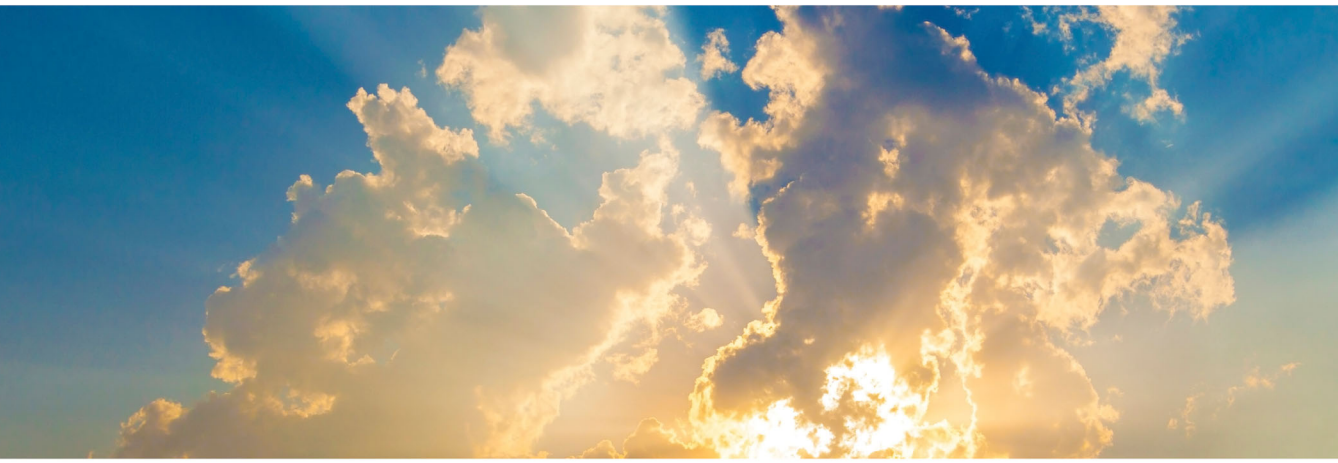
SECOND EDITION

Grief and Loss Across the Lifespan

A BIOPSYCHOSOCIAL PERSPECTIVE



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Grief and Loss Across the Lifespan

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Second Edition

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This text is dedicated to:

Ryan Patrick McCoyd and Ian Walter McCoyd, my sons who have navigated losses resiliently and who fill my life with meaning and joy.
—Judie McCoyd

The family of Carolyn Walter: Bruce Bryen, Carolyn's husband, who has supported her in all of her efforts to complete this second edition, Kim Remley, Brian Walter and her grandchildren, Matthew, Connor, and Hazel, who have brought her incredible joy during midlife and now older adulthood.
—Carolyn Walter

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Preface

This new edition of our book has been a labor of love—for the new grief literature that we got to include, as well as for the chance to share it with students and clinicians. Our first edition came as a result of our work together as consultants and our shared frustration about the dearth of texts that could meet the needs of the Grief and Loss classes we each taught. Our philosophy that loss is at the heart of growth and that death loss is only one type of loss animated our work. We were happy to share new information about continuing bonds, meaning-making, disenfranchised grief, and the dual process model in our first edition, and have enjoyed hearing from instructors and students about how helpful the text has been.

Sheri W. Sussman, our editor extraordinaire for the first edition, contacted us to discuss a second edition and we were thrilled. The field of grief theory and intervention has been growing rapidly, informed by trauma theories, neurobiology, and new interventions. Further, social media and other technologies have been changing the way we mourn. We were delighted to have the opportunity to collaborate and update these areas in this second edition.

Death and Dying courses in social work, nursing, counseling psychology, and medicine traditionally focused on topics such as the experience of dying, the delivery of health care during the end of life, and the experience of mourning after a death. Classic texts such as Rando's (1993) *Treatment of Complicated Grief*; Worden's (2002) *Grief Counseling and Grief Therapy;* and Parkes, Laungani, and Young's (2000) *Death and Bereavement Across Cultures* have been joined by newer ones, yet we believe our text offers a unique biopsychosocial perspective. We include neurobiological aspects of development and grieving as we truly believe our students need to understand these aspects of biology if they are to claim a biopsychosocial perspective in the 21st century. Also, identification of maturational losses and the developmental aspects of grieving are foci seldom found in typical texts that address grieving and loss, though we believe they are quite important. The readings that end each life-stage chapter enliven the pedagogical material and add additional dimensions to the material. We have developed ancillary materials available to qualified instructors (e-mail textbook@springerpub.com) that include outlines, PowerPoints, and activities for each chapter and have also included the readings from our first edition to supplement the case materials available to readers of the second edition. We hope this second edition helps each reader feel prepared to help grievers of all ages and types.

