving primarily complete absence of threat to the self structure, experiences which are inconsistent with it may be perceived and examined, and the structure of self revised to assimilate and include such experiences" (Rogers, 1951, p. 517). Grieving can be understood as a process of assimilating and including our often painful and confusing experiences of loss into our ever-evolving and revised understandings of who we

are and how we link with the world around us. For group work to meet the needs of individuals, an adequate sense of personal safety must be perceived. This sense of safety arises from a growth in trust within the group and, being therefore a relational matter, is not something that can be unilaterally imposed by facilitators. Facilitators nevertheless have a significant ethical responsibility to do all they can to engender a safe-enough group. Additionally, if Rogers is correct, doing so represents a significant contribution to what is a highly potent therapeutic factor in and of itself.

The following suggestions indicate ways in which facilitators may pay attention to this therapeutic need for safety. Specific techniques can of course be developed and modified to suit specific contexts and preferred ways of working.

Pay Attention to the Recruitment of Participants

Whether or not formal screening is undertaken it is important to carefully consider individual participants, and any factors (e.g., gender, age, type and recency of bereavement, personality, and personal preferences) that may potentially undermine group cohesion and development. Consideration should be given to possible options should any irresolvable tension emerge between the needs and tendencies of the group and those of an individual.

Think About the Practicalities

How groups are set up and managed on a practical level can send powerful messages to participants. Initial information should explain clearly what to expect and invite questions and the expression of any uncertainties. How participants are met when they arrive at the venue can convey the importance or otherwise that is attached to their comfort and well-being. Where can they hang their coats? Are tea/coffee or other refreshments available when they arrive? Making the room as comfortable and welcoming as possible might involve using reduced or indirect lighting or fresh flowers. It can also be helpful to offer the chance to gather informally after each meeting, giving an opportunity to “wind down” from the intensity of the meeting and to engage in social chit-chat without having to pretend that “everything’s fine,” something that is often difficult for bereaved people.

Spend Significant Time “Preparing the Ground”

Establishing a sense of safety in groups cannot be hurried. It is important to give adequate time and opportunity for participants to articulate their hopes and fears about involvement and to support the group in developing a mutual understanding of which “ground rules” are most likely to lead toward the fulfillment of hopes and addressing of concerns. Confidentiality is of central importance. Participants can be supported to identify what this means to them and what agreements need to be established to ensure that a sense of safety is developed in the time *between* meetings as well as when people are physically together. Additionally, safety is enhanced when participants feel a sense of ownership of the group and are enabled to use it to address what really matters to them in their grieving. It can be helpful to give time for the group to develop an agenda for the meetings, not as a restrictive list of what is to be covered in linear fashion, but as a way of ensuring that what matters to each person can receive ongoing attention as, if and when participants so wish. Participants are often impatient to begin to talk about their experiences. It is important that facilitators find sensitive ways to allow them to begin to tell their stories, but which do not subsequently prove unsafe because insufficient attention has been given to establishing the norms upon which the work of the group is based (see Neimeyer & Sands, 2016, Chapter 59).

Explicitly Welcome and Discuss Difference and Diversity within the Group

It can be helpful to explain that similarities with others in the group are likely, but so too are differences and disagreements. These may be a challenging and possibly unexpected aspect of the group, but it should be noted that, with adequate mutual respect, each can be as fruitful as the other. Sometimes an event in the group will prompt such a conversation early on, but if not it should be initiated by facilitators.

Work as Transparently as Possible

A sense of safety can be compromised when facilitators allow any air of mystique to gather around their work. This transparency can be communicated (and modeled) simply by remembering to explain why a suggestion is being made, question asked, or comment made. It can also serve as a stimulus for facilitators to regularly check with participants if the group work is meeting their needs or whether any modifications in focus and/or approach are required, insuring that the “fit” of the group keeps pace with its ongoing development.

Case Illustration

In the first meeting of a closed eight-session support group, Kevin became gradually quieter, having initially been actively involved in discussion about hopes and concerns for the group and also beginning to speak about the circumstances of his wife Wilma’s distressing illness and death 10 months before. It was not immediately apparent that he was unhappy, but at the end of the evening he confided to a facilitator that he might not return due his fear that honestly describing his experiences had been upsetting for others, particularly those with obviously different experiences and understandings of their grieving. The facilitator reiterated the value of difference and diversity within the group and gently encouraged Kevin, if he felt able, to return for the next meeting when further conversation and discussion could take place.

Kevin, with considerable apprehension, did return and facilitators spent substantial time in the second meeting “preparing the ground,” seeking agreement on exactly how the group could best work together. As part of this, Kevin was supported to describe how out of place he had felt when he had spoken openly and emotionally about his raw experience. He described his fear that he had “created unpleasantness” for others. This conversation illustrated to other participants the potential benefits of openness to discussion about personal experiences of being in the group and not only to its subject matter—to its “process” as well as its “product.” It modeled and encouraged honest sharing and offered a concrete situation from which to explore, over the subsequent meetings, the inescapable reality of both similarities and differences from griever to griever. Within the increasing sense of safety that developed in the group over the following weeks, these were gradually articulated, acknowledged, and validated among the group participants. They provided valued and instrumental opportunities to be supported in preferred ways of grieving, to be challenged by the existence of alternatives, and to examine and reconsider thoughts and feelings that may have felt taboo in family or other social situations, just as they had initially appeared to Kevin to be taboo within the group.

Concluding Thoughts

Bereavement support groups provide a range of support to participants, including psychoeducation and the imparting of useful information and ideas for grieving individuals. However,

with careful, responsive, and ongoing preparation and thought, they also can provide a valued interpersonal climate in which, with sufficient attention to its safety, profound and meaningful conversation can develop that recognizes commonalities of grief, deeply respects the reality and centrality of each person's experience, and explores the interplay between the two.

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Co-facilitating Bereavement Support Groups

Beverly Feigelman and William Feigelman

Clients for Whom the Technique is Appropriate

Co-facilitation as a leadership model is most useful for groups for the traumatically bereaved or those suffering complicated grief. It may not be as important for general bereavement groups, psychoeducational groups, or very small groups, where a competent solo facilitator may be adequate to meet the needs of group members.

Description

Support groups have had a venerable history, dating to the earliest groups founded in the 1930s for recovering alcoholics. From the 1950s onward, they have expanded into the bereavement arena, with the formation of the Samaritans organization in the United Kingdom for suicide bereaved and in the United States with the formation of the Compassionate Friends organization for bereaved parents, founded in the early 1970s. Since then, these groups have grown exponentially, becoming an important component in the arsenal of healing aids used by the bereaved after a loved one's death. In the case of homicide, suicide, and drug poisoning fatalities, traumatic deaths that are sudden and violent, support groups have often become indispensable. They provide special opportunities for the bereaved to surmount the societal stigma, isolation, shame, and self-blame that often follow these types of deaths, offering a safe, compassionate, and nonjudgmental healing environment.

Important to note is the role of the facilitator in these groups; while the literature points to potential challenges in structuring a group with two facilitators, such as different leadership styles, extra energy required to develop and maintain the relationship, and competition for affection and control, specialists in the group work and bereavement fields now are recognizing the many values of having two leaders who complement and support each other in doing group work with the traumatically bereaved (Jordan & McIntosh, 2011; Knight, 2006; Yalom & Leszcz, 2005).

The co-facilitation model helps facilitators “read the room” more effectively, with verbal and nonverbal messages of individuals as well as the group as a whole. Jordan and McIntosh (2011) refer to co-leadership as offering a “binocular” view of the group, making it possible to see parts of group process that might be obscured if there were only a single facilitator.

Having two leaders in the group with complementary and diverse backgrounds, with different training, pacing, styles, use of humor, and/or intellectual underpinnings, also has the potential to facilitate member affiliation, enhance engagement, and promote group retention. For example, an emotionally guarded newly bereaved father, who was silent throughout the meeting, was clearly able to connect to the facilitator who presented some relevant but dry suicide statistics during the group session. After the meeting, the father personally thanked this co-facilitator and committed to return to group.

Co-facilitation allows for a division of the many tasks required to keep a support group running efficiently. Screening potential members, orienting new members before group meetings, performing opening and closing rituals, handling emergency or crisis situations, addressing group silences and effectively dealing with challenging situations such as monopolizing, proselytizing, expression of inappropriate rage, signs of decompensation or suicide risk—these are among the many essential tasks that support group leaders must deal with if the group is to endure over time. Similar to having a CPR partner when handling a medical emergency, having two people performing these functions helps to reduce facilitator burnout and compassion fatigue while meeting the needs of the group. Co-facilitation also provides role modeling for group members regarding communication, resilience, posttraumatic growth, acceptance of different grieving and coping styles, and utilization of different healing tools.

Case Illustration

Helen, a middle-aged woman, gave a long and graphically detailed account of finding her deceased husband's body in the kitchen in a pool of blood. He had taken his life by slitting his wrists with a kitchen knife. Helen was extremely angry at her husband for dying this way and exposing her and her children to this grisly spectacle. She wanted other group members to know her story and the depth of her anger.

The co-facilitators noted that several group members were showing signs of discomfort during this lengthy presentation but before anything was said, Mary, another middle-aged newly bereaved survivor of her son's suicide, abruptly left the room, obviously distressed. With two facilitators available, one followed Mary out of the room, while the other kept the meeting going. Had there been only a single facilitator present, it would not have been possible to respond to Mary's distress without having to stop the meeting. While Mary was being counseled out in the hallway, the remaining facilitator provided support, noting that "telling our loss stories can sometimes create grief overload for those telling their stories as well as those listening, and perhaps we need to be sensitive to how much and what we share." In the hall Mary shared her inability to separate Helen's loss story from her own recent loss and the facilitator suggested that in addition to the group, Mary might benefit from the added support of individual sessions with a grief counselor. Mary thanked her for leaving the meeting to assist her and was grateful for the referral.

After the group meeting, the two facilitators processed what had been an emotionally challenging session. They reviewed their communication and interventions, assessed individual member participation, group functioning, and evidence of mutual aid. They examined why they had allowed Helen to disclose more than was good for anyone and explored alternative interventions such as containment and a more beneficial group discussion of anger. They agreed to revisit this issue at the next meeting and encourage group participation and problem solving. They also decided to follow up with a phone call to Mary to see how she was doing and whether she had pursued the referral. If, instead of this respectful collaboration, a single facilitator had to shoulder the weight of second-guessing himself alone, it would have been a more burdensome and potentially overwhelming session.

Concluding Thoughts

Co-facilitation is a model that is beneficial in group work with the bereaved after the loss of a loved one from a violent, unexpected, or self-inflicted death. Co-facilitation expeditiously helps to meet the complex emotional needs of survivors while supporting facilitators both during and after challenging group sessions. As demonstrated, this model also reduces the risk of re-traumatization, enhancing opportunities for growth and healthy integration after loss.

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Containing the Story of Violent Death

Robert A. Neimeyer and Diana C. Sands

Clients for Whom the Technique is Appropriate

Adults who are participating in a professional or peer-led support group for suicide, homicide, or other forms of violent death bereavement can benefit from the establishment of group processes that mitigate the risk of monopolizing, group contagion, or mutual “triggering” resulting from prolonged, detailed, and immersive accounts of the death by any given member. However, precisely such prolonged exposure to narratives of traumatic loss can be appropriate to facilitate in professionally led groups featuring “restorative retelling” procedures.

Description

A common challenge confronted in mutual support groups for those bereaved by the violent death of a loved one is the “uncontained” telling of the stories of such loss, complete with traumatic sensory details of the circumstances of the death and the scene of dying. Immersion in such accounts frequently can be overwhelming for both the narrator and other group members, whose strong emotions of helplessness and horror can be triggered by the intensity, vividness, and duration of the speaker’s story. Newly bereaved members are especially likely to be swept up in the press to pour out their stories in this undigested form, which research suggests can be one factor promoting attrition on the part of other recent members of the group, who can feel emotionally re-traumatized by such extended immersive accounts. Likewise, long-time members can leave the group when they feel “stuck” in the anguishing stories of early survivors, to the neglect of the issues they face in longer-term adaptation (Feigelman & Feigelman, 2011).

Negotiating this need to narrate the loss in emotionally vivid detail in group settings can be tricky, as a fundamental premise of group support is “the permission it offers survivors to talk about all aspects of their loss, including some things viewed as taboo by non-survivors” (Feigelman & Feigelman, 2011, p. 174). However, when such storytelling begins to monopolize the group, overwhelm vulnerable members at risk of attrition, or become ruminative rather than restorative, it calls for skillful management by group facilitators. Quality training for peer facilitators of the sort offered by the American Foundation for Suicide Prevention (see afsp.org) provides a solid foundation for functioning in this role, but more specialized practices may be necessary to contain and process the stories of violent death if the potentially adverse effects of engaging them are to be avoided or mitigated.

To address this issue we recently convened a group facilitator's workshop in the context of the biennial meeting of Postvention Australia: National Association for those Bereaved by Suicide (<http://www.postventionaustralia.org>), an organization devoted to education, training, and support in the area of suicide bereavement. The focus of the workshop was to identify and address practical problems encountered by the 50 or more group facilitators who participated, and breaking into small groups, to share practical experience in how to best manage them (Figure 59.1). Containing the story of violent death emerged as the leading challenge with which facilitators grappled, and they eagerly collaborated on brainstorming group strategies for handling it therapeutically over a 2-hour period.

Here we draw on their wisdom, adding our own experience as group facilitators to offer several recommendations for respecting the need of members to speak candidly about their loss, while mitigating the personal and group-level risks of doing so. Strategies for containing the traumatic story of loss are described below.

Establish Group Guidelines

In the first session of a closed group, or as new members join an open group, review expectations regarding sharing loss experiences in a way that invites the participation of others, turn-taking, and listening as well as speaking.

Model Disclosure

Facilitators and seasoned group members can relate their own stories in a way that exemplifies candor balanced by empathic consideration of others.



Figure 59.1 Veteran group facilitators brainstorm procedures for containing traumatizing stories of the death

Summarize the Story

Especially on a first telling, suggest that members summarize their experience of the loss in a few sentences, as ample opportunities will follow to delve into the parts of the story that merit special attention.

Lead with Dyadic Disclosure

Especially in a closed group with stable membership, encourage “pairing and sharing” by having group members turn to one other group member and share a brief (5–8 minute) account of their loss, and then change roles of speaker and listener (Neimeyer, 1988). Following this dyadic disclosure, ask that partners introduce one another’s story to the group in summary form, thereby bridging from private to group discussion. This procedure can have several benefits in addition to helping contain the event story of the death, by offering a safer context of mutual empathic listening with a single peer, promoting more evenness and reciprocity of self-disclosure, and enhancing a “self-distancing” perspective during the group introduction, as members witness their stories reflected in the summary of another. This perspective, which contrasts with a “self-immersive” narrative of the traumatic event, has been found to assist traumatized people with meaning-making, emotion regulation, and problem-solving in a series of experimental studies (Kross & Ayduk, 2010).

Segment the Story

Suggest engagement with a part of the story at a time, such as how members first learned of the loved one’s death, their initial emotional reactions, how they handled the first day, how their experience evolved across time, etc. Inviting targeted telling in this fashion encourages engagement of several group members, whose similarities and differences can lead to mutual validation and fruitful problem-solving.