Acknowledgments

We have many to acknowledge and thank for their help in our work with this text. First, we would like to thank the instructors, students, and clinicians who have given us feedback on the first edition. All have helped us to improve and update this edition. Second, we thank our "Readings Writers" who wrote the readings at the end of each chapter and are experts, sometimes academically and often experientially. We appreciate your willingness to share your stories to enliven this text. Third, we want to thank our clients and research participants who have shared their loss experiences and meaning-making thereby teaching us ever more about the subtleties and nuances of multiple types of loss. Fourth, we owe gratitude and respect to the people who taught us about grief and loss experientially: for Judie McCoyd those include Judy Achuff (high school "best friend"), Eunice and Ben Maurer (grandparents), Mary and Walter McCoyd (in-laws), and Doug Moyer (sibling). For Carolyn Walter, these experiential lessons of loss started early and included Joseph Penrose Ambler (father) and John Walter (first husband) who taught Carolyn many important lessons in grief, recovery and meaning-making. Fifth and not least, we thank Jim Baumohl for his close editing of most of the chapters to help us clarify our points and protect us from garrulousness and vagueness.

We give deep thanks to our family and friends who have supported us in this endeavor. Carolyn Walter thanks her husband, Bruce, for supporting her through many difficult moments in writing this second edition, as well as friends, Norma, Janet, and too many to name! Carolyn also thanks the grad assistants at Widener who helped gather recent literature for this second edition. Judie McCoyd thanks all her friends, especially Corey Shdaimah and Anne Dalke, who helped her navigate recent rough transitions. Great thanks to Jim Baumohl for his "over and above" help with editing and the household.

Finally, we wish to thank Sheri W. Sussman at Springer Publishing Company for believing in us and this book enough to ask us for this second edition. We are grateful to be working with her.

ONE

Introduction

Loss is at the heart of life and growth. When we wrote this in the first edition of this text, it reflected a relatively new understanding of some functions of loss and grief. Now, nearly a decade later, it is not at all controversial. Life changes and maturation are understood to result from losing (changing) an attachment relationship, a prior lifestyle, a behavior pattern, or otherwise modifying the status quo. We regularly encounter books that suggest that individuals grow and mature as a result of loss (Okun & Nowinski, 2011). Still, we are cautious and observe Klass' admonition (2013) to avoid approaching grief as if it will *always* create growth and we recognize that the sorrow involved may linger. Yet, as practitioners who strive to assist clients in their growth, we must be aware that change and maturation, even toward a more positive state of functioning, often involve losses that are unrecognized, but felt nonetheless.

We offer this text to reflective practitioners of all levels of experience, as well as to educators searching for a text on loss that explicates developmental differences. We have significantly revised this edition with new literature, more information about technology and social media, integration of new neurobiological understandings and discussion of how attachment, trauma, and mindfulness practices may intersect with grief and loss. We believe that our focus on loss as a normal, though destabilizing, experience has been welcomed by educators, practitioners, and grievers because it reflects more closely the experiences they have gone through following losses of various sorts.

Here, we convey the most recent understandings of loss and grief theory, trauma and attachment theories, developmental aspects of grief from a biopsychosocial perspective (including neurobiological and genetic information), research on specific responses to loss situations, and discussion of intervention strategies that are supported by practice wisdom and empirically based research. Normal maturational changes are recognized not only as growth, but also as a special form of loss in which one is expected to delight in the growth and ignore the loss aspect of the change, a perspective we challenge. The customary, destabilizing force of loss promotes self-reflection and this can lead to growth, particularly when the mourner's experience is validated and supported.

Our approach toward what is customary or typical is quite deliberate. We not only identify various losses that are common during different developmental stages, but maintain that loss and subsequent grief is normal. We are using the term normal in the sociological sense meaning that it reflects statistical norms: It reflects the most common experience. We are not using it to indicate that there is moral content attached to the occurrence. Loss and grief, though uncomfortable, are part of human existence and can produce growth and

insight, with or without professional help, though we believe that most people process losses more easily when they talk with someone. Although complicated grief reactions exist, most grief is not pathological. As practitioners, we have learned that most people are able to cope with even tragic loss when they have someone who is able to accompany them on their grief journey. We hope to help you, the reader, feel comfortable helping grievers of all types.

We hope this text allows practitioners to understand how the experience of grief is influenced by biological responses to stress, psychological responses to loss in the face of previous attachments, and by social norms and supportive others. We further hope that this understanding allows practitioners to conceptualize their work in ways that allow the mourner to make meaning of the loss and process it in each griever's unique way. We envision a practitioner who may *seem* passive in not "pushing" one grief model, but who actively helps the mourner explore her or his new identity in the face of the loss. Good grief work allows the mourner to learn more about themselves and their "fit" in the world and to grow as a result of the work the practitioner and griever do together.

TEXT STRUCTURE

This text is arranged so that each level of development from infancy through aging will be addressed in four ways. Each chapter opens with a vignette about an individual who is experiencing losses characteristic of a specific age group. The objectives of the chapter follow each vignette. (For this chapter that has no vignette, they will be found between this section and the main content of the chapter.) This is followed by a review of normal developmental issues for that age, particularly the abilities and challenges that are specific to it. The next section describes how an individual of that age tends to cope with a death loss. The third section addresses how an individual of that age may experience her or his own life-threatening illness and how significant others tend to react to and mourn the death of someone in that age range. The fourth section of each chapter identifies the typical losses someone of that age is likely to experience and addresses protective and risky ways of coping with those losses. Each chapter ends with short readings by experts who share a broader range of losses, while also providing intervention suggestions from practice wisdom and empirically supported research perspectives.

Typical losses are those that are relatively common to a specific age group, but which often are met with little support precisely because they are "normal." Pet loss, for example, is likely to occur during the school years, just as the loss of a romantic relationship is common in emerging adulthood. These are examples of typical loss. **Off-time losses** occur during a stage of life where they are not expected. Although parents often die when children have reached middle age, it is considered an off-time loss when a parent dies during a child's adolescence or emerging adulthood. Off-time losses are more challenging because few peers are available to provide role models for grieving, peers may distance themselves due to unfamiliarity and discomfort, and formal support resources may not be appropriately responsive because the loss is off-time.

Other typical losses are due to development and we refer to these as **maturational losses**: for example, when a toddler loses unconditional

positive regard and is no longer viewed as "cute" for misbehavior, but is held accountable; or when a young adult marries and must give up the freedom of single living. We believe maturational losses to be a form of "disenfranchised grief" (Doka, 2002). In this volume we name such losses, recognizing that until named they cannot be acknowledged and mourned. We also sound a note of caution that while recognition of the loss is necessary, overt mourning is not always required.

OBJECTIVES

After reading this chapter the reader will be able to:

- *Review biological impacts, psychological experiences, and social contexts of grief.*
- *Trace the evolution of classical grief theory to the task- and stage-based grief theories of the modern era.*
- *Describe postmodern grief theories including the dual process model (DPM), meaning-making, continuing bonds, disenfranchised loss, ambiguous and nonfinite loss.*
- *Explore cultural impacts and the role of ritual in coping with loss.*
- *Provide social and historical context for grief therapeutics, including recent changes in the DSM-5.*
- *Discuss concepts of mindfulness, attachment, and cultural humility and their intersection with grief work.*
- *Utilize the perspective that loss is a normal and necessary part of life.*

BIOPSYCHOSOCIAL ASPECTS OF GRIEF

As our title indicates, we take a biopsychosocial perspective on grief and loss across the life course. This requires that biological aspects of human development, including neurobiological and other physical changes, be incorporated into our thinking as well as the more typical psychological and social aspects of development. Much of this material will be new to many clinicians, yet practice in the 21st century requires that mental health practitioners of all stripes understand immunological, hormonal, and other biochemical responses humans have to stressful events; genetic and epigenetic influences on psychosocial behavior (and vice versa); and the neurobiological impacts of grief and trauma. We provide ample citation so that readers may explore this material in more depth.

Biological Effects of Grief

The association of higher mortality with bereavement has been strong, long-lasting, and significant (Parkes, Benjamin, & Fitzgerald, 1969; Stroebe, Stroebe, Gergen, & Gergen, 1981). Although some older studies found no

statistical significance to risk of death after loss (Clayton, 1974), more recent studies confirm that individuals can and do "die of a broken heart" at double the rate of nonbereaved people matched for age and other demographics (Carey, Shah, DeWilde, Harris, & Victor, 2014; see also www.sciencedaily.com/releases/2014/02/140225101258.htm). Additionally, widowers die at higher rates than widows (Stroebe & Stroebe, 1993). How and why does that happen? What are the biological mechanisms that function to put grievers at risk? How might practitioners intervene to promote health after the death of a loved one?

Explaining the complex mechanisms of morbidity and mortality due to a "broken heart" is beyond the scope of this book. However, a basic understanding of how immune systems, genetic/epigenetic factors, neurological systems, and cardiovascular (and other organ) systems can be affected by stress and grief (and by depression and anxiety) helps practitioners recognize the impact of psychosocial factors on physical health and think about how to promote health despite bereavement. For those interested in more detail, Koch (2013) provides a useful summary of diseases caused by mind–body interactions including "broken heart," otherwise known as Takotsubo cardiomyopathy.

Popularly, physical health is viewed in Western societies as "about the body" and psychological well-being is "about the mind/brain." Yet, the interaction of mind and body has been assumed in some cultures for eons, and the recent embrace of mindfulness and other practices originating in Eastern religious and cultural practices has shed light on those interactions (Siegel, 2010a, 2010b). Often, people have associated positive emotions with good health (Seligman, 2012), yet recent findings strongly indicate that a mix of positive and negative emotions (tempering bad with good and good with caution) actually seem to promote health even better (Hershfield, Scheibe, Sims, & Carstensen, 2013). The interactions of emotions, stress, trauma, and physical health are mediated through immune, genetic, hormonal/biochemical, and neurological functions, all of which impact organ functions.