Turn Monologue to Dialogue

Practice responsive listening by introducing affirmation and attuned questions in the midst of longer accounts of loss, and diplomatically interrupt a self-absorbed narrator to ask if it is alright to invite the comments of others. Modeling and encouraging turn-taking in this way can gently create space for useful feedback and reciprocal self-disclosure, which are among the healing components unique to group work (Yalom, 2005).

Offer Additional Support

Recognize that not all needs experienced by survivors of violent deaths can be accommodated in a mutual support group. Options for offering more attention to especially needy survivors can include the facilitator, rather than another group member, joining as the listening partner for the “uncontained” narrator during dyadic sharing exercises, visiting with the member briefly before or after group sessions, and referring the member for adjunctive individual therapy.

Use Talking Sticks, an Expressive Arts Intervention

Talking sticks offer a creative medium for sharing manageable pieces of the violent death story in dyadic and group conversations. Each group participant makes a talking stick that holds hope and one segment of the death story. This process edits the violent story in ways that

support responsive, empathic listening. Working with the hands in a physical, tactile, sensory, and creative way allows new meanings to emerge that are often lost in tired, overused words (Sands, 2014).

The following case study illustrates the use of talking sticks to incorporate a number of the strategies described in this chapter.

Case Illustration

In the center of a group of adults bereaved by the suicide of a family member, the therapist has arranged a variety of straight and twisted sticks, shells, feathers, stones, beads, leaves, flowers, raffia, ribbons, colored papers, paints, pencils, etc. These items were provided by the facilitator as well as by participants. Participants were then invited to relax and breathe slowly into their hearts, allowing a memory of their loved one that helped soothe their grief to surface, a memory that warmed and strengthened and brought hope and aliveness into their body, a memory that was a treasured resource they wanted to tuck into their hearts for safekeeping. Participants were then invited to reflect upon an indigestible piece of the death story that they found themselves returning to and ruminating upon again and again. The facilitator suggested that this part might be about something that happened before the death, at the time of the death, or in the aftershocks following the death. It could be about the pain of the loved one's dying, or about hurt and damage to their family or their own sense of self. Participants chose a stick and craft materials, weaving and affixing objects, symbols, images, or written words onto the stick to represent both the difficult part of the death story and the special memory (Figure 59.2).

Group members were then invited to pair, and two men, Rob and Steve, sat together holding their talking sticks. These two men had paired before and there was a thickening of intent between them that spoke of deep and meaningful sharing. Rob, a gentle and intense man grieving the loss of his daughter to suicide, shuffled his stick back and forth between large hands. The second man, Steve, had taken years to find his way into a group like this following a long history of traumatic loss. His body was covered in a tapestry of tattoos—a living, visible representation of his life story drawn upon his skin. Yet the tattoos also hid the man beneath this bold display, warning others away and leaving him in self-imposed isolation.

Head bowed, Steve looked at the stick and said, "Life is a hard thing to avoid . . . you have to get up and keep going. The thing is, we had an argument that night. The stupid thing is it wasn't anything important. . . . I keep thinking if things had only gone differently . . . It's like a monkey on my back . . . a heavy shadow always with me. I keep going back over it, you know, thinking, 'if only.'" After a few moments heavy with emotion, Rob indicated the plaited string around his stick: "This is the rope . . . they couldn't . . . (breaks down) . . . they didn't . . . they didn't get her down. It feels like a phantom limb, always there aching but absent. I didn't know how to help her. It should never have happened. . . . it's just wrong." Both men sat immersed in a profound and intimate understanding that went beyond words.

After a long silence, Rob pointed to the green leaves he had attached to his stick and added, "She loved the land. When she was a little girl she was always showing me things she found in the garden. That's what I remember . . . she had such wonder. That's what these leaves are about and it helps remembering that." He pointed to a spiral shape: "That's eternity . . . we will meet again." After a heartfelt pause, Steve responded, "The texture of this stick reminds me of Sam. She could be so stubborn once she got an idea about something. She was like this stick; you couldn't make her see another way. But I



Figure 59.2 Steve's talking stick, used to hold both the pain of the event story of the loss and the memories and resources for embracing it

loved that about her too, she was something else. . . . Sometimes I feel her and it's almost like she's guiding me, you know, to do the right thing . . . the good thing." He pulled his collar to one side revealing the words encircling his neck, disappearing into a whirl of dense pattern: "To thine own self be true" (*Hamlet*, Act 7, Scene 1; Shakespeare). "This is for her . . . she's always with me." Rob reciprocated with more responses to his own loss, his moist eyes meeting Steve's as they spoke in near whispers. After a time the facilitator called the group to again gather in a circle and share briefly the talking stick story on behalf of the other, using the stick itself as a prompt and container of the story. Told with sensitivity by another, the related part of the violent loss story was deepened through group conversations and reciprocal disclosures, opening to new meanings.

Concluding Thoughts

Despite our advocacy of the guidelines discussed above in the context of typical mutual support groups, we also recognize that “restorative retelling” (Saindon et al., 2014; Sands, 2014) or “situational revisiting” (Shear, Frank, Houch, & Reynolds, 2005) of even the horrific details of traumatic death have been found to be therapeutic in both open and controlled trials of such interventions. However, helping clients voice, hold, and find empowerment in such experiences requires skillful facilitation of the event narration and its subsequent processing, of a sort that is not easily managed in routine support group settings. Detailed description of such professional intervention can be found elsewhere (Neimeyer, 2012; Sands, 2012).

Functioning as a “conversation manager” in a bereavement support group can sometimes be daunting, especially when some members feel great emotional press to pour out the traumatic stories of a loved one’s death by suicide, homicide, or fatal accident. In most such settings this entails balancing sometimes opposing needs: to hear and be heard, to share one’s grief and to problem solve about it, and to reengage the most painful aspects of the loss narrative while also learning to contain it and come to terms with it. We hope that some of the ideas offered here—many of them generated by veteran peer facilitators of support groups—offer useful practices that help achieve this balance.

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The Collaborative Poem

Nicholas F. Mazza

Clients for Whom the Technique is Appropriate

The collaborative poem is appropriate for grieving families, groups, and communities. While this technique can be adjusted with respect to group and/or family composition, additional considerations include the stage of family and group development, therapeutic purpose (e.g., build cohesion, termination device), and capacity, noting history, literacy, culture, and health.

Description

Poetry therapy is the use of language, symbol, and story in therapeutic, growth, educational, and community-building capacities (Mazza, 2003). There is increasing evidence of the mental health benefits of expressive writing (e.g., l'Abate & Sweeney, 2011) and the larger theoretical and practice methods of poetry therapy (Mazza, 2003; Mazza & Hayton, 2013). Mazza's (2003) RES multidimensional poetry therapy practice model encompasses the complete range of poetry therapy methods through its three primary domains: (R) Receptive/Prescriptive, (E) Expressive/Creative, and (S) Symbolic/Ceremonial.

(R) Receptive/Prescriptive

Introducing pre-existing poems (or other forms of literature and song lyrics) in a therapeutic capacity (e.g., connect the poem to the content/dialogue of the session to validate a feeling, promote self-expression, advance group process). Poetry and music are used as a springboard for self-disclosure and group discussion. For example, Mike and the Mechanics' recording of "The Living Years" can be used as a springboard to discuss the death of a family member and internal conflict or regret regarding past conflicts, such as not taking the time to be closer to the individual or failure to express loving feelings. Linda Pastan's poem "The Five Stages of Grief" (based on Kubler-Ross) can be used to validate clients' feelings that grief is circular and re-occurring rather than a linear sequence.

(E) Expressive/Creative

Facilitating written expression (e.g., poetry, letters, journals, and stories) is the focus of the expressive/creative domain. Various individual and group exercises can be used to deal with death and loss. Focused expressive writing can serve as a safety valve to express painful feelings, provide a sense of order and control, honor the memory of a loved one, and promote group interaction. Some of the expressive/creative writing techniques include:

- *prestructured sentence or poetic stems* (e.g., What I miss most . . .);
- *clustering*, whereby one can free associate (similar to brainstorming) images and feelings related to a central word (e.g., “loss”);
- *sensory poems*, a prestructured exercise to create a poem based on the senses (e.g., Loss sounds like . . .);
- *acrostics*, whereby one starts each line with a letter from a particular word (e.g., the first name of the deceased person);
- *dyadic poems*, whereby two individuals from a family unit (e.g., father–daughter) create a two line poem; and
- *collaborative poems*, whereby each member of a group or family has the opportunity to contribute one or more lines to a poem.

(S) Symbolic/Ceremonial

The use of metaphors, rituals, symbols, storytelling, and performance (e.g., dance and movement) can be used as a means to deal with death and loss. The symbolic/ceremonial component includes elements of both the expressive/creative and receptive/prescriptive elements; however, it speaks primarily to the importance of symbols in our lives and the need for meaning.

Collaborative Poems

The focus of this chapter is on the collaborative poem as an expressive/creative group technique. The group facilitator identifies a theme or predominant feeling in the group (e.g., frustration, loss, hope) and invites each member to contribute one or more lines to the poem. When necessary, the group facilitator can offer connecting words between lines. The facilitator can also guide the group by asking members to think about what the theme or feeling looks like, feels like, etc., or what images come to mind. It should also be emphasized that the offering of lines is voluntary and even silent members contribute by their very presence. Sometimes a reluctant member can be asked to serve as a recorder (writing lines down). Once the poem is completed, the facilitator asks if anyone would like to read it, thus providing group ownership. After the session, the poem is printed with group member names noted as authors (if permission is granted) and copies are distributed in the subsequent session. This is helpful in transitioning from one session to another and allows members to revisit where they were the previous week and where they are during the current session. The poem can serve to affirm their strengths and provide some measure of support. The reading and perhaps posting or framing of the poem can also serve in a symbolic/ceremonial capacity. Overall, the collaborative poem allows group members to express their feelings in a safe environment, engage in problem-solving, promote supportive relationships, and advance group cohesion.

Case Illustration

The focus of this section is on the illustration of collaborative poems in two contexts relating to grief and loss. In the first, a grief support group for children (ages 5–12; 8 members), the collaborative poem was used toward the end of a 60-minute session to bring together a range of feelings and reduce some of the isolation expressed by the children.

Grief

Is like a wave
 or a rollercoaster.
 Taking us through different emotions.
 You have good days
 and bad days
 Although no day is the same.
 Everyone has to grieve
 Know that you are not alone
 And that you have a right to talk
 There's always a shoulder to cry on
 So express yourself
 through all this ordeal.

(Mazza, 2012, p. 446)

This poem served to affirm the strengths of group members and universalized their feelings. Through the poem, each member found voice to grieve, seek support, and help each other. The poem was later taped to a wall for a special event for grieving children and their families thus also serving in a symbolic/ceremonial capacity.

The following is an example of a collaborative poem used in a supervisor/consultation capacity to help professionals deal with their own issues on grief and loss. The poem was created by staff members (psychology, social work, mental health counseling, art therapy). The members were asked to draw from their own personal experiences as well as their experiences in working with clients who presented problems relating to death and loss.

Loss

Loss is an empty hole
 What can I fill it with?
 I try and try to no avail
 It leaves me feeling invisible
 The silence of the room deafens me
 Just give me one more minute
 I get lost in my thought
 Left to feel—Is it all my fault?

This poem helped the practitioners identify their own struggles in dealing with clients' loss and how it touched on their own vulnerabilities. Ultimately the poem served to promote constructive approaches to dealing with trauma and loss. Through shared and universalized experiences, staff members found support and renewed hope/confidence.

Concluding Thoughts

The collaborative poem, as part of the expressive/creative component of the RES poetry therapy model, shows promise as a therapeutic tool that builds on the shared pain and collective strengths of those affected by death and loss. The collaborative poem as an expressive/creative technique can also be used in combination with the receptive/prescriptive domain, writing a poem in response to a pre-existing one. Additionally it can enter the symbolic/ceremonial domain by reading it in a community activity celebrating the life of a deceased loved one, or framing and placing it in a home or agency, or posting it to a support group website.

As with any technique, the use of the collaborative poem and other expressive writing requires caution. A client may not be ready to express painful feelings and there may have been previous traumatic experiences that become reactivated. Perhaps the best safeguard against such problems is to allow but not push the clients to tell their stories in a safe and supportive environment. The promise of the poetic is to provide a special healing connection through word and deed that is affirming, respectful, and a tribute to those who have passed.

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The Red Tent

Diana C. Sands

Clients for Whom the Technique is Appropriate

The Red Tent is a group intervention for bereaved women, and particularly for women grieving a violent death, who can benefit from a sense of reinclusion in a caring community. The Red Tent intervention helps bereaved mothers to access internal and interpersonal resources and is an effective way of resourcing and strengthening the family system. However, because it draws on archetypal feminine forms and symbols, the technique is not suitable for men or children.

Description

This expressive arts intervention brings together story, metaphor, and symbolism to deepen social engagement, trust, and intimacy between group participants. It was developed for use in *Reweaving the Songlines*, a group for mothers of young children whose father had died through suicide. Children grieving the loss of a parent to violent death depend on the surviving parent to make the world safe and understandable, yet bereaved mothers report feeling fragile and overwhelmed by the task of rebuilding safety and hope for their family (Sands, 2010).

The Red Tent uses the language of symbol and sensory experience to create a net to catch the unspeakable, emphasizing the significance of attending to somatic narratives as a source of information to support healing. The flow of unfolding meanings that emerge presents different possibilities for reconstructing distressing material from the death story to rebuild safety and hope.

Central to the intervention is the book *The Red Tent* (Diamant, 1997), a fictional work, loosely based on the biblical story of Joseph. The red tent story is rich in metaphoric meanings about love, betrayal, and violent loss, but most importantly, it is a story about the strength and understanding to be found among women. It is a story that illustrates how good memories are woven at a sensory level into our bodies as a resource to sustain us through dark times. The red tent is the symbol for these resources; it is where female coming of age, marriage, birthing, and seasonal rituals are observed. In a similar way to the bereaved women's group, the red tent is the place women share their stories and nurture each other, celebrating happy events and holding each other through trauma and sorrow.

The intervention can be used in the first session, following group guidelines, introductions, and contextual information. A 5-minute version of the red tent story is told and the ensuing group discussion highlights parallel experiences. Next, a guided visualization invites participants to move their attention into their hearts, attuning participants to healing memories of hope, joy, love, laughter, kindness, and care. Memories involve sensory material encoded at a nonverbal level, and participants are encouraged to allow their body wisdom to guide them, noticing their sensory experience and symbols, images, or words that emerge. Participants play with the memory as they imagine the sensory information encoded in that memory, now flowing through their body, filling it with light and warmth, touch, smell, movement, and visual images.

Participants are then guided to notice a place in their body where they hold a part of their grief that they struggle with alone, that shadows and corrodes hope. Participants are encouraged to feel a sense of separation, or observation of this part of their grief as they imagine pouring or pounding it into a stone. The size, shape, color, and texture of the stone are visualized. Participants imagine placing or throwing the stone within the river of their life memories, where it is tumbled and washed through with the whole of their life experience.

After that visualization, participants are directed to a basket filled with red materials in various shades, patterns, and textures. Participants select a material with a texture and shade of red that captures the feeling sense of their resource memory. Participants then select from a basket filled with stones, their grief stone. Standing in a circle, participants in turn share their memory and tie the red material around a tent-pole-like structure in the centre of the group (Figure 61.1). When all participants have shared their resource memory and tied the materials together, they share the meaning of their grief stone. The stone is placed within the red tent that they have constructed. During this process the facilitator gently guides participants to explore the somatic narrative that is emerging, bringing attention to self-regulation, while soothing and calming intense sensory experiences that are distressing (Neimeyer & Sands, 2011; Schore, 2012).