The immune system is one of the most potent mediators of mental and physical health in connection with levels of expressed emotion (Brod, Rattazzi, Piras, & D'Acquisto, 2014; Salovey, Rothman, Detweiler, & Steward, 2000). A significant body of work (well summarized in Salovey et al., 2000) shows that negative emotions decrease secretory immunoglobulin A (S-IgA), which then causes individuals to be more susceptible to infection by viruses such as the common cold. Likewise, the negative emotions of grief reduce the immune system's efficiency and provoke inflammation, which has negative cardiovascular (Gianaros et al., 2014) and neurological effects.

Although genetic endowment is frequently viewed as static, new understandings about how genes are "turned on and off" has led to new understandings of how genetic expression changes as a result of environmental stresses (McCoyd, 2014; Rothstein, 2013). Further, the genome is actually changed over time in ways that can be passed down to offspring (epigenetics) (Bienertová-Vašků, Nečesánek, Novák, Vinklárek, & Zlámal, 2014; Zucchi et al., 2013). Some of these genetic and epigenetic effects involve exposure to stress for extended periods of time, which has clear implications for people who are stressed by grief. Yet, genetics is even theorized to play a part in the differences between people who experience complicated grief and those whose

grief follows a more customary trajectory (O'Connor, Schultze-Florey, Irwin, Arevalo, & Cole, 2014; Schultze-Florey et al., 2012). Indeed, the Mindfulness practices that we suggest for help with managing grief have been shown to help calm the inflammatory response believed to negatively impact both immune system function and genetic expression (the inflammatory response is regulated by genes) (Creswell et al., 2012). In short, we should not neglect the reciprocal relationship between genetics and grief.

Neurotransmitters and other neurochemical interactions also play a role in the interaction of mental and physical health. The major mediator of brain chemistry under stress is the hypothalamic–pituitary–adrenal axis (HPA), which, when activated, causes a release of cortisol, the stress hormone. Norepinephrine and adrenocorticotropin hormone (ACTH) are also released when the HPA is activated, with rises in ACTH typically creating a feedback loop with cortisol (which then rises, ideally leading to lowered ACTH production). This feedback loop seems to break down in depressed and stressed individuals, with cortisol staying elevated. Children and youth are reported to have disturbed cortisol functioning after the death of a parent: the cortisol awakening response becomes blunted and heightened levels of cortisol remain in their systems (Dietz et al., 2013; Kaplow et al., 2013)

Other work (Gundel, O'Connor, Littrell, Fort, & Lane, 2003; O'Connor, Gundel, McRae, & Lane, 2007) has focused on the neuroanatomy of the brain. Researchers used functional magnetic resonance imaging (fMRI) to scan acutely bereaved individual's brains after interviewing them about their loss. They found indications that the posterior cingulate cortex, the cerebellum, and the inferior temporal gyrus are all affected; each has a role in autobiographical memory and creation of the "storyline" of individuals' lives. Freed, Yanagihara, Hirsch, and Mann (2009) showed that differing levels of attention to one's grief are associated with changes in the way the amygdala (the "emotion center" of the brain) interacts with the dorsolateral prefrontal cortex (where "thinking" and executive functions process emotions and meaning). These changes suggest that rumination (attention focused unremittingly on grief) may create neuroanatomical changes over time. O'Connor et al. (2008) have shown that the reward center where attachment "shows up" is stimulated when individuals with complicated grief are examined with functional magnetic resonance imaging (fMRI): both pain and reward centers are stimulated as reminders of the attachment figure who died are shown whereas those with customary grieving show only the pain. In short, grieving affects both the neurochemistry and structure of the brain.

The cardiovascular system is affected by psychological factors due to the disruption of hormones like cortisol and neurotransmitters like norepinephrine and ephedrine (Lazzarino, Hamer, Gaze, Collinson, & Steptoe, 2013). Mental health factors that create stress on the cardiac system constitute another mechanism through which bereavement is related to morbidity and mortality (Dande & Pandit, 2013; Stroebe & Stroebe, 1993).

With such issues in mind, it is important for the grief counselor to promote physical health. Regular exercise, balanced diet with an increase of B vitamins and antioxidants, increased omega-3, and exposure to light (Zisook & Shuchter, 2001) can all be encouraged. Urging a checkup by a physician is recommended, along with encouraging self-care and decreasing risks during the bereavement period.

Psychological Effects of Grief

Development plays an important role in the processing of loss. This text explains many of the psychological aspects of grief and loss at each developmental phase of life and addresses the impact of cognitive functioning and development on the understanding of death. Our motivation for this text is to integrate understandings of loss with knowledge of human development over the life course. We assume that every loss is framed within the griever's stage of development. When a loss happens in childhood, that loss will need to be reworked as development proceeds; the loss of a sibling at the age of 7 will need to be reassessed in adolescence and young adulthood as the secondary losses inherent in the death evolve. The 7-year-old will miss his or her brother as a playmate, but the 35-year-old may miss the help of a sibling with aging parents' needs.

Grief nearly always entails psychic pain, challenges in coping, and irritation, sadness, and rumination. Less commonly discussed is the heightened sense of vulnerability and fear that accompany grief (Sim, Machin, & Bartlam, 2014). Although clinicians working with grievers have long known that newly bereaved individuals fear another loved one dying and often become afraid to go out into the world or sleep alone at night, this aspect of grief has not received the attention it deserves. Loss stimulates an acute sense of vulnerability and subsequent hypervigilance just as trauma does (Lopez Levers, 2012). Rando (1993) captured this in her extensive list of symptoms of grief, yet vulnerability is seldom recognized as an expected aspect of grief. Helping grievers recognize this customary part of grieving helps them to feel less frightened and "crazy" when they feel anxious.

Rando (1993) also echoed Simos' (1979) observation that major losses are made up of many smaller, secondary losses. For example, the death of a parent during childhood is a tragic loss of an attachment figure, but also incorporates losses of guidance, economic support, a sense of a secure base, a protector, etc., not to mention losses of friends and a familiar school if adjustment requires a new living situation. For a griever to fully mourn the primary loss, these secondary losses must be recognized and validated.

Rando (1993) also described how time and grief interact. Although many grief theorists and others try to put a time limit on grief, she recognized that grief continues to be felt long after the acute phase resolves. The "anniversary reaction" wherein the griever has a Sudden Temporary Upsurge of Grief or STUG reaction is an example (1993, pp. 64–77). At times, the griever may not even be conscious of the occasion, yet feels dysphoric every April, the month a loved one died earlier in the griever's life. STUG reactions can be inspired by something as commonplace as hearing a song or having a reminder of the loved one.

Practice wisdom has long held that multiple losses accumulate, leaving more intensity to grief. However, while the nursing literature is rife with discussion of cumulative grief because nurses experience loss when patients die (Marino, 1998; Shorter & Stayt, 2010), few empirical studies have directly explored it. Some of the better research does not find the expected negative outcomes of cumulative grief (Cherney & Verhey, 1996). Nursing literature notes the possibilities for burnout and compassion fatigue while Cherney and Verhey (1996) suggested that there could be adaptive habituation to grief. This is an area where much more research is necessary.

Still others note the role of cumulative grief through historical and other losses in addition to death losses (Brave Heart, 1998) and persuasively argue that prior losses create a backdrop that can impede coping with new losses. As it is likely that individuals manage cumulative losses differently, the clinician needs to take a thorough and accurate history, including the prior losses (of all kinds) experienced and the griever's response to them. We also believe that losses due to development will be part of this cumulative load.

Social Aspects of Grief

Social rituals are fundamental to most important transitions, including those provoked by loss and death. Traditionally, funerals were grounded in religious practice and a community of believers and provide a deeply social way of mourning losses (Parkes, Laugani, & Young, 2000). Yet, as Parkes et al. observed, by the 1990s fewer U.S. citizens participated in organized religion and its mourning rituals. Recent studies suggest that fewer U.S. or European citizens engage in religious funerals than in previous generations (Norton & Gino, 2014). Yet, Norton and Gino (2014) show that the use of specified performed behavior defined as ritual is useful in both allowing a griever to have a sense of control and to lower levels of grief and mourning. Reeves (2011) asserts that a ritual involves "out of the ordinary" (p. 409) activities, at least one other person, and symbols of the lost entity. Vale-Taylor (2009) observes that as Western societies become less religious, hospice services of remembrance now often provide secular or ecumenical rituals for the bereaved. Creative activities that memorialize the deceased, assist the grieving, and support the caregivers, are also increasingly being used to aid mourning (Bertman, 2015).

Undoubtedly, technology is changing the way people are socialized generally (boyd, 2014) and in the realm of death and dying. The evolution of social media and other technologies has also had an impact on grief and loss. In the absence of shared religious rituals, some communities turn to Facebook and other Internet sites to share their grief (Falconer, Sachsenweger, Gibson, & Norman, 2011). Indeed, group treatment modalities for support after loss are arising on the Internet despite some resistance from traditional group work practitioners (Lubas & De Leo, 2014). Websites are designed to help confront death anxiety and avoidance (www.orderofthegooddeath.com) and virtual memorials are becoming ubiquitous (www.forevermissed.com; www.legacy.com/ns; www.muchloved.com/g_home.aspx; www.virtual-memorials.com).

When social expectations are violated, grief and grieving are affected. Disenfranchised grief and ambiguous grief (both discussed later in the postmodern theories section) derive from inconsistencies between the feelings of the griever and what is culturally recognized as a "real" loss, and an "allowable" state of grief. Such "feeling rules" (Hochschild, 1979) vary by religious, national, ethnic, and generational contexts. Some have explored the "sympathy biography" (Clark, 1987) that defines what losses and events generate sympathy and how sympathy functions as something exchanged among friends and family with an awareness of what is fair trade. Norms and rules about losses to be mourned and the people entitled to mourn them (and for how long) are social creations not artifacts of biology or individual psychology.