Figure 61.1 The Red Tent is used to support somatic narratives related to tragic loss

Case Illustration

The following case illustration focuses on a group for mothers of young children whose father has died by suicide (website resource for Reweaving Songlines Program <http://www.bereavedbysuicide.com.au/>).

Forming a circle, the women listened to Gillian, a young mother bereaved by suicide, as she talked of the night her daughter was born. This was a time when Gillian and Roger, her husband, shared tears of happiness. Gillian sobbed, "It was a moment outside time . . . a moment I will always . . . always have . . . I can feel it now deep in my body, the love between us, holding each other . . . holding our baby. And I'm not going to allow what's happened to take that away from me." As Gillian knotted a piece of red material, intricately threaded with gold, to the tent poles, the women moved around her and held the wonder of her daughter's birth, while also acknowledging the horror of Roger's death.

Daria, a small, quiet woman, stepped into the space to speak next of her parents' courage that she now finds deep within herself. Daria related the story of her parents' harrowing and courageous escape from a communist-controlled country. Daria's eyes moved around the circle of women as she forcefully said, "You just have to keep going . . . one foot in front of the other . . . and . . . keep pushing back the darkness . . . you . . . just have to keep pushing it away." One hand firmly holding her abdomen, Daria said, "I feel their strength here in me."

After a pause, as the group absorbed the potency of Daria's words, Sharon talked of a family day at the beach. Sharon shielded her eyes behind tissues as she recalled the warmth of the sun on her skin, the smell of summer, the sound of the waves and the easy laughter of George, her partner, in the water with their boys. "It was such a perfect day . . . it couldn't have been more perfect. I could never have known what was going to happen . . . how the illness would change him . . . destroy the person I loved . . . change him so terribly . . . and take him away from us."

After all the women in the group had shared their resource memories they were invited to speak about the part of their grief now held within the stone. Gillian talked of the night Roger killed himself, how she was fast asleep when she suddenly woke with her heart racing and panic spreading through her body as she fought to breathe. She felt as though she was suffocating. After that moment of wakefulness she fell back to sleep, only to discover Roger's body in the morning. Gillian spoke of how she often re-experienced these feelings, and her fear of waking during the night to this nightmare. "It feels like Roger is angry with me . . . and I wonder . . . was that him saying, 'help me?'" Gillian's tears muffled her words, as she placed her stone within the tent, "I feel so guilty . . . why didn't I get up and look for him?" The facilitator supported Gillian's grief and her efforts to self-regulate, drawing on the empathic support of the group.

In the deepened emotional space now created, Daria, her hand on her throat, shared, "It's so difficult to say this . . . because I loved Theo . . . (lengthy pause) . . . but when it happened . . . all I could feel was relief (sobbing). I'd been so terribly frightened about what Theo might do to me, or that he would hurt the kids. He would be OK . . . you know . . . normal . . . and then he'd stop taking his medication and I didn't even know who he was then . . . I was so scared." Daria rubbed her throat, moving her painful, physical blockage out and into the stone.

Sharon responded, "That must have been awful. . . . Even when George was really in a bad way . . . I knew deep down he'd never do anything to hurt us." Sharon went on to share that the difficult part of her grief was the realization that she hadn't understood the anguish George was experiencing. "He must have been in so much pain to do this . . .

I thought I knew him, I thought I understood . . . but I didn't." As Sharon placed a heavy stone within the tent, she indicated that the pain of her failure to keep George safe was heavy in her heart. The other women held Sharon's anguished words within the group, offering not superficial words of comfort but the healing presence of their witnessing. As the participants physically and emotionally created their own red tent, the group space transformed into a sacred place of support, not only for the women's pain and sorrow but also for their healing as the realization that they were not alone moved through them, a whisper of hope.

Concluding Thoughts

Research in developmental neuroscience and psychotherapy has stressed the importance of processing trauma at a sensory level, and in that process, the significance of using emotional connections to support effective self-regulation in reducing hyperarousal (Schore, 2012). The Red Tent is a way of working around the edge of violent, traumatic loss using the group emotional connections to assist self-regulation of intense experiences. For those violently bereaved, constructing a healing, integrative narrative that repairs family safety is a fundamental part of the bereavement process and the red tent functions to facilitate this process (Sands, Jordan, & Neimeyer, 2011; Sands & North, 2014). The Red Tent could be adapted and tailored for use with a range of different types of traumatic and violent losses, and would also be suitable for those who have experienced abusive relationships.

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62

Grief Ball

Alison J. Bomba

Clients for Whom the Technique is Appropriate

Children, adolescents, and families may benefit from this game of catch that elicits dialogue about grief experiences. However, when losses are complex and responses to them are complicated, more intensive family, group, or individual interventions are indicated.

Description

Adults have varying levels of comfort talking about death, and children are no different in this regard. All grieving people, regardless of age, benefit from reassurance that their feelings are okay and opportunities to express those feelings (Jeffreys, 2011). When appropriate, specific activities can be utilized in session to increase clients' comfort levels while talking about death and the deceased. One activity for children and adolescents involves engaging them in a game of catch via a "grief ball."

A grief ball is created by using a marker to write questions pertaining to grief and loss on the various colored sections of a beach ball and engaging clients in a game of catch. When the ball is caught, the receiver of the ball reads and answers a question under one of his or her hands before tossing it to another person. Prior to beginning a game of "grief ball," it is often helpful to identify the deceased person who will be discussed as the client's "special person" or "SP." Any age-appropriate questions related to grief and loss can be written on the ball. Some recommended questions include:

- What comes to mind when you think about death?
- How did you learn about your SP's death?
- How did you feel when your SP died?
- How did your family express emotion when your SP died?
- How do you remember your SP on special days?
- When do you think about your SP?
- How do you feel when you think about your SP?
- If you could turn back time, what would you say or do with your SP?
- What is the first thing that comes to mind when you think about your SP?
- If you could say something to your SP now, what would you say?
- What is your favorite memory of your SP?

Grief ball can be used in individual, family, or group therapy settings. During individual sessions, the client and therapist play the game together, with the therapist normalizing and modeling healthy emotional expression. When used in family therapy sessions, the therapist facilitates healthy dialogue among family members while engaging them in the game of grief ball. Finally, grief ball is an invaluable tool to use during therapeutic bereavement groups with children or adolescents, as the sharing of grief experiences through question and answer (Q&A) provides clients with the opportunity to begin to slowly share their stories in small doses and often helps to “break the ice” during the initial group session.

There are other modalities for implementing Q&A games with children, adolescents, and families. A game of “fortune teller” can be developed with school-age children in session by creating an origami paper fortune teller and having child clients assist in drafting questions to add. Another method involves clients drafting their own questions by writing them down on slips of folded paper and then drawing questions out of a “hat.” This option may be a nice alternative to grief ball for use during family therapy sessions, as it often elicits specific questions that child and adolescent clients have for their adult family members that can be further explored or discussed (“Who will take care of me if my other parent dies?” “Are we going to have enough money to survive?” “Who will die next?”). The Q&A paper version may also be more age-appropriate for older adolescents who may not be as receptive to participating in a game of catch with the grief ball. Grief ball and other Q&A games are creative and fun ways to facilitate dialogue, normalize, validate, and assist clients in externalizing emotion. Additionally, Q&A games of catch can be used to explore other types of loss by creating beach balls that include questions pertaining to terminal illness, divorce, pet loss, etc.

Case Illustration

Six school-age children participated in a child bereavement psychotherapy group. Initially, most of the children felt a bit nervous and reluctant to share their grief stories with the group. During the initial group session, time was spent making introductions, developing rules for the group, and laying the groundwork to create a safe therapeutic environment. After several “icebreaker” activities, the one commonality that brought the children together was acknowledged . . . each of them had recently experienced a death of a parent.

The therapist led the children in a game of catch with the grief ball. This structured activity allowed the children to feel comfortable enough in the therapy session to share small portions of their stories with the group. The children were also able to have some fun with the game of catch, as they tossed the beach ball back and forth to each other while sharing stories of their grief journeys. The activity proved to be a normalizing experience for the children, as quite often in response to one of the children’s answers to the grief ball questions, the other group members would say things such as, “Me too!” “That’s how I felt,” and “I thought I was the only one who felt that way!”

The grief ball activity unified the group of children and helped solidify their common bond. The children had created for themselves a safe therapeutic environment in which to share their stories, externalize their emotions, feel heard, and begin processing their losses.

Concluding Thoughts

The grief ball question and answer game is a tool that can, depending on the specific questions written on the ball, assist clients with each of the four tasks of mourning identified by William

Worden (2009): (1) accept the reality of the loss, (2) process the pain of grief, (3) adjust to the world without the deceased, and (4) find an enduring connection with the deceased in the midst of embarking on a new life. However, one should be aware of the possibility of re-traumatization and recognize each client's readiness and where he or she is in the grief journey before engaging in the game. Some clients may not be receptive to discussing certain information related to their grief experiences. In these instances, therapists should normalize the reticence and allow clients to "pass" or choose different questions from the grief ball to answer if preferred.

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Part XII

Recruiting Ritual

Playing with Ritual

Ellen G. Levine

Clients for Whom the Technique is Appropriate

Children, adolescents, and adults can all benefit from imaginative engagement in rituals, both in individual therapy and in families or groups, to give meaning to a loss or facilitate a transition in grieving. At other times, however, these will naturally be supplemented by realistic discussion of clients' needs and concerns, and direct support in embracing the life changes required by bereavement.

Description

Play and imagination are resources that help people deal with challenging life situations. I would like to present an example of the deliberate shaping of play into a ritual in a therapy treatment with a 7-year-old girl. Playing with ritual was a key element in the grieving process for this child. Turner and Van Gennep write about the phases of a ritual process as beginning with the preparation period, then crossing the threshold into the "liminal space," where the transition from one state of being to another is enacted, and ending with an emergence into a new social status or state of being (Turner, 1969; van Gennep, 1960).

For a community, such events as funerals or weddings are "rites of passage" that help the participants to pass from one state to another. For an individual, the creation of a ritual can help particularly with mastery of an experience of loss. What is interesting from my point of view, as an expressive arts therapist, is the role of the arts and art-making in the construction and the carrying out of a ritual process.

Case Illustration

Jon and Sue came to see me to discuss the idea of therapy for their 7-year-old daughter, Pia. Jon had been diagnosed 10 years before with a malignant brain tumor. After the diagnosis and several surgeries, and despite the poor prognosis, he and Sue had decided to have a child. Everyone was amazed that he had managed to stay alive for 10 years after the diagnosis. However, Jon's condition had recently begun to worsen, and he knew that he would not live for much longer.

The couple knew that their daughter would be deeply affected by Jon's death, that she was already struggling with his illness and the periodic hospitalizations that had become a part of their lives. Jon seemed to understand intuitively what Pia needed: particularly someone to make art and to play with her and someone with whom she could feel relaxed. In subsequent conversations with Sue, it became apparent that Jon was the major play partner for Pia and that Sue rarely played with Pia or joined in the fun between Pia and her father.

When I first met Pia, I was struck by how much she resembled her father. She is an unusually tall, thin child with long curly, strawberry-blonde hair. At first, she was quiet and a bit shy. I observed right away that she was very bright, had a great capacity for play and her imagination was rich and fertile. I knew that these would be important resources in our work together. Pia loved making up stories, playing, and drawing. There were several themes that emerged in the first 10 sessions. Her mother attended most of the sessions throughout the treatment, and we worked on helping Sue become more comfortable with playing. Pia often wanted to make something to bring to Jon during the course of his illness. His impending death was always a subtext for our work together. Throughout our time together, Jon was declining, in and out of the hospital and finally in hospice care. Pia often drew and spoke about a "magical baby" who had special powers of healing. However, the most significant theme that emerged during the treatment was the story of *The Lion King*, which Pia knew in detail along with the music and all the lyrics. Often, Pia pretended to be a lion and, with the lights off in the playroom, she crawled around on the floor and roared fiercely, enjoying the feeling of being scary. Pia wanted us to join in, and Sue began to be more comfortable crawling around on the floor with Pia and me.

Pia's emphasis in the story was on the relationship between the baby lion, Simba, and his father, the king, Mufasa. In the story, Simba and his father were very close. They often played together and the father taught the son many things about being a lion. Life was rich and peaceful. Mufasa told Simba that they would "always be together," and that "the stars in the sky are the King lions who would always be there to guide you." The critical scene came when Mufasa's brother, Scar, tricked Simba into setting a trap to kill Mufasa. Scar killed his brother and arranged it so that Simba felt responsible. Pia talked about how much she loved the scene when Simba went to his dead father and laid for a while under his paw. She told me that she watched that scene over and over. Pia sang the songs from the movie; she remembered all the words and knew all the names of the animal characters. Whenever she told the story and sang the songs, her mood became happy, playful, and she was clearly enjoying herself immensely.

Jon died just before our 18th session. I opened the session with an acknowledgment that much had happened since our last meeting. Sue talked about all the activities that Pia had participated in as Jon was dying and after he died. A music therapist had visited Jon and had sung songs at his bedside. Pia joined in with the singing, and she told me what she had sung to Jon: *Twinkle, Twinkle, Little Star* was a favorite. Pia and Sue told me that after Jon died, Pia spent several hours in and around the room where his body lay. She played and drew on the floor, moving freely in and out of the room. Pia was quite talkative and engaged in this session, and she asked Sue and me whether we wanted to be in a coffin or cremated. She said that she wanted to be in a coffin. She wondered aloud: "What happens to your spirit when you die?" Pia wanted us to join her in drawing pictures of ourselves as spirits looking down from the sky. While we drew, she talked about how we all become stars shining in the sky and that her Daddy is "watching" her. She said that she could hear his voice.

In the 21st session, Pia became thoughtful and began talking about the "lion spirit" from our play in a previous session when she had become a very aggressive "lion spirit" who was wounding, killing, and eating all the animals. She went back to *The Lion King* story and talked about how Mufasa's spirit talked to Simba at the end to give him the

strength to go on and become the new king. At this point, Pia talked about Jon and how she wanted to let his “spirit go away.” I suggested that we could make something together that might help her let his spirit go away. I asked her what she thought we could do together.

Pia came up with the idea that we should have a fire and burn it, and then it would float away to the sky and into the clouds. From this, I imagined that Pia wanted Jon’s spirit to go up into the sky where it could stay like the spirit of Simba’s father and talk to her periodically. I took this as a very serious piece of work that Pia needed to do to continue the process of mourning her father’s death. I felt that she needed a frame for her play, a frame that would be effective for her.

I began thinking about the appropriateness of designing a ritual that might help Pia at this point. It seemed like an opportune moment to engage in a kind of structured experience that would help her to accomplish the goal that she had set out for us, which was to turn her father’s spirit from a rather scary aggressor into a benign helper. Drawing upon what I knew about arts-based ritual processes, I decided to invite Pia to begin by engaging in a period of art-making as preparation for the first stage.

As part of the preparation phase, I said that unfortunately we could not make a real fire in the playroom, but we could make a pretend fire. This emphasized the therapeutic action of play therapy, which came through the enrichment of the imagination. Empowering Pia to take the lead, I asked her how she thought we could do this. She immediately rose to my challenge and came up with some ideas. I could tell that she was now getting excited and mobilizing her imagination.