One aspect of the social world is the set of assumptions each person carries about the way the world works. It is a set of assumptions (e.g., my husband will always be there to kiss me good night; children outlive their parents) that make the world familiar and predictable. This is known as the "assumptive world." Traumatic events violate it and trigger distress (Janoff-Bulman, 1989, 1992). Attig (2001) asserts that bereavement requires that the mourner "relearn the world," another way of recognizing that assumptions must be revised and one must learn how to live in the new world without the loved one. Parkes (1988) defines grief as a psychosocial transitional state necessitating a readjustment of assumptions:

> For a long time it is necessary to take care in everything we think, say, or do; nothing can be taken for granted any more. The familiar world suddenly seems to have become unfamiliar, habits of thought and behavior let us down, and we lose confidence in our own internal world. (p. 57)

Although Parkes implies this is primarily an issue of "our own internal world," the assumptive world entails assumptions that are both personal and social. We argue that the assumptive world must be understood in much the way social workers use an ecological perspective. For instance, on the micro level, assumptions exist along the lines of "I'll pre-decease my child"; on the mezzo level, one may hold assumptions like "once a mother, always a mother"; but macro level assumptions can be violated too as when Hurricane Katrina devastated Mississippi and Louisiana and assumptions that "communities and the country will always take care of people when tragedy hits" were shown to be false. Whenever assumptions require revision, an individual's world feels uncertain, yet when these assumptions are dashed at multiple levels, we would expect that the challenges of adapting and revising the assumptive world ("re-learning the world") will be greater.

INTRODUCTION TO GRIEF THEORY

Classical Grief Theory

Task-Based Theories

> *For everything there is a season, and a time for every matter under heaven: a time to be born, and a time to die; a time to plant, and a time to pluck up what is planted; a time to kill, and a time to heal; a time to break down, and a time to build up; a time to weep, and a time to laugh; a time to mourn, and a time to dance—Ecclesiastes 3:1-14 ESV*

> *Mourning is regularly the reaction to the loss of a loved person, or to the loss of some abstraction which has taken the place of one, such as one's country, liberty, an ideal, and so on—Freud, 1957, p. 243*

Grief is as ancient as consciousness, yet is a relatively recent subject of scholarly attention. Freud was one of the first to address grief, melancholia, and

mourning in a scholarly manner. He observed that we can mourn for things, values, and statuses, not only as a response to a death. He also assures that grief and mourning are "not pathological," even when psychotic thoughts, feelings, and behaviors occur as an understandable (and usually normal) reaction to loss.

Freud proposed a "task-based theory," predicated on the idea that the mourner must decathect from the lost entity. Freud's theory of behavior states that the psyche cathects people and loved entities with libidinal energy and that that same libido must be withdrawn in order for a mourner to heal after loss. He believed people experiencing melancholia (what we might now call dysthymia or depression) had not successfully withdrawn the libidinal energy (decathexis) and needed help to do this. In Freud's understanding, the next task was to transfer libido to a new love object via cathexis. He asserted (Freud, 1957) that mourning is only completed when the ego becomes free by virtue of decathecting libido from the lost love object. He suggested a year as the customary time necessary for this to occur. (As a person of Jewish heritage, despite his religious skepticism, he may have adopted the traditional year of mourning accepted and ritualized in Jewish faith.)

Freud's was the primary theoretical paradigm for early grief work. Usually couched in the language of "letting go," counselors have long held to the idea that a mourner must separate from their attachment to the lost entity, even if they did not necessarily view this through Freud's theory of decathexis. Though simplistic, this task-based model for grief work has periodically re-emerged as a template for grief work in other forms. Indeed, this task of decathexis, separation or "letting go" continues to inform practice wisdom despite the development of new understandings of loss and grief. Freud himself set the context for some of the modern re-interpretations of grief work. He wrote to a friend who experienced the death of a child (as Freud himself had):

> [A]lthough we know that after such a loss the acute state of mourning will subside, we also know we shall remain inconsolable and will never find a substitute. No matter what may fill the gap, even if it be filled completely, it nevertheless remains something else. It is the only way of perpetuating that love which we do not want to relinquish. (Translated letters, Freud, 1961)

He implies that decathexis may occur but that recathexis is not likely to fill the gap, that it "remains something else" that mourners do not relinquish easily. We will return to this idea as we address the theories of meaning-making (Neimeyer, 2001) and continuing bonds (Klass, Silverman, & Nickman, 1996).

Some of the first empirical work to explore the grieving process was done by Erich Lindemann (1944), who studied the responses of grievers following the Cocoanut Grove nightclub fire in Boston in November 1942. He designed the study in advance to be fielded immediately after a tragedy so that there would be no anticipatory grief, but a sudden loss. He believed this would allow him to assess mourners' responses more accurately. He theorized that grief normally includes somatic distress, preoccupation with the deceased, guilt, and sometimes, hostile reactions. He asserted that eight to ten sessions with

a psychiatrist over the course of a month and a half were sufficient to manage grief work. This was based on his findings, yet few would agree with him today. Evidence can enlighten or mislead, and research does not always produce conclusions that stand up over time. The evidence in support of any "best practice" is always the best evidence at the time and always subject to revision.

Following traumatic death, Lindemann believed that tasks of grief must be accomplished, but he moved beyond Freud's two tasks of decathexis and recathexis. He postulated the following tasks:

1. Emancipation from bondage to the deceased
2. Readjustment to the environment in which the deceased is missing
3. Formulation of new relationships.

In some ways, step one mirrored decathexis and step three mirrored recathexis, but Lindemann contributed the idea that this was not a totally interior, psychological process. He acknowledged in the second task that bereft individuals must adjust to a social world in which their loved one is no longer living. Yet he defined 4 to 6 weeks as the time frame to accomplish these tasks as a norm. The unfortunate consequence of his time frame was that mourners who wanted to be perceived as healthy avoided grief expression after 4 to 6 weeks and grief work practitioners began to view grief that lasted much longer as pathological.

The time frame of grief has long been contested (Kendler, Myers, & Zisook, 2008) and the "normal" duration of grief remains controversial (Costa, Hall, & Stewart, 2007; Penman, Breen, Hewitt, & Prigerson, 2014). Penman et al. (2014) note that while more variability in grief trajectories is acknowledged today, there is still uncertainty about how to define grief that seems to be out of the norm. When the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association came out most recently (*DSM-5*; American Psychiatric Association, 2013), it no longer included what was called the "bereavement exception." Previously, depressive symptoms that might rise to the level of a major depressive disorder (MDD) were excluded if there had been a death loss up to 2 months before. Many declared the 2-month cutoff unrealistic as mourning often extends well past 2 months (Wakefield, Schmitz, & Baer, 2011). At this point, the focus is on diagnosing MDD when criteria are met (with recognition that grief seldom includes the level of self-loathing and feelings of worthlessness that generally accompany MDD); for more discussion, see www.dsm5.org/Documents/Bereavement%20Exclusion%20Fact%20Sheet.pdf).

J. William Worden (2009) has become known for a task-based grief theory and intervention framework that encompasses the following steps (Worden & Winokuer, 2011):

1. Acknowledge the reality of the loss
2. Process the pain of the grief
3. Adjust to a world without the deceased
4. Find an enduring connection with the deceased while embarking on a new life.

Worden's tasks provide a way to work with grievers without the assumption of "cure," but with the expectation that grievers can be assisted in moving

through their grief. Worden adds the experience of processing pain and many embrace Worden's task-based strategy as it provides an action plan and a way of taking hold of a process that often feels very out of control.

These task-based theories of grief and intervention were a major step forward from assumptions that the bereaved were pathologically affected if they could not move on with their lives as if little of import had occurred. Freud depathologized grief and the other task-based theorists explicated what the bereaved needed to accomplish in order to heal. In the undisciplined, untidy world of grief (Foote & Frank, 1999), a structured response lends a sense that there is a map to guide the way.

Stage-Based Theories

Like Lindemann, Kübler-Ross (1969) was interested in empirical data. As part of a seminar on death and dying at Chicago Theological Seminary, she and her students talked with dying patients about their thoughts, feelings, and expectations about their conditions at a time when medical practice wisdom held that patients were not to be told of their life-threatening illnesses. Her book *On Death and Dying: What the Dying Have to Teach Doctors, Nurses, Clergy and Their Own Families* (1969) was the source of the now widely accepted and reified stages of "Denial and Isolation," "Anger," "Bargaining," "Depression," and "Acceptance." It is notable that following these stage-based chapters in her book, there is a chapter entitled "Hope," a characteristic that she identifies as crucial:

> No matter what we call it, we found that all our patients maintained a little bit of it and were nourished by it in especially difficult times. They showed the greatest confidence in the doctors who allowed for such hope—realistic or not—and appreciated it when hope was offered in spite of bad news. This does not mean that the doctors have to tell them a lie; it merely means that we share with them the hope that something unforeseen may happen that they may have a remission, that they will live longer than is expected. If a patient stops expressing hope, it is usually a sign of imminent death. (Kübler-Ross, 1969, pp. 139–140)

Her stages of adjustment to a terminal diagnosis are now widely applied to all types of losses. Yet, her stages were developed for people who are losing their lives, not those who have lost loved ones; these are different experiences. She has become known as the mother of grief theory, yet her classic stages have been applied to a population that was different from the population she researched.