We set to work with ordinary objects that we found [?] in the playroom: a piece of drawing paper rolled up and some paper tissues. Pia cut the paper roll in half and taped the two pieces together, crossing each other like two logs. Next, she directed me to help her color the tissues to make it look like flames. We worked together on this with red and orange pastels. We taped the flames (tissues) to the logs (paper rolls). Finally, Pia took some more tissues and balled them up saying, “This is his spirit.”

After organizing our materials, we were ready to enact the ritual play and to move into the “liminal space” of imagination and play. This required a step out of ordinary reality. The everyday objects had now been transformed into imaginal tools and imbued with a magical or fantasy status. We put the “fire” into the center of the table and lit it, letting it grow and develop. Next, Pia put the “spirit” (ball of tissues) into the fire. I suggested that we say some words as it was burning and we, together, came up with the following chant: “Fire, burn up the spirit! Fire, send the spirit up to the sky!” We had to say these words over and over several times. Pia then declared: “His spirit is up there!”

Because Pia was so definitive in her declaration, it now felt as if the job was finished, that the excitement of the chanting and enactment had diminished. Pia said that she wanted to keep the “fire” and the “spirit” in her private drawer so that she could look at it again. She carefully put these objects into the drawer. They had become very special because of the use they had had in the ritual. Their everyday appearance as simply tissues and paper rolls had been transformed. I noticed that Pia seemed calm and settled.

Through a ritual process that involved play and art-making, Pia was able to accomplish the task of setting things right in terms of the placement of Jon’s spirit and the role his spirit would play in guiding her into the future. He had to go up into the sky, to be “up there” in a new form, as a star shining down on Pia, just like what happened to Mufasa in *The Lion King*. It was my sense that this concrete placement of Jon had helped Pia to contend with the emptiness of his absence. Pia was changed through the play that we made together in the ritual and, most importantly, Jon changed his form so that he could remain with her. The ritual helped to create an imaginal world that could be useful to Pia in living with the fact of her father’s death.

Concluding Thoughts

I have also used arts-based ritual processes in the closing phase of treatment with a young adult woman (Knill, Levine, & Levine, 2005) and with an entire family in which the children had been abused (Levine, 2012). When a life cycle event such as a death has occurred, it is often helpful to create artwork that functions as a totem or memorial object to stand in place of the lost person. Examples of such objects or art works are altars, collages with significant photographs, poems, stories, songs, and dramatic scripts.

Creating art objects and art works within a framed experience such as a ritual process makes these objects and works special. These significant objects then carry the presence of the lost person and embody them in a shape or form. In this way, arts-based ritual play that mobilizes imagination, inspires creativity, and comes into form through the making of art works can help to carry the pain of grief and loss.

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Spiritually Based Healing Rituals

Judy H. F. Chew

Clients for Whom the Technique is Appropriate

Spiritually based healing rituals are well-suited for individuals who value symbolic work that incorporates spiritual values. These rituals are also potentially efficacious for relationship losses not adequately recognized by the wider community. Rituals may not be appropriate for clients who are unable to tolerate emotional intensity. Commitment to participate is vital for optimal healing, so informed consent is crucial.

Description

The traumatic experience of child loss through forced abandonment touches the core of a parent's identity. Healing rituals offer a powerful resource for meaning-making after traumatic loss. The premise is that the individual's symptom or complaint represents an attempt at healing by altering one's identity in relation to trauma (Gilligan, 1993). The healing ritual is "an intense, experiential-symbolic structure that re-creates or transforms identity" (Gilligan, 1993, p. 239). The ritual empowers the individual to disengage from the deleterious and dissociative effects of the "old self" which may experience anxiety, guilt, and isolation. Components of the "old identity" are externalized, which allows the client to claim a new identity that provides healthy connection to self and community. An integration of personalized, relevant activities and symbolic images are woven into the structure of healing rituals.

Gilligan (1993) outlines a four-step method to address the symptom that is the client's focus of change. In this case study, the method is adapted for a spiritually based healing ritual.

Step 1: Frame the Symptom in Ritual Terms

1. Identify the repetitive symptom.
2. Frame the symptom positively as an incomplete attempt to engage the healing process.
3. Enlist the client's full cooperation and motivation to participate in the ritual.

Step 2: Plan the Ritual

1. Invite client to select physical symbols of old self-identity (e.g., clothing, books, photos).
2. Invite client to select physical symbols of new identity, including living symbols.

3. Specify the ritual act (e.g., disposing, burying, burning, sealing).
4. Specify details of the ritual (e.g., time of day, location, other participants).
5. Invite client to begin to generate the experiential and symbolic focus (e.g., reading, mindfulness meditation, journaling).

Step 3: Enact the Ritual

1. Perform pre-ritual induction such as meditation, reading, or prayer. This transitions the person to a ritual space that generates change.
2. Enact the ritual itself.
3. Engage in post-ritual processes such as a celebration, quiet time, or outing.

Step 4: Reincorporate Self into Community

1. Develop structure for expressing the remnants of old identity (mementos, exercises).
2. Establish structures for expressing the new identity (symbols, clothing, activities).

Case Illustration

Xiao Hong sought counseling as the 16th birthday of her twin daughters approached. Married in China, Xiao Hong became pregnant with twin girls. Her husband and his parents had ordered her to produce a boy. Under China's one-child policy, Xiao Hong's options were to abort the girls or give them up. On August 8, Xiao Hong gave birth to Hope and Grace. Late one autumn evening, her husband and father-in-law dropped the baby baskets off at a hospital as Xiao Hong sat in the car, enraged and grieving.

During pregnancy, Xiao Hong befriended a United Church minister who offered some solace amidst her description of "many lifetimes of grief." After immigrating to Canada, she left her marriage and joined another United Church. Xiao Hong was referred by her current minister after sharing her agony of recurring dreams about the last day she saw her twin girls. Xiao Hong was also remorseful that her pregnancy was in China instead of Canada, because it meant she lost her twins. She sought to understand how God could accompany her in this anguish.

In our work, Xiao Hong identified and honoured her steps taken to gain independence and pursue her dream to be a graphic designer. We took time to create a sense of safety and access her resources to address in-session and out-of-session needs. Xiao Hong admitted that being secretive carried a physical, emotional, and spiritual toll, but was cautious about opening up. A breakthrough came in a positive dream in which she felt God's presence as she emerged from a dark, wooded valley. She shared this with her minister, then agreed to pursue therapy.

The first stage of therapy included education on how the "symptoms" of negative recurring dreams serve as positive attempts to engage in healing. Given her artistic inclinations and exposure to some healing activities through her faith, Xiao Hong was eager to incorporate a healing ritual. In our second stage, she gathered symbols of her old identity, which she also described as her identity-in-progress. Her box of old identity symbols from China included her wedding photo, and the shoes and dress she wore the day she last saw the twins. Xiao Hong produced copies of the note she tucked into each daughter's sleeper, which included their first names and the words, "lovingly placed in God's care and protection." Xiao Hong constructed a collage of the number eight to

commemorate the double joy of the twin's birth, and brought out a tattered copy of the Bible given to her by the minister in China.

The symbols for her new identity included a photograph of herself in new shoes and a colorful dress, a new Bible, and a prayer she wrote to God asking for His ongoing protection over the twins. She also included the copies of the original note for them. Over two sessions, I created space for Xiao Hong to slowly share the story of herself in her old identity. Her symbols enabled her to produce a narrative openly and fully for the first time, and externalize the identification of herself as an immoral, wretched woman for having left her children. This was the condemning identity she internalized for years. A vision of a retributive God left her fearful, despite her minister's reassurance. Her new identity symbols reflected a permission to discover joy expressed with an array of eight plants—the number eight denoting “new beginnings” in Hebrew thought. Her new Bible reflected a spiritual shift from a judging to compassionate God. The new unsent letter to her twins freed her to regard them as teenagers rather than infants.

In the third stage of the ritual, Xiao Hong spent a few weeks discerning her next steps. She returned with a decision to continue with the healing ritual work in session. She brought back her box of old identity items and then decided to place these in a locked trunk in the garage until further notice. She also read a favorite scriptural passage that inspired her newfound confidence in God's grace and care for her.

In the fourth stage of the ritual, the symbols of Xiao Hong's new identity-in-progress prompted a commitment to herself. She tearfully acknowledged her identity as a loving mother—an identity not now threatened by the absence of her children or assaults from dark dreams, which were less frequent and burdensome. Xiao Hong said she was discovering hope and grace.

Concluding Thoughts

Spiritually oriented healing rituals can connect the past, present, and future, and the co-construction of “tailor-made” therapeutic rituals is effective in meaning-making. It is crucial to assess a client's unique faith expression and the ways in which spirituality or religion is situated in the context of the loss. Murray-Swank and Murray-Swank (2012) stress the importance of assessing the role of spirituality in meaning-making and understanding spiritual struggle.

Clients will vary in their emotional capacities to engage healing rituals outside of sessions. It is essential to conduct a thorough assessment to ensure that such activities and processes are ethically appropriate and timely. Cultural considerations need to be factored in the co-creation of spiritually oriented healing rituals. For example, the use of journaling, prayer, or meditation exercises may not be salient or even positive. Xiao Hong's artistic and spiritual capacity enhanced her readiness to engage in similar therapeutic rituals.

It is important for therapists to reflect on their own comfort and competence with spirituality and co-creative healing rituals. To explore loss and meaning-making can involve us in *wei ji*—the wisdom that events can, at the same time, contain both loss and hidden opportunities (Slattery & Park, 2011).

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65

The Wise Elder

Damita SunWolf LaRue

Clients for Whom the Technique is Appropriate

The Wise Elder technique can be utilized broadly across many cultural groups who honor their elders and hold the belief that guidance can be received through seeking the wisdom that elders have accumulated from a lifetime of experiences. This technique invites adult and adolescent clients to seek advice from an older part of themselves to access their internal wisdom in order to acknowledge their respect for elders while finding the path that is best for them in grieving a loss. It might be inappropriate for very young children, or for clients who struggle with authority, making the imaginative attribution of wisdom to older persons difficult.

Description

At a deep level, humans have an internal wisdom about the answers to their dilemmas in life. However, there are times when this wisdom may be difficult to access. The Wise Elder tool is a metaphoric experiential technique that assists clients in accessing their own internal wisdom while respectfully aligning with their unique cultural practices. The Wise Elder technique, initially discussed by Dolan (1991), was modified by Hays (2014) as a cognitive behavioral therapy thought-change tool. While this technique has some similarities to *age progression* in hypnosis, the clinician is not asking the client to experience life in the future based on a specific situation, but inviting the client to ask for guidance and advice from a future self (Hammond, 1990; Hays, 2014). After identifying a stressor that had resulted in negative thoughts or feelings, Hays utilized the technique to assist the client in visualizing himself or herself at the age of 90. The client would then ask the 90-year-old version of himself or herself about the specific situation and seek advice.

From a relational constructivist model, the Wise Elder can be modified to investigate the constructs clients have created and the options they have been unable to access with respect to a particular situation. Once a positive, collaborative, therapeutic relationship has been established, the experiential technique opens the way for the elder version of the client to share internal wisdom with his or her younger self through the use of metaphors while exploring the situation. The therapist then facilitates an exploration of metaphors that represent the person's grieving experience, which can assist the individual in the meaning-making process. This exploration helps the client to find understanding and new ways to heal from a variety of situations.

I utilize this technique in therapy, along with *analogical listening* (Neimeyer, 2012), when clients begin to feel that there are no answers to a situation or no way to deal with the emotions and pain they are feeling. This allows us to move past rational or logical conversation and into a state of immediate felt experience. Once we have determined the specific dilemma or emotion that the client is struggling with, I ask the client to participate in visualization with me. There is no formal hypnotic induction, but after the client has agreed to participate, I lower my voice and begin using a focused, calm pacing and rhythm. I invite the client to close his or her eyes if he or she chooses. I then close my eyes to lead the client by example. I ask the client to move around in the chair to find a place of comfort. Then I utilize a series of statements and questions to prompt the client's visualization. I instruct the client: "Imagine that you are 90 years old, with a lifetime of experiences, learning, and wisdom" (Hays, 2014, p. 110). Figure 65.1 depicts one visualization of this image.

I open my eyes to observe how the client is responding to my suggestions. I close my eyes again and ask the client what he or she is seeing. I do not expect a verbal description, but sometimes clients will tell me what they are seeing. By closing my eyes, I am trying to join the client's visual experience and imagine that I am seeing what the client is seeing and feeling what the client is feeling. Oftentimes, I can feel the client's emotions, and tears form in my eyes due to the heavy weight of the grief in the room. I ask very specific questions at a very slow pace, with pauses to allow the client to discern the answers and see himself or herself as clearly as possible, utilizing all of his or her senses. My questions may include the following:

- Where are you located? (Oftentimes clients will see themselves outside in nature.)
- What are you doing?
- What do you smell?
- What do you hear around you?



Figure 65.1 The wise elder. Visualized and depicted by Rachael LaRay Calton. Reproduced with permission of the artist

- Are there any tastes that you are experiencing?
- What do you look like at the age of 90?
- What color is your hair?
- How long is your hair?
- Look at your hands; what does your skin look like on your hands?
- What does your skin feel like?
- Do you see or feel wrinkles on your skin?

I find that the more detail that clients are able to produce, the more they are moved from a logical state into the experiential where they can more fully access their own inner wisdom. As I observe the client settling into the visualization, I notice his or her physical reactions and facial expressions, which offers me guidance to provide a longer pause, so the client can access more details, or move forward in the experiential process. Then I say:

Now because you are 90 years old, you have the wisdom of life experiences. You are a person who is respected, and other people seek out your guidance and direction. So, now let wise (client's name) speak to young (client's name) and tell young (client's name) how (he or she) can face this situation or handle it in the most effective way.

I then listen very carefully to each word the client uses and the metaphors that spontaneously emerge. When the client responds with a metaphor, I ask the client to expand the metaphor through questions or statements, such as, "Tell me what you see," "Tell me more about ____," and "What does that mean to you?" This allows the client to elaborate on his or her elder's advice and interpret the advice himself or herself. The goal of this technique is not solution-focused; instead it is focused on exploration of thoughts, ideas, and ways of coping with loss that clients may not be able to access in their logical or emotional mind without the visualization. It allows the client to step outside of the constructs that he or she may be using and potentially see new alternatives and constructs that the client has not previously been able to entertain.

On a cautionary note, as with any visualization or hypnotic technique, it is imperative to ensure that the client has "returned" fully and is oriented to the present moment before leaving the office. This can be accomplished through grounding techniques, such as having the client identify colors in the room, drink some water, or engage in a more mundane surface conversation to ensure that he or she is ready to leave the office fully aware and safely in the present.

Case Illustration

This case illustrates the use of the Wise Elder tool as a culturally specific metaphor to assist a Native American client who was grieving the domestic violence-related loss of a romantic relationship. Since Native Americans often communicate through stories and metaphors that facilitate their meaning-making process and ability to heal, this proved to be a powerful tool with this client. I had been working with this client for several months and we had a very comfortable relationship, which established an important foundation that allowed him to trust the use of the visualization in session.

The client came into therapy feeling very sad and upset. He had broken off his relationship with his long-time fiancée because she had continually accused him of having a romantic relationship with his child's mother when he went for visitation, which had resulted in his not seeing his daughter in three months. His fiancée was verbally and physically abusive, so he was trying to prevent her from "flipping out" by keeping her

happy, at the cost of his feeling extreme sadness and guilt due to the loss of time with his child. We explored the situation using open-ended questions and he began to cry. He was able to articulate that, although he had left his fiancée and moved into his mother's home two days prior, he was still struggling with whether he had made the right decision and acknowledged that he was "crying all the time." He did not like the consequences of the choice he had made, and was wondering if the pain he was experiencing was a sign that he had made the wrong decision. He stated, "I've got my child who I love so much on this hand and I've got my fiancée who I love so much on this other hand, and I just don't know what to do." In this moment, I realized the construct that he had created was a fight between competing agendas within himself, resulting in his being pulled in two directions. The best way I could see for him to solve the dilemma was to ask a part of himself, the wise elder, for his advice.

I personalized the basic script described above for his situation. As he was a Native American man, it felt important to focus on the details of his hair to help him see the older version of himself. I expanded on the details of his long hair that had now turned gray, and was braided. I then described how he was sitting in front of a fire outside by a pond in his favorite place to go when making decisions and reflecting on his life. When I asked him about the advice that the wise older version of himself had given, his answer was unexpected, as well as raw and real. He said that he was told, "Get your head out of your ass! It may be comfortable in there because you only see what you want to see, but it's time to get your head out of your ass, see the sun, and see the real world as it really is, even though it's sad." This response provided him with his own way of handling his situation using his unique verbiage and understanding, along with metaphors we explored further together. I asked him the questions, "What does that mean?" "How does that look for you?" along with frequent statements requesting that he "Tell me more." He stated that when the wise elder said to, "Get my head out of my ass," he meant that he must see his daughter regardless of what his fiancée wanted. If his fiancée could not accept his decision, then it was time to end their engagement even though it meant feeling the sadness and profound loss of the relationship. The wise elder told him that he deserved to be loved instead of being verbally and physically hurt by his partner. The wise elder said that although he would feel sad and grieve the loss of the relationship, it would be something he would be able to move past. However, he told him that the loss of his child was something that would haunt him forever; he would feel guilty and sad for the rest of his life.

The loss experienced by this client had two parts. He was grieving the loss of the romantic relationship and reaffirming his decision to leave the situation and reestablish his relationship with his young daughter. He was struggling with the construct of a changing identity, one where it was no longer acceptable for him to be involved in a domestic violence situation. This led to an identity transformation by facing his reality and feeling the loss of the woman he loved, knowing that he was giving up that relationship to make a change that was more important to him: being with his child, who "makes me happier than anything on earth." However, he had to feel the emotions about the loss of the current relationship with his fiancée, along with the loss of the life he had constructed that involved their marriage, obtaining custody of his daughter, and their living happily as a family. Through the process, he articulated in his own words the way he felt about his situation, shared his feelings, and found the answers to the dilemmas he faced from his own inner wisdom. After the visualization was completed, he created a plan to move into a hotel temporarily, move the rest of his belongings out of his fiancée's house, and go see his daughter on his next day off work.

Concluding Thoughts

The Wise Elder tool can be modified based on culture, ethnicity, religion, and situation. Hays (2014) stated that some clients may find it easier to visualize someone they admire who is either living or deceased, a religious figure, or a character in a book. She indicated that it is important to caution the client that if the visualization is of someone else, the client needs to remember that person's weaknesses in order to avoid creating a perfect person who cannot be a true model for providing advice in the situation that is being explored. If clients visualize a deity based on their personal religious affiliation, they might not seek specific advice from the deity, but rather the loving and compassionate encouragement and support that the deity would provide while they sought their own inner wisdom and advice.

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Bedside Singing

Judith Spencer Williams

Music begins where words end.—J.W. von Goethe, 1749–1832

Clients for Whom the Technique is Appropriate

Bedside singing can be used with the dying and their loved ones who are receptive to the idea. Unresponsive or actively dying patients are also appropriate recipients and may benefit from music's soothing effects. In these instances, any loved ones who are present may find an outlet to grieve as they listen. Some individuals may initially decline, depending upon circumstances, but be receptive at another time.

Description

Music can create a peaceful environment for those who are dying and their loved ones. As these people experience the anticipatory grief of approaching death, music comforts with melody and lyrics. It can address physical, emotional, and spiritual suffering and foster a sense of well-being and peace. Music can help encourage communication between the dying and their family or friends by providing another means for expressing feelings and thoughts. When the swirling of inner emotions cannot be conveyed by words, lyrics of an appropriate song can help convey what is in the heart. Memories suggested by certain songs pave the way for meaningful and satisfying life reviews for the dying. Listening to music can relieve stress, causing the breathing to calm and the body to relax (Taylor, 1997). Seeing these changes in the dying person can be consoling to loved ones. Finally, since hearing is the longest lasting of the senses—it is believed to function till near the final moments of life—music becomes perhaps the last way to reach out to the dying individual, delivering messages of love and farewell (Freeman et al., 2006).

Live bedside singing is very intimate and surprisingly moving for the listener. A CD player provides music, but a person standing close by and singing becomes very personal and powerful, especially when combined with songs that are dear to the listener. At times it mirrors the tenderness of a mother comforting her child with a lullaby.

I sing songs to hospice patients at their bedside, sometimes in the home or hospital, but usually at the local residential hospice house in my community. Frequently family members and other loved ones are present as well. When I sing to a dying patient, I stand as close as possible to where the person is facing, even if it means squeezing between the bed and a wall. I have an acoustic guitar that I finger pick and if I strum I do so softly.

I have a small songbook with loose-leaf pages that I can rearrange or add to as needed. I have nearly 100 songs of different genres (hymns, folk, popular, country) that contain lyrics suggesting hope, peace, love, or comfort. They are chosen according to the lifestyles of the patients and the frequency with which the songs are requested. Occasionally someone will ask for a certain song that is not in my book. Thanks to the Internet, I can usually find most lyrics and chords. Even a classic rock song can be adapted to a slower, softer version without sacrificing the meaning for the listener.

Many of the songs I sing are hymns since they are frequently requested. One of the most often asked for hymns is “Amazing Grace” (Newton, 1790). Its lyrics provide the spiritual solace craved by many and deliver hope in a seemingly hopeless situation. Some hymns suggest eternal happiness and reunion with loved ones who have died before.

Occasionally individuals request a favorite song that was popular at some time in their past. Hearing the song again may encourage a life review. The poetry of the lyrics and memories of earlier times can evoke a sense of emotional well-being and satisfaction. Songs that are well received include “Let It Be” (Lennon & McCartney, 1970, track 6), “Bridge Over Troubled Water” (Garfunkel & Simon, 1970, track 1), and “If I Needed You” (Harris & Williams, 1981, track 3). I once sang for a woman who politely listened to hymns, but when I sang a song she requested by a popular band from the 1970s, she closed her eyes and smiled. Afterward she shared with me the memories she recalled while hearing the song.

Live singing may also move others in the room. I have witnessed family members who, upon hearing the first few notes of a song, walked outside and wept. Later they hugged and thanked me and told me it was a much-needed cry, brought on by hearing the singing. Sometimes the music will stimulate those in the room to make physical contact with each other and the dying person—like holding hands or patting each other’s backs. On one occasion, while singing “You’ve Got a Friend” (King, 1971, track 7), I noticed a woman caressing the head of her dying sister. Her sister had suffered multiple strokes and found speech difficult, yet she was able to mouth the words to the song.

Case Illustration

The first time I met Marie she was sitting up in her bed. I introduced myself to her and told her that I had a guitar and would sing for her, if she would like. She was quick to invite me in. Within a few minutes of conversation I had a sense of what kind of songs she might enjoy—all of which she listened to and softly sang along. On my second visit she asked if I knew a particular gospel hymn, “I Won’t Complain” (Jones, 1993, track 4). Sadly, I did not—in fact I had never heard of it. A week later, after hours of Internet searching, I returned with the song in hand and sang it to her. Tears streamed down her face as I sang. She told me this had been her mother’s favorite song. Hearing that song touched her deeply and I made sure to always include it when I sang to her. During one visit her adult children were present. Marie asked that I sing the song so her children could hear it. As I sang they came close beside their mother’s bed, touching her and holding her hands. The last time I visited Marie she could no longer speak. Her children were there and I sang the song again. Her son told me the song had been special to their family and he knew how much it meant to his mother.

On another occasion, a family member of an actively dying hospice patient heard me singing for another patient and asked me to come into his father's room. The dying man's children explained to me that their father had been a music director at the church where he was also the pastor. They told me how their father had sung in choirs all his life and how music had been a part of who he was, and how he had instilled a love of music in them as they were growing up. I shared my songbook with the son and he selected hymn after hymn. I began singing and was joined by the family members, the son harmonizing with me. The dying man's wife, who was lying beside him on his bed, stroked his face and softly sang to him. During those 30 minutes the family detected a relaxed appearance on the father's face and a calming in his breath as we sang. They were comforted knowing that they had brought peace to their father during his final few hours of life. The family members were also comforted by the music. Their father had brought music into their lives and now they were bringing music to him at the end of his life.

Concluding Thoughts

Bedside singing is a noninvasive method of delivering emotional care to the dying and their loved ones. Lyrics can help to quell feelings of fear or despair and refocus the listener on thoughts of promise and love. Music can deliver physiological benefits such as relaxation and slowed breathing. Meditation or prayer becomes possible by listening to the song, even when words are not spoken. Some nostalgic lyrics can enhance a positive life review, awakening memories of happy times. Music can lead the grieving out of despair and into a sense of security and peace.

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Author Index

Page numbers in italics signify bibliographic references to work by a given author. Page numbers in roman font represent textual citations of the work or general acknowledgement of the contributions of the author to the field.

- Abakoumkin, G. 224, 227
Abbey, J. 182, 185
Adame, D. D. 161, 164
Adams, K. 218–19
Addis, M. E. 125, 127
Allen, D. 46, 48–49
Alves, D. 52, 56
Anderson, B. 76, 79
Armour, M. 71, 74
Armstrong, C. 255
Arnold, C. 22, 24
Aslan, M. 87, 91
Attig, T. 216, 219, 268, 272
Au, T. 201, 204
Austin, D. 236, 238
Ayduk, O. 308, 311
- Baddeley, J. L. 256, 258, 311
Baldwin, S. A. 236, 238
Bar Nadav, O. 87–88, 91
Beall, S. K. 201, 204
Beck, A. T. 100–1
Benson, H. 135, 138
Berish, M. 51, 56
Berman, J. S. 21, 23
Bernecker, S. L. 21, 23
Berzoff, J. 191, 193
Boelen, P. A. 18, 59, 62, 155–56
Boerner, K. 20–21, 24
Bogatin, L. 8, 12
Bonanno, G. A. 51, 56, 59, 62, 173, 175, 224, 227
Boss, P. 170, 172, 268, 272
Bowlby, J. 8, 12, 15–16, 18, 223–24, 227
Bowman, T. 268, 272
Breen, L. J. 239, 243
Breitbart, W. 182, 185
Briere, J. 181
Broad, W. J. 144, 149
- Brock, K. I. 181
Brown, C. 258, 311
Brown, G. K. 100–1
Brown, T. D. 161, 164
Bryant, R. A. 47, 49, 259, 263
Büchi, S. 287, 289
Burgess, P. 47, 49
Burke, L. A. 6, 12, 46, 49, 76–77, 79, 190, 193, 205, 207, 275, 278
- Cacciatore, J. 6, 9, 12
Cacioppo, J. T. 15, 18
Cacioppo, S. 15, 18
Calhoun, L. G. 10, 12, 71, 74
Carr, D. R. 20, 23
Carroll, B. 246–47
Caserta, M. S. 20, 23, 65–66, 68, 337, 339
Cassileth, B. R. 182, 185
Chan, C. L. W. 143
Chavis, G. G. 190, 193
Chen, L. 139, 143
Cherry, S. 27–28
Chisty, K. 46, 48–9
Chochinov, H. M. 251, 255
Choi, T. Y. 140, 143
Chong, G. 48–9
Classen, C. C. 100–1
Cloitre, M. 27–8
Cohen, S. R. 51, 56
Cole, S. P. 161, 164
Coleman, R. A. 46–50, 59, 62, 78–9
Combs, G. 251, 255
Coolican, M. 39, 43, 100–1
Correa, F. 256, 258
Couden, B. A. 170, 172
Craig-Bray, L. 3, 12
Crawford, M. 76–7, 79
Creamer, M. 47, 49

- Cruess, D. G. 205, 207
 Cruz, M. 76–7, 79
 Currier, J. M. 9, 12, 20–21, 23, 47–50, 59, 62, 78–9, 82, 84, 192–93

 Dash, M. 144, 149
 Davis, C. G. 59, 62, 71, 74
 Davis, M. 209, 211
 Davis, N. L. 76–7, 79, 205, 207
 Davis, R. 289
 Day, R. C. 138
 de Vries, B. 66, 68
 Delaney, E. 81, 84, 201, 204
 Delespaulx, E. 20–1, 23–4
 Dennard, S. 46, 49, 76–7, 79
 Denninger, J. 138
 Dennis, M. R. 4, 13, 182, 185
 Dennis, T. 105, 108
 Derrida, J. 185
 DeSantis, L. 99, 101
 Diamant, A. 316, 319
 Dijkstra, I. 20, 24
 Doka, K. 99, 101, 105, 108, 158, 160, 165, 169
 Dolan, Y. M. 332, 336
 Doss, E. L. 243
 Dowdy, A. 337, 339
 Drescher, K. D. 81–2, 84
 Duan, N. 87, 91
 Dyregrov, A. 99, 101, 295, 296
 Dyregrov, K. 99, 101, 295, 296

 Easterling, L. W. 39–41, 43, 99, 101
 Ecker, B. 198, 200
 El-Jawahri, A. 30, 35
 Ellison, W. D. 21, 23
 Emmelkamp, P. M. G. 201–2, 204
 Ensing, D. 77, 79
 Erikson, E. H. 4–5, 7, 12
 Ernst, E. 140, 143
 Erskine, R. G. 280, 286
 Exline, J. 111

 Falgout, K. 77, 79
 Farber, C. H. 6, 12, 27–8, 29, 117, 119, 179, 181, 219
 Fauchère, J.-C. 287, 289
 Feigelman, B. 306, 311
 Feigelman, W. 39, 41, 43, 306, 311
 Feinstein, D. 140, 143
 Feldman, G. 173, 175
 Feudo, A. 46, 49
 Feuer, C. A. 27–8, 29, 117, 119, 179, 181, 219
 Field, N. P. 100–1, 224, 227
 Finkenauer, C. 275–76, 278
 Flint, M. 6, 12
 Floyd, F. 287, 289
 Foa, E. 27–8
 Folkman, S. 65, 68, 71, 74
 Ford, L. 161, 164

 Fox, A. B. 201, 204
 Foy, D. W. 81–2, 84
 Frank, E. 27, 29, 76, 79, 173, 175, 228, 231, 236, 238, 311
 Frankl, V. E. 182, 185
 Freedman, J. 251, 255
 Freeman, L. 337, 339
 Freud, S. 224, 227
 Fried, I. 251, 255

 Gallagher-Thompson, D. 46, 48–9
 Gal-Oz, F. 224, 227
 Gamble, S. G. 27, 29, 180–81
 Gamino, L. A. 39–41, 43, 99, 101
 Garfunkel, A. 338–39
 Garrison-Diehn, C. 125–27
 Gendlin, E. T. 131, 134
 Gibbons, J. A. 46, 49
 Gilburd, D. 138
 Gillies, J. 46, 49, 51, 56, 59–60, 62, 71, 74, 113, 116, 236, 238
 Gilligan, S. 329, 331
 Glaser, A. 287, 289
 Gofer-Shnarch, M. 88, 91
 Goldenberg, H. 292–93
 Goldenberg, I. 292–93
 Gonçalves, M. 52, 56
 Goodkin, K. 87, 91
 Gorman, B. E. 39, 41, 43
 Gorman, E. 170, 172
 Gorscak, B. 76–7, 79, 117, 119
 Gottlieb, G. 3, 12
 Granello, D. H. 51, 56
 Greenberg, J. H. 287, 289
 Greenfield, D. A. 39–41, 43, 99, 101
 Grossman, P. 161, 164
 Gupta, S. 173, 175

 Haber, D. 228, 231
 Haime, V. 138
 Hall, C. 31, 33, 35
 Hammond, D. C. 332, 336
 Hanel, M. 296
 Hansson, R. O. 65, 68
 Harris, D. L. xviii, xix, 8, 12, 22, 24, 170, 172
 Harris, E. 338–39
 Hayes, A. 173, 175
 Hayes, S. C. 73–4
 Hayman, S. L. 31, 33, 35
 Hays, P. A. 332–33, 336
 Hayslip, B. 275, 278
 Hayton, C. 312, 315
 Hedtke, L. 8, 12
 Heeren, A. 20, 23
 Hembree, E. A. 27–8
 Hendricks, M. N. 133–134
 Henning, J. A. 8, 12
 Henry, M. 51, 56
 Heron, M. 25, 28

- Herrera, S. 46–49
Hershberger, P. J. 71, 74
Hibberd, R. 71, 73–4
Hinton, D. E. 161, 164
Hoffmann, S. G. 161, 164
Hogan, N. S. 39–41, 43, 99–102
Holen, A. 51, 56, 59, 62, 224, 227
Holland, J. M. 9, 12, 46–50, 59, 62, 77–9, 82, 84, 153, 156, 205, 207
Hooghe, A. 51, 56, 275, 277–78, 287, 289
Horowitz, M. J. 51, 56, 59, 62, 87, 91, 100–1, 224, 227
Houck, P. R. 27, 29, 173, 175, 228, 231, 236, 238, 311
Hourizi, R. 244, 247
Hu, X. L. 139, 143
Hudcovicova, M. 201–2, 204
Hulley, L. 198, 200
- Idsoe, T. 99, 101
Iliya, Y. A. 238
Ippolito, M. R. 76, 79
Isaacson, S. 170, 172
- Jackson, C. L. 27–8
Jacquart, J. 138
Jacobs, S. C. 77, 79
Jacobs, S. S. 87, 91
Jacobson, N. S. 125, 127
Janoff-Bulman, R. 59, 62, 71, 73–4
Jeffreys, J. S. 111, 290, 293, 320, 322
Jenewein, J. 287, 289
Jenko, M. 228, 231
Johnson, T. A. 256, 258
Jones, P. 338–39
Jordan, A. H. 26, 28
Jordan, J. R. 39, 41, 43, 303, 305, 319
- Kamuf, P. 185
Kasl, S. 76, 79
Kawano, K. 115–16
Kawashima, D. 115–16
Keesee, N. J. 59, 62
Kelly, C. 81, 84
Keshaviah, A. 87, 91
Kesler, S. R. 46, 49
King, C. 338–39
Klaassen, F. 161, 164
Klass, D. 4, 8, 12–13, 182, 185
Knaevelsrud, C. 201, 204
Knight, C. 303, 305
Knill, P. J. 328
Koch, C. 251, 255
Koenig, H. 77, 79
Koren, D. 88, 91
Körner, A. 51, 56
Kosminsky, P. 157, 160
Kounonen, M. 39, 43
Kreiman, G. 251, 255
Kross, F. 308, 311
Kumar, S. M. 173, 175, 211
Kupfer, D. J. 76, 79
- L'Abate, L. 312, 315
Laippala, P. 39, 43
Landreth, G. I. 212, 214–15
Landry, K. 246–47
Lange, A. 201–2, 204
Larson, J. 71, 74
Laurie, A. 39, 43
Lebowitz, L. 81, 84
Lee, M. 146, 148–49
Lee, M. S. 140, 143
Lee, M. Y. 143
Lee, S. A. 46, 49
Lehman, D. R. 26, 29
Lennon, J. 338–39
Leshner, A. 81, 84
Leszcz, M. 299, 302–3, 305
Leung, P. Y. 143
Lev, B. T. 27, 29, 180–81
Levine, E. G. 328
Levine, S. K. 328
Levy, K. N. 21, 23
Lewis, C. S. 223, 227
Li, H. 139, 143
Li, Y. 182, 185
Lichtenthal, W. G. 10, 12, 46, 49, 76, 79, 182, 185, 205, 207
Litz, B. T. 26, 28, 81, 84, 201, 204
Lund, D. A. 20, 23, 65–66, 68, 337, 339
Lynn, L. 8, 12
- MacCallum, F. 259, 263
Maciejewski, P. K. 87, 91
Mackay, M. M. 190, 193
MacKinnon, C. J. 51, 56
Macklin, E. 138
Maercker, A. 47, 49, 201, 204
Maguen, S. 81, 84
Malkinson, R. 51, 56, 87–8, 90–1, 232, 235
Mallinckrodt, B. 21, 23
Malott, J. 48–9
Marquett, R. M. 46, 49
Martell, C. 125, 127
Mascolo, M. F. 3, 12
Mazza, N. 312, 314–15
McCartney, P. 338–39
McDevitt-Murphy, M. E. 6, 12, 76, 79, 157, 160, 275, 278
McFague, S. 105, 108
McIntosh, J. L. 303, 305
McNeil, J. 280, 286
Meichenbaum, D. 117–19
Meier, A. M. 20, 23
Melhem, N. 173, 175, 228, 231
Mendes, I. 52, 56
Michaeli, E. 88, 91
Mikulincer, M. 15, 18, 22–3
Miller, K. 138
Milman, E. 51, 56, 59–60, 62
Moncur, W. 244, 247
Monk, T. 173, 175, 228, 231
Moon, T. W. 140, 143
Mörgeli, H. 287, 289

- Moulds, M. L. 47, 49
Moursund, J. P. 280, 286
Murray-Swank, A. B. 331
Murray-Swank, N. A. 331
- Nash, W. P. 81, 84
Naveen, K. V. 144, 149
Negi, L. T. 161, 164
Neimeyer, R. A. xv, xvii, xviii, xix, 3–6, 8–11, 12–13, 18, 20–21, 23, 39, 43, 46–52, 56, 59–60, 62, 71, 74, 76–79, 87, 89, 91, 105, 108, 111, 113, 115, 116–17, 119, 131, 134, 153, 155–56, 166, 169, 182, 185, 188–90, 192–93, 205, 207, 210–11, 214–15, 229, 231–32, 235–36, 238, 243, 268, 272, 275, 277–78, 287, 289, 300, 302, 308, 311, 317, 319, 333, 336
Newton, J. 338–39
Neyer, F. G. 296
Ng, S. M. 143
Nichols, C. 224, 227
Nickman, S. 8, 12
Nolen-Hoeksema, S. 71, 74
Nooner, K. 27–8
Noppe-Brandon, G. 6, 13
Norcross, J. C. 21, 23
Nord, D. 153, 156
Nordin, C. 6, 13
North, J. A. 319
- O'Connor, M. 239, 243
O'Hara, M. 299, 302
O'Hara, R. 46, 48–9
Ober, A. M. 51, 56
Ogden, T. H. 209, 211
Oliver, L. 46, 49, 76–7, 79
Olsen, H. 77, 79
- Pace, T. W. 161, 164
Page, K. S. 275, 278
Papa, A. 125–27, 201, 204
Pargament, K. 77, 79
Park, C. L. 46, 49, 51, 56, 59, 62, 71, 74, 206–07, 331
Park, T. Y. 140, 143
Parkes, C. M. 87, 91, 294, 296
Partenheimer, A. 337, 339
Pattison, P. 47, 49
Paunonen, M. 39, 43
Payàs, A. 279–80, 285–86
Pearce, M. J. 10, 13
Pearlman, L. A. 6, 13, 27–28, 29, 117, 119, 179–81, 188–89, 219
Pennebaker, J. W. 111, 201, 204, 211, 219
Perez, L. 77, 79
Petkova, E. 27–8
Philbin, K. 144, 149
Piaget, J. 11, 13
Piazza Bonin, E. 76–7, 79, 205, 207
Pidgeon, A. M. 161, 164
Pitsillides, S. 244, 247
Poppito, S. 182, 185
Posadzki, P. 140, 143
- Prigerson, H. G. 30, 35, 76–7, 79, 87, 91, 201, 204
Proctor, W. 135, 138
- Radestad, I. 6, 13
Radossi, A. 138
Raison, C. L. 161, 164
Rando, T. A. 26–8, 29, 99, 101, 117, 119, 131, 134, 157, 160, 179, 181, 219
Reiser, R. P. 46, 49
Rengifo, J. 48–9
Resick, P. A. 27, 29
Reynolds, C. F. 27, 29, 76, 79, 173, 175, 228, 231, 236, 238, 311
Rheingold, A. 256, 258, 311
Rietdijk, D. 201–2, 204
Rober, P. 275, 277–78, 287, 289
Roberts, J. M. 76, 79
Rogers, C. R. 22, 24, 299, 302
Rojas-Flores, L. 46–9
Root, B. 111
Rosenfeld, B. 182, 185
Rossa, S. 337, 339
Rothbaum, B. O. 27–8
Rozalski, V. 46–9
Rubin, S. S. 87–8, 90–91, 232, 235
Rummel, C. 125–27
Runtz, M. 181
Ryckebosch-Dayez, A. S. 20–21, 23–4
Rynearson, E. K. 256, 258, 311
- Saakvitne, K. W. 27–8, 29, 180–81
Sadek, S. N. 138
Saindon, C. 256, 258, 311
Salzberg, S. 161, 164
Sands, D. C. 6, 13, 51, 56, 59, 62, 111, 188–89, 300, 302, 311, 316–17, 319
Santino, J. 239–40, 243
Satchidananda, S. S. 144, 149
Schmid, P. 299, 302
Schmidt, L. A. 39–41, 43, 99–102
Schnicke, M. K. 27, 29
Schnyder, U. 287, 289
Schore, A. N. 317, 319
Schorr, Y. 201, 204
Schreiner, M. 165, 169
Schrieken, B. 201–02, 204
Schut, H. 6, 13, 17–18, 19–21, 24, 48–9, 65–8, 99, 101, 170, 172, 175, 188–89, 224, 227, 275–76, 278
Schutz, K. 81, 84
Schwartz, R. 188–89
Scott, C. 181
Scott, D. 189
Scott, L. N. 21, 23
Seagal, J. D. 219
Seltzer, M. M. 287, 289
Sensky, T. 287, 289
Sewell, K. W. 39–41, 43, 99, 101
Sewell, M. T. 125–27
Shaver, P. R. 15, 18, 22–3

- Shay, J. 81, 84
 Shear, M. K. 18, 27, 29, 46, 49, 76–7, 79, 87,
 91, 117, 119, 155–56, 173, 175, 228, 231, 236,
 238, 311
 Shojima, S. 115–16
 Siegel, D. 224, 227
 Sillowash, R. 173, 175, 228, 231
 Silva, C. 81, 84
 Silverman, P. R. 8, 12
 Simon, N. M. 87, 89, 91
 Simon, P. 338–39
 Sivilli, T. I. 161, 164
 Sjogren, B. 6, 13
 Slattery, J. 331
 Smale, U. 6, 13, 299, 302
 Smigelsky, M. A. 10, 13
 Smith, B. 77, 79
 Smith, N. G. 51, 56
 Smyth, J. M. 206–7
 Song, J. 287, 289
 Spence, S. 6, 13, 299, 302
 Stang, H. W. 138, 144–45, 148–49, 161, 164
 Steer, R. A. 100–1
 Stein, N. 81, 84
 Steineck, G. 6, 13
 Stoll, E. J. 8, 13
 Stroebe, M. S. 6, 13, 17–18, 19–21, 24, 48–9, 65–68, 170,
 172, 175, 188–89, 224, 227, 275–76, 278
 Stroebe, W. 6, 13, 20–21, 24, 99, 101, 224, 227
 Storolow, R. 7, 13
 Stovall-McClough, K. C. 27–28
 Strosahl, K. D. 73–4
 Sudheimer, K. 48–9
 Sweeney, L. G. 312, 315
 Swenson, K. L. 66, 68
- Tarkka, M. 39, 43
 Taylor, D. B. 337, 339
 Tedeschi, R. G. 10, 12, 71, 74
 Telles, S. 144, 149
 Thompson, B. E. 6, 8, 11, 13, 39, 43, 59, 62, 155–56,
 188–89, 214–15, 232, 235, 243, 268, 272
 Thompson, K. L. 46–9
 Thompson, L. W. 46, 49
 Thornton, G. xviii, xix
 Ticic, R. 198, 200
 Tieman, J. J. 31, 33 35
 Tucci, A. 105, 108
 Turner, V. 325, 328
- Utz, R. 66, 68
- van de Ven, J.-P. 201–2, 204
 van den Bout, J. 20, 24, 59, 62
 van den Hout, M. 59, 62
 van der Heijden, P. G. M. 20, 24
 van Dyke Stringer, J. G. 190, 193
 van Gennep, A. 325, 328
 Vandenberg, B. 71, 74
 Varra, E. M. 181
 Verberg, N. 59, 62
 Vickers, A. J. 182, 185
 von Goethe, J. W. 337
- Wagner, B. 201, 204
 Wagner, J. 296
 Wall, M. 87, 91
 Wallace, W. M. 258, 311
 Walsh, W. B. 71, 74
 Walter, T. 244, 247
 Weiser, J. 267
 Wheaton, J. E. 51, 56
 Wheeler, I. 71, 73–74
 White, M. 116
 Wijngaards-de Meij, L. 20, 24
 Williams, A. F. 26, 29
 Williams, J. L. 256, 258
 Williams, J. S. 337–39
 Wilson, K. G. 73–74
 Winokuer, H. R. xviii, xix, 22, 24
 Winslade, J. 8, 12
 Witztum, E. 87–88, 90–91, 232, 235
 Wohl, M. J. A. 59, 62
 Wolfelt, A. D. 187–89
 Worden W. J. 99, 101, 109, 111, 322
 Wortman, C. B. 26–28, 29, 117, 119, 179, 181, 219
 Wortmann, J. H. 206–07
 Wrzus, C. 296
- Xie, S. S. 139, 143
- Yalom, I. D. 182–83, 185, 299, 302–3, 305, 308, 311
 Yang, H. Q. 139, 143
 Young, A. J. 76–77, 79, 205, 207
 Young-Eisendrath, P. 10, 13
- Zebrack, B. 170, 172
 Zech, E. 20–22, 23–4
 Zhang, B. 30, 35
 Zisook, S. 87, 91
 Zoellner, T. 47, 49
 Zorbas, P. 27–8
 Zubenko, G. S. 76, 79

Subject Index

- abandonment 211, 230, 252, 292, 329–30
abuse 165, 179, 264, 292; childhood 180
acceptance 26, 183; of different grieving/coping styles
304; of the loss 238, 322
Acceptance and Commitment Therapy (ACT) 73
accident 25, 39–40, 162, 311; automobile 26, 110, 133,
153
accommodation 47
acrostics 313
activities 330; creative 181
activity monitoring/scheduling 125–26
acupuncture/acupressure 140
acute trauma symptoms 131
adaptation of post-loss world 110
addictive behaviors 181
adjustment to the world without the deceased 322
aerobic exercise 137
affect tolerance 179–81
African American 78
afterlife 106, 115
AfterTalk 232–35
age 300; of decedent 41; progression in hypnosis 332
agency 113, 124, 126
ahimsa 146
AIDS 153
altar 328
ambiguous loss 172, 268, 272
ambivalence 90, 131–33, 165–69, 264; avoidance of 165
American Foundation for Suicide Prevention 306
analogical listening 131, 333
anger 40, 42, 60, 78, 90, 124, 137, 148, 159, 161, 166, 199,
279, 281, 304; toward God 77, 206
anniversaries 107, 118, 289, 295
antecedents 126; eliciting maladaptive behaviors 124
anticipatory grief 251–52, 264, 267, 337
anxiety 27, 135, 137–38, 140, 144, 161, 181, 279, 299,
329; social 161
archetypal feminine forms 316
articulating 132
art-making 325, 327
arts-based ritual processes 327
asana 144, 146
assessment 118
assimilation 47
Association for Death Education and Counseling
(ADEC) 233
assumptive world 59
attachment behavioral system 20
attachment 4, 7–8, 15–16, 20, 28, 60, 180, 272; anxious
20, 226; bond 8; figure 188, 224; history 225; to the
deceased 155, 223; disorganized 21; generalized style
16; insecure 16, 20; related avoidance 20; relationship
14; secure 20, 197, 224; security 11, 15; specific style
16, 19; system 15; theory 21, 228
attachment-based interview 224
attending 132
attrition of group members 306
authenticity 183, 185
autobiographical schemas 59
autopsy 61
avoidance 41, 47, 100–01, 124–27, 140, 155, 180–81,
201, 230, 256; experiential 173, 188
avoidant coping 19
awareness 67; internal 145; present-moment 145

Beck Depression Inventory II scale 100
bedside singing 337–39
benefit-finding 46–47, 52, 60, 183
bereaved adolescents 99, 212, 256, 279, 322, 325, 332
bereaved adults 59, 135, 138, 256, 325, 332
bereaved adult children 89
bereaved children 11, 135, 138, 143, 153, 170, 212, 256,
293, 322, 325
bereaved families 322
bereaved older adults 59, 143, 153, 170
bereaved parents 39, 59, 100; by cancer 182; of adult
children 89
bereaved partners 89
Bereaved Sibling Interview (BSI) 279–86
bereaved young people/young adults 59, 212, 246

- bereavement coping script system 285
 bereavement groups 162; with children and adolescents
 321; structured 299
 bereavement overload 153
 bereavement research xv
 bereavement type 300
 Bereavement Search Filter 31, 33, 35
 bereavement-specific challenges 27
 betrayal 81, 292
 Bible 331
 bio-genetic factors 3, 11
 biological regulatory processes 15
 biopsychosocial functioning 87–8
 bipolar depression 252
 blame 40, 42, 60, 164, 191
 blog 233; grief 52
 blood pressure, high or low 144
 bodily experience/sense 132
 body pain 135, 140
 body scan 146
 body wisdom 317
 bodywork 145
 boundaries 295
 brain mechanism 15
 brainstorming 313
 break-up 268
 breath work 144, 166, 237, 309
 Brief RCOPE 77
 Buddhism 77, 115
 Buddhist metta meditation 161–62, 164; script 162
 Buddhist workshop 10
 building resources 27
 burnout: facilitator 304; workplace 48
- camera phones 264
 cancer 7, 137, 140, 148, 170, 174, 183, 218, 252, 281, 292,
 325
 caregiver 15, 182–83
 caregiving 16, 161, 230; behavioral systems 8, 15
 CareSearch 30–35
 caring relationship 188
 Catholic faith 240
 celebration 330
 Center for the Advancement of Health 30
 chair work 53, 79, 224, 237–38, 280
 chance to say goodbye 41
 Children's Bereavement Center of South Texas 212
 Christianity 77, 206
 chronic fatigue 140, 144
 client-centered dialogue 145
 client's protective system 186
 clinical screening 89
 clinical supervision 314
 clinical trial 48
 close relationships 14–15
 closure 106–7, 236, 240
 clustering 313
 cognitive and behavioral adaptation 111
 cognitive behavioral: perspective 51; therapy 27, 201;
 treatment 202
- cognitive control mechanisms 15
 cognitive fixation 260
 cognitive processing therapy 27
 cognitive restructuring 201–2
 cognitive stress theory 19
 coherence 47
 collaborative poem 312–15
 collage 219, 328, 330
 college students 46
 combat 82
 commemorative: items 239; sessions 256; performative
 240
 committed action 73
 communication 304; couples 289
 community 329
 community-building 312
 compassion 6, 9, 53, 161, 164, 179–80, 299; internal
 186–89
 compassion fatigue 304
 Compassionate Friends 303
 complicated bereavement 87, 89
 complicated grief 18, 30, 48, 59, 67, 76, 78, 117, 139, 144,
 173, 188, 201, 203, 224, 240, 303
 complicated spiritual grief (CSG) 76–7, 205
 comprehensibility 47
 confidentiality 300
 conflict with relatives 26
 conflicted relationship with the deceased 88–89
 confrontation 19; imaginative 202
 connection vs. isolation 5–7
 constructivist psychotherapy 52
 containing the story of violent death 306–11
 containment 5–6, 304
 contextual behavior activation 124
 contextual behavioral therapy 73
 continuing bond 5, 8, 10, 17, 21, 53, 59–61, 87, 90,
 109–10, 182, 224, 232, 235–36, 238, 241, 243–44, 289
 control 67, 174, 192; loss of 180
 conversation manager 311
 coping 53, 65; skills, 179; passive 125; spiritual-based 78
 core therapeutic conditions 21–2
 correspondence with the deceased 8, 148
 cortisol 48
 countertransference 28
 couples therapy 277
 coworkers 296
 co-facilitating bereavement support groups 303–05
 creating/rebuilding safety 166, 316, 321
 cremation 288
 criminal justice system 256
 cultural appropriateness 143; attitudes 252; discourses
 12; factors 4, 11, 114; norms 289; permission 7–8
 culture 48, 138, 140, 187, 214, 237, 252, 276, 288, 293,
 296, 312, 330, 332, 334
- daily activities 113–14
 daily living skills 66, 295
 dance and movement performance 313
 death: accidental 210; cause/type of 294; natural 26,
 125; preventable 25; sudden 25, 179, 183, 229, 261;

- traumatic 41, 279, 303; unjust 25; untimely 179;
violent 20, 25, 46, 179–80, 239–40, 242, 256, 258, 306,
316
- death of a child 7, 26, 39, 110, 159, 179, 183, 246, 257,
277, 279, 281, 287–89
- death of a grandchild 154
- death of a grandparent 214
- death of a parent 22, 25, 137, 140, 148, 153–54, 174, 218,
223, 233, 252, 292, 316–19, 325
- death of a peer/friend 153–54, 206, 223, 246
- death of a pet 187, 214, 321
- death of a sibling 140, 153, 223, 233, 237, 281
- death of a spouse/partner 19, 23, 26, 89, 114, 125, 133,
153–54, 164, 167, 174, 192, 202, 210, 223, 225, 229,
233, 240, 261, 292, 295, 304, 316–19
- death story 6, 8, 87, 214, 232; violent 308
- decompensation 304
- definitional ceremony 116
- deity 336
- dementia 137
- Dementia Search Filter 31
- demographic factors 48
- denial 109, 111
- dependence 20, 225–26; on therapist 277
- depression 26–27, 33, 46, 66, 73, 82, 125, 135, 138, 140,
157, 161, 206, 225, 229, 233–34, 255, 281; symptoms
100; family history of 174
- despair 40–1, 60–1, 100–1
- detachment 40–42, 60, 100
- developmental disability 154
- Developmental Model of Grieving 4
- developmental process 3, 228
- differentiation 225
- dignity portraiture 251–55
- disasters 25, 153
- disenfranchised grief/loss 4, 139, 143, 165, 172, 242, 272
- disengagement 127
- disentangling multiple loss 115, 153–56
- dismissive 21
- disorganization 40, 43, 60
- disorganized or fearfully avoidant 20
- disruption in religious practice 77–8
- dissociation/dissociative disorders 131, 144, 162, 181,
201
- divorce 269, 321
- Doctor Who 212
- domestic violence 334–35
- doubling 237
- dramatic play 212
- dramatic scripts 328
- dramaturgy/dramaturgical listening 6, 197–200
- drawing 214, 293
- drawing images of violent death 256–58
- drawing questions out of a hat 321
- dreams 53, 330
- drug overdose 154, 159, 164, 303
- DSM-5 87
- Dual Process Model of Coping with Bereavement
(DPM) 19, 48, 65, 175
- dual rose 259–63
- dyadic disclosure 308
- dyadic poems 313
- dyadic-relational factors 4, 11
- dying 339
- dysfunction 88
- “E” strategies (explore, empathize, educate, encourage)
179
- early family relationships 224
- efficacy of grief therapy 61
- embodiment 12
- emotion 113–14; dysregulation 126, 181; regulation 5–6,
17, 27, 90, 135, 153, 161, 165, 173, 226, 308
- emotional: disclosure 139, 143; exploration 135;
expression 109–11, 210; flooding 173, 181; processing
27; reactivity 106; responses 109; safety 145; upsurges
118
- Emotional Freedom Therapy (EFT) 140
- empathic listening 6, 308–9
- empathy 22, 294
- emptiness and meaninglessness 60–61
- enacting the ritual 330
- end-of-life 252, 339; care 228
- energy system 139, 143
- epigenetic 10; systems perspective 3, 11
- Eriksonian theory/crises 4, 7
- establishing group guidelines 307
- ethics 300
- event narration 311
- evidence-based healthcare 30
- evidence-based practice/strategies xv, 30–35
- exiles 186, 188
- existential psychology 182
- existential questions 10, 106, 299
- expanding the system 275–78
- experiential: approach 21; exercises 262; learning xviii
- exploratory system 16
- exposure 124; activities 28; imaginal 27, 256; in vivo 27
- expressive arts 147, 155, 214, 268, 308, 316, 325
- expressive/creative domain 313
- externalizing 116
- eye movement desensitization and reprocessing
(EMDR) 197
- Facebook 232, 245–46
- facilitating mourning 27
- facilitating safety in group work 299–302, 308
- faith 256, 331; community 77, 197, 252; crisis of 76;
tradition 252
- families 51
- family: bond 53; communication 293; photos 251; safety
319; social context 276
- family coat of arms 290–93
- family therapy 275–76, 321
- fantasy 327
- father interview 280
- fear 144, 161, 279
- feedback 308
- felt sense/experience 6, 131–32, 333
- felt shift 132

- fight-or-flight response 135
 finding an enduring connection with the deceased 322
 firefighters 186
 five stages of dying/grieving 105, 312
 flashbacks 26, 131
 focusing 131–34
 fog of grief 153
 footing in the world 47
 forgiveness 158–59, 166, 229
 fortune teller 321
 four R's (relax, repeat, return, remember) 136;
 meditation script 136
 framing the symptom in ritual terms 329
 frozen grief 209–11
 functional behavior assessment 125
 funeral 124
 future 113
- gender 300
 ghost bikes 240
 glaucoma 144
 goal 27, 73, 125–26; pursuit 15; setting 110
 goal-directed behavior 124
 goal-oriented responding 127
 God 206; compassionate 331; retributive 331
 good deeds 78
 goodbye letter to the therapist 216–19
 gratitude 166
 grief 17–18; acute 89, 106, 228–29; cancer-related
 170; early 5; in the workplace 295; intensity 73;
 overload 304; integrated 228; later 5, 9; middle 5, 7;
 pathological 201; systemic process of 276
 grief ball 320–22
 Grief and Meaning Reconstruction Inventory (GMRI)
 59–64
 grief drawer 173–75
 grief etiquette coaching 294–96
 Grief Experience Inventory 40
 grief loop 125–26
 grief river 105–8
 grief spot 287–89
 Grief to Personal Growth Theory 41, 100
 grief work 65, 88
 ground rules 300
 groups 51, 145, 157, 303; agenda 300, 304; cohesion
 300, 312; contagion 306; differences/disagreements
 301; diversity 301; development 312; interaction
 313; process 301, 304, 312; setting 258–59; silences
 304; work 299–302; hopes and fears about 300;
 monopolizing 304, 306; proselytizing 304; rage 304
 group facilitator's workshop 307
 group intervention for bereaved women 316–19
 group therapy 255, 321
 guerrilla warfare 81
 guided meditation 135, 137–38, 164
 guided poetry 209–11
 guided visualization 317
 guilt 16, 26, 48–49, 83, 110, 153, 157–61, 164, 166, 191,
 202, 230, 237, 329, 335; existential 185
 guilt prayer or inventory 158, 160
- healing flowers 268–72
 healthcare professionals 99
 heart attack/disease 89, 144
 Heart Failure Search Filter 31
 helplessness 41
 hierarchy of anxiety-provoking situations 27
 Hinduism 77
 Hogan Grief Reaction Checklist (HGRC) 39–45, 60, 100
 holding environment 6
 Holocaust survivors 197
 homicide 25, 39–40, 162, 303, 306, 311; bereavement
 78; loss 6
 honoring loved one 313
 hope 192
 hopelessness 40–41, 292
 hospice 251, 255, 338–39
 humanistic psychology/approach 133, 280
 hymns 338
 hyperactivating and deactivating behaviors 16
 hyperarousal 319
- identity 9, 60, 65, 125, 182–83, 188, 190, 202, 205,
 216, 224, 239, 329–30; change 19, 52, 118, 335; of
 the family unit 290; reconstruction 46; symbols of
 330–31
 if only 309
 illness 39–40; terminal 321
 imagery 124, 131, 166–67; of the death scene 89, 202,
 256; reenactment 256; traumatic 262
 imaginal dialogue 5, 49, 61, 236–38; with God 79
 imagination 251, 325–27
 immigration 175, 330
 Impact of Event Scale 40, 100
 impermanence 10, 262
 improvisation 237
 improvised explosive device (IED) 81
 individual therapy 275, 321
 infertility 175
 inner connection 181
 Inner Experience Questionnaire 181
 inner representation 259
 inner world 280
 insecure preoccupied 21
 insecurity with God 77–8
 insomnia 135, 137, 139–40, 144
 intangible losses 268
 Integration of Stressful Life Experiences Scale (ISLES)
 46–50, 78
 integrative psychotherapy 280
 integrity vs. despair 106
 intellectual disabilities 259
 intellectual responses 109
 intent 67
 interapy 201
 internal conflict 312
 Internal Family Systems (IFS) 186, 188–89
 internal working model of attachments 224
 internalized bond/relationship 111, 179–80
 internet 244, 338
 interpersonal religious support 78

- intervention: body-mind-spirit 140, 143; faith-based 76; psychoeducational 279, 303; trauma-focused 201
- introducing the deceased 8
- intrusion 41, 100, 201
- intrusive: imagery 131, 179, 202, 256; thoughts 26, 257–58, 262
- Inventory of Altered Self Capacities 181
- Inventory of Complicated Grief-Revised (ICG-R) 60, 77–8
- Inventory of Complicated Spiritual Grief (ICSG) 76–80
- Inventory of Daily Widowed Life (IDWL) 65–70
- Inventory of Social Support (ISS) 99–102
- Islam 77
- isolation 139, 153, 329
- job performance 26
- journaling 52, 146–47, 163, 181, 205, 313, 330–31; directed 5, 9, 53, 205; spiritual 205–08
- Judaism 77, 198
- kinship 89
- Kripalu 145
- leadership styles 303
- legacy product 251
- legacy projects 5
- letters 313; to self 190–93; to a hypothetical friend 202; to the deceased 28; unsent 331
- life: goals 185; lessons 60; narrative 47–8, 53; later 153; post-loss 125
- life stories 158, 166–67; alternative 116
- life review 106, 228, 337–39
- life significance 71; active 72, 74; negative 73; receptive 73–4
- life-threatening experiences 81
- LifeForce Yoga for Depression 145
- limbic brain 251
- liminal space 325
- limited mandate for family therapy 276–77
- Lion King, The* 326–27
- literature 312
- living losses 170
- loneliness 19, 66, 124, 161, 225, 230, 252, 276, 292
- loss 77; cancer-related 172; circumstances of 48; integration of 106, 167; irreversibility of 110; nontraumatic 256; of intimacy 229; of sexual intimacy 28; previous 106
- loss boxes 170–72
- loss-oriented/orientation 19–20, 48, 65–70, 175
- lost identity/selfhood 52, 198
- lost innocence 52–3
- love 14, 166
- loving kindness 9
- loving-kindness meditation 161–64
- major depressive disorder (MDD) 124–26
- managers 186
- mantra 136
- manual of therapeutic procedures xviii
- mapping the influence of loss 113–16
- marital: closeness 287; conflict 159, 161; relationship 277
- marital therapy 276
- meaning 6, 11, 59, 71, 73, 90, 109, 113, 125–26, 155, 170, 172, 182, 197, 209, 211, 229, 240, 242, 257, 272, 275, 310; global 46–47, 59; categories 52; in life 46; oriented procedures 124; reconstruction 51, 59, 105, 113, 115, 193, 210, 232, 316; searching for 11–12, 19, 26, 51, 205, 230, 256, 313; situational 46–7; sources of 184–85
- Meaning Centered Grief Therapy (MCGT) 182–85
- Meaning-Centered Psychotherapy 182
- meaning made of stress 46–8
- meaning making 20–21, 39, 46–7, 49, 51–3, 60–1, 78, 106, 164, 190, 210, 214, 228, 268, 308, 329, 331–32, 334; model 52, 205; spiritual 205
- Meaning of Loss Codebook (MLC) 51–58
- meaning vs. meaninglessness 5, 9
- mechanisms of change xviii
- medical examiner 256
- meditation 118, 137, 161, 331; inner wisdom 146–47; mindfulness 137, 146, 330
- memento 330
- memoir 52, 199–200
- memorial: highway 240; object 328; public 239
- memorialization 5, 8
- memory 15
- memory artist 251–52, 255
- memories 16, 41, 224; positive of the deceased 202
- men's grief 110, 118, 183, 187, 192, 293, 309
- mental fogging 295
- mental health 48
- meridian tapping 139–143
- metaphor 105, 109, 190, 209–10, 313, 332, 334
- military: combat 25; personnel 81
- mindfulness 6, 138, 158, 186; techniques 188
- mixed feelings 168
- modeling disclosure 307
- monotheism 77
- moral conflict 82
- moral injury 73; symptoms 82
- Moral Injury Questionnaire-Military Version (MIQ-M) 81–6
- morally injurious experiences (MIEs) 81, 83; exposure to 82
- mortality 26, 106, 172; risk of 6
- mourning process 28
- moving on 53, 237
- multiple losses 25, 41, 153, 155, 218
- multiplicity of personality 186
- murder 179, 206
- music 137, 245, 337; therapy 236
- musical instruments 238
- mutual triggering 306
- narcissistic wound 5
- narrative 193, 224, 255; healing 319; coherence 188, 197, 203; constructivist perspective 51; disorganization 8, 229; disruptions 229; of relationship 228–29; of the loss 135, 306; practices 115, 214; reconstruction 198–99; themes 229; therapy 228; self-immersive 308; somatic 316–17

- Native American 7
 need to suffer 159
 negative affect 73
 negative-meaning themes 53
 negative religious coping 77–8
 negative self-talk 118
 neglect 179
 nightmares 179
 non-finite loss 170
 non-judgmental inquiry 281
 non-verbal level 317
 normalization 109, 111, 125, 158, 166, 173
- Older Women's Group 167
 On-going Attachment Scale 100
 online: diagnostic procedure 201; memorial 244–47;
 memorial sites 245–46
 operant conditioning 124
 oppression 264
 organism-environment system 4
 organizational settings 294
 oscillation 17, 19–21, 65, 175, 188; balance 66–7; intent
 67
 outing 330
 over-identification 280
- pairing and sharing 308
 palliative care 31
 Palliative Care Search Filter 31
 panic: attack 137; behavior 40, 42
 parentified child 214
 passive responding 126
 penance 158–59
 Perceived Life Significance Scale (PLSS) 71–75
 persistent complex bereavement disorder 87
 person-centered approach 21–22
 personal-agent factors 3, 11
 personal growth 10, 40–2, 47, 52–3, 60–61, 100–1
 personality and temperament 106, 300
 Phoenix Rising 145
 photographic review 61
 photograph/photography 108, 174, 224, 244–46, 253,
 328
 photographing relationships for remembering 264–67
 physical health 48, 207
 planning the ritual 329
 play 325–26
 play therapy 212, 214, 327
 poetry 10, 118, 209, 313, 338; therapy 312; pre-existing
 312
 positive-meaning themes 52–3
 positive religious coping 78
 positive reminiscence 259
 possessions 224
 posttraumatic growth 5, 9–10, 144, 164, 183, 207, 268,
 304
 posttraumatic stress disorder (PTSD) 26–7, 81, 83, 118,
 124, 126, 144, 201, 203, 206, 240; symptoms 48
 Postvention Australia 307
 prayer 137, 330–31
 preparing the ground 300–1
 presence 14, 22; authentic 179
 preventability 41
 pre-loss relationship 90
 Princess Diana 239
 priorities 9, 113–15; changes in 185
 problem-solving 15, 125–26, 135, 304, 308
 processing the pain of grief 322
 progressive muscle relaxation 137
 prolonged exposure 27, 261
 prolonged grief 117, 201, 259
 prolonged grief disorder (PGD) 124–26, 205–6
 prompting questions 257
 protective part 187–88
 protectors 186
 protesting against culturally sanctioned attitudes 239
 proximity seeking 16
 psychiatric distress 48, 60
 psychodynamic perspective 51
 psychoeducation 202, 279, 301
 psychological immune system 17
 psychology 268
 psychometric measures 11
 psychosis 201
 psychosocial resources 11
 psychosomatic symptoms 40
 psychotherapy research/outcomes xviii, 21
- Q&A games 321
 quality of life 26
 quiet time 330
- rage 180
 Rando's six Rs 28
 "re" verbs 118
 reading 330
 reading the room 303
 receptive/prescriptive domain 312
 reciprocal disclosure 308, 310
 recruitment of group participants 300
 Red Tent 316–19
 regret 52–53, 157–58, 252, 312
 regulatory functioning 16
 reincorporating self into community 330
 reinforcement 125–26; source of 124
 reintegrating attachment after loss 223–26
 relapse prevention 118
 relational active grief and trauma 88
 relational constructivist model 332
 relational context of bereavement 278
 relations 6
 relationship review 228–31
 relationship to the deceased 87–8, 106, 216; back story
 of 8, 214; close and positive 88–89
 relationship with the self 192
 relaxation 147; response 135; training 135
 release 188
 religious and spiritual beliefs 206
 religious: avoidance 78; discontent 77–8; figure 336;
 pleading 77–8

- Religious Coping Activities Scale (RCA) 77
 RES poetry therapy model 312–13, 315
 resilience 26, 40, 107, 117–18, 161, 256, 290, 293, 304
 resistance 126, 131–32
 resonating 132
 restoration-oriented 19, 48, 65–70, 175
 restorative retelling 256–57, 306, 311
 restoring the bond with the deceased 239
 retreat for women with cancer 171
 reweaving the songlines 316
 re-framing 118; the story 199
 re-traumatization 6, 306, 322
 Ride of Silence 242
 rites of passage 325
 ritual 9, 49, 202, 294, 313; 325–29
 role relationship models 59
 role-playing the child 280
 rumination/repetitive thinking 65, 67, 110, 124–26, 173
- sadness 26, 144
 safe haven 15, 22
 Samaritans Organization in United Kingdom 303
 sand tray 214
 savasana 145–46
 saying goodbye 49, 237
 school personnel 99
 screening 300, 304
 script-cure 280
 second guessing 17
 secondary losses 28, 182, 279
 secure base 15, 22, 90
 secure relationship 15
 security and safety needs 224
 security vs. insecurity 5, 8
 segmenting the story 308
 self 186, 188; future 332
 selfies 264
 self-acceptance 5–6, 10
 self-actualizing tendency 133
 self-blame 16, 161, 202, 261, 303
 self-capacities 6, 179–81
 self care 32, 66; in bereavement 33
 self-compassion 17
 self-concept 15; complexity 15
 self-confrontation 201–2
 self-determination 17
 self-disclosure 312
 self-distancing perspective 308
 self-efficacy 135, 144
 self-esteem/self-worth 90, 153, 179–81; low 161
 self-expansion 15
 self-expression 312
 self-narrative 9, 59, 71, 182, 184, 198
 self-nurturance 190–91
 self-organization 223
 self-pity 161
 self-punishment 157
 self-redefinition 16
 self-reflection 190
 self-regulation 15, 179, 317, 319
- self-soothing 135, 256
 self-therapy 235
 sense of coherence 9
 sense of peace 60–61
 sense-making 26, 46, 52, 59–61, 71, 77, 157, 207, 223
 sensitivity 31
 sensory poems 313
 sentence completions 198
 sentence of poetic stems 313
 separation anxiety 8, 155, 232
 session recordings 52
 severe mental illness 162
 shame 164, 303
 shattered assumptions 26
 Sherpa guides 14
 shooting 294; drive-by 241
 shoulding 186
 shrines, customized 239
 significant others 275
 singing an imaginal dialogue 236–38
 situated interpretive and communicative activity 4, 10
 situational revisiting 311
 sleep problems 26, 140
 social action 5
 social media 201, 232, 247
 social order 239
 social sharing 201–02
 social support 4, 27, 41, 99–100, 181, 202, 294; culturally
 attuned 294; negative 6
 somatic symptoms/reactions 143–44, 188, 280
 song lyrics 312
 songbook 338
 songs 328; popular 338
 specificity 31
 spinal and head injury 144
 spiritual: commitments 9; grief 77; issues 299; lessons
 10; struggle 26, 76, 78, 83, 207, 331; suffering 337
 spirituality 5, 10, 41, 60, 113–14, 118, 136, 162, 205, 252,
 293, 330–31
 spiritually based healing rituals 329–31
 spontaneous memorialization 239–43
 stabilization 256
 stage model 51, 105, 109
 stigma 293, 303
 stillborn child 53
 stories/storytelling 190, 214, 251, 255, 313, 328;
 preferred 251
 strategies for coping with grief 117
 stress 135, 137–38, 161; management 136
 stress-and-coping perspective 51
 stress-related disease 135
 stressors 19; concurrent 106–107
 suffering 10, 158, 185
 suicidal thoughts/ideation 126, 139, 162, 201
 suicidality 48
 suicide 25, 39–40, 61, 114–15, 118, 137, 157, 162, 168,
 202–03, 233, 257, 294, 303–04, 306, 309, 311, 316;
 prevention 115; risk 82, 304; statistics 304
 suicide bereavement 303, 307
 summarizing the story 308

- support 106; grief/bereavement 6, 294; internet-based 201
 support group 6, 117, 159, 165, 245, 299, 301, 303; 306–311; bereavement 39, 60, 167; online 201; for children 314
 support system/network 256, 275–77, 294, 296
 suppressed feelings and thoughts 116
 surviving children 279
 survivor guilt 158, 233, 237
 symbol/symbolism 210, 238, 313, 329
 symbolic/ceremonial domain 313
 symptom 329–30
 systemic perspective 51, 278
- tai chi 137
 talking sticks 308
 talking/not talking in an intimate relationship 277–8
 Tapas Acupressure Technique (TAT) 140
 Task Model 51
 tasks of mourning 109, 321
 tattoos 309
 tending and befriending 6
 termination in grief therapy 219, 312
 terrorism 81, 179
 Texas Revised Inventory of Grief (TRIG) 40
 thanatology xv, 105
 theory and practice xviii
 therapeutic alliance 268, 279, 332
 therapeutic relationship as a container 216
 therapeutic window 181
 therapist presence 6
 therapy of an introjected other 280
 Thought Field Therapy (TFT) 140
 thoughts: automatic 27, 202; dysfunctional 201–2; irrational 139; obsessive 110; of death 125–26
 time machine 214
 time revisited 212–15
 time together 53
 time travel, symbolic 212
 timeline, life 190
 tissue donation 100
 totem 328
 traditional Chinese medicine 139
 training for peer facilitators 306
 transcendence 9; self 10
 Transcendental Meditation (TM) 135
 transitional objects 230
 transparency 301
 trauma 81, 90, 117, 140, 144, 180, 292, 319; processing 27, 179; work 159
 traumatic bereavement/loss 25, 117, 124, 139, 179, 240, 303, 329
 traumatic memories of the death scene 90
 treatment effectiveness 89
 trolls 245
 trust 181, 316
 turning monologue to dialogue 308
- Twitter 232
 Two-Track Bereavement Questionnaire for Complicated Grief (TTBQ-CG31) 87–98
 Two-Track Model of Bereavement 87, 90, 232
- uncomplicated grief 20, 294
 unconditional acceptance 133
 unconditional positive regard 22
 unconscious protective strategies 279
 uncontained telling of stories of loss 306
 unfinished business 61, 110, 230, 239, 293
 unique outcomes 116
 unrecognized relationships 143
 unresolved grief 139
 unresolved issues 237
- values 9, 27, 73, 125, 183, 185, 290; cultural 15, 106; religious 106; spiritual 329
 valuing life 52–53, 60–61
 valuing relationships 53
 verbal and nonverbal messages 303
 verbal psychotherapy 139
 verbatim transcripts 197
 veterans 46, 81; Iraq/Afghanistan 82
 vicarious traumatization 28
 video 245
 violence 73, 82
 visual art 219
 visualization 224, 333–4
- war 153
 warzone 138
 website: 244; memorial 201
 Who am I? 182–85
 who or what of being 185
 widows/widowhood 39, 107, 124, 167
 wisdom 144, 332; embodied 132; internal 132
 wise elder 332–36
 withdrawal 6, 125
 working model 15–16, 22
 workplace 296
 work/social functioning 82
 World Assumptions Scale 73
 World Trade Center tragedy 240
 world view 46, 113, 205; secular 77
 wounding 12
 writing: creative/expressive 190, 209, 312–13, 315; internet-based 201–4; reflective 206; therapeutic 190; assignment 202; from adult to child 191; from child to teen 191; from present to future self 191; to deceased loved ones 232
 written disclosure procedure 201
- yearning 17, 19, 26, 259
 Yin Yoga 145
 yoga 137; sutras 144
 Yoga for Grief 144–49; group 145, 148, 164