The stage of denial is particularly misunderstood. Kübler-Ross originally conceptualized it as a stage during which the diagnosed would "shop around" to ensure an accurate diagnosis and/or express hope that testing results and a terminal diagnosis were incorrect. She viewed this as a "healthy way of dealing with the uncomfortable and painful situation with which these patients have to live for a long time" (1969, p. 39). It is unfortunate that this stage has been widely misinterpreted and misapplied in grief counseling. It has often been viewed as a stage to be "broken through" or confronted, with counselors often applying Draconian methods to ensure that denial is not maintained in

connection with a death loss. Indeed, Volkan (1985) developed "re-grief therapy" as an intervention for those viewed as pathologically bereaved. His useful concept of a linking object, an object that reminds the mourner of the lost one, is used within a therapy designed to cut through any "denial" that may remain:

> Throughout treatment, patients experience a variety of emotions as they gain insight into their inability to let the dead person die. . . . The use of the linking object brings about special emotional storms that are not curative without interpretation that engages the close scrutiny of the patient's observing ego. (Volkan, 1985, pp. 289–290).

This assertive confrontation of denial has become one of the suspect interventions associated with early grief work counseling. The fact that denial is viewed as a stage to break through, rather than as the protective adjustment time that Kübler-Ross described, reveals one of the difficulties of stage theories more generally. Both the bereaved and less reflective practitioners can view these models as a recipe, an intervention plan to be broadly applied. This assumes a one-size-fits-all quality to mourning. It also implies that knowledge of the stages or phases can allow one to move more quickly through them—a fallacy with major implications.

Kübler-Ross's model of moving from protective denial to a state of anger and irritation (in her study, often directed at caregivers) is usually viewed as a one-way journey. It is portrayed as if an individual, once in touch with the reality of their loss, will now become angry (either at the lost loved one or at others), and will then move into a bargaining stage. Clinical work with bereaved individuals shows that anger and irritation flare throughout bereavement. Further, the bargaining that was so intuitive with the terminally ill patients Kübler-Ross interviewed (e.g., if I make amends to everyone I have wronged, I will get well/improve) seems less applicable to the bereaved. Once aware of the loss, particularly a death loss, there is little that the bereaved has to bargain *for* as they are aware that the loved one is, according to the resolution of the denial stage, already dead. Yet grief work counselors sometimes believe that expressions of bargaining are necessary before a client can move into the depressive states so characteristic of grief. Once a bereaved individual moves into expressions of sadness, tearfulness, and depressed activity, their family and friends (as well as professionals) then recognize this stage as classic grief and mourning.

The bereaved individual may fluctuate among the various stages and "acceptance" comes gradually (most often), not in one delineated event. The stages imply a progressive, linear movement through the stages (characteristic of theories of the "modern" era) rather than the back and forth movement seen most commonly among the bereaved. It is notable that "acceptance" for Kübler-Ross' population has a very different quality than that of the acceptance of loss by a bereaved person. For Kübler-Ross:

> Acceptance should not be mistaken for a happy stage. It is almost void of feelings. It is as if the pain had gone, the struggle is over, and there comes a time for "the final rest before the long journey" as one patient phrased it. This is also the time during which the family needs usually

> more help, understanding, and support than the patient himself. While the dying patient has found some peace and acceptance, his circle of interest diminishes. He wishes to be left alone or at least not stirred up by news and problems of the outside world. (Kübler-Ross, 1969, p. 113)

This is quite different from acceptance in the bereaved, from whom we expect *more* breadth of emotional expression (including happiness occasionally), *more* involvement with prior interests and *more* engagement with the greater world. These differences are seldom acknowledged in the simplified formats often provided as the stage theories for loss. Kübler-Ross was quite clear that these were stages characteristic of individuals who were dying, and might not apply to other populations, although she later said they could apply to the bereaved as well (Haupt, 2002), a claim about which we are skeptical. She cautioned against believing stages will occur in exact sequences. This caution is seldom incorporated when people learn the stages she postulated, with the result that a fluid and complex process is given a mechanistic cast.

A second classic stage theory grows from the empirical data of Bowlby (1998) who followed the children of World War II as they were separated from their parents in war zones and cared for in safer areas. He later studied widows (and a few widowers) and believed that this population confirmed his findings in the study of children. He postulated stages of:

- Numbness—defined as being shocked and stunned, not as denial; Bowlby identified the protective nature of this stage.
- Separation anxiety (yearning/searching)—defined as an alternating state of despair and denial, with anger folded in, much like that found in children separated from parents. He claimed that pathological grief is characterized by being stuck in one of these modes—either yearning, or angry and detached.

> Thus anger is seen as an intelligible constituent of the urgent though fruitless effort a bereaved person is making to restore the bond that has been severed. So long as anger continues, it seems, loss is not being accepted as permanent and hope is still lingering on. (Bowlby, 1998, p. 91)

- Despair and disorganization—As the loss sinks in, there is an attempt to recognize the loss and develop a "new normal." It is a time of lost objects (keys, etc.) as well as lost thoughts and lost time.
- Acquisition of new roles/reorganization—When the bereaved relinquishes attempts at preparing for the deceased's return (gets rid of clothes, etc.) and moves into new aspects of life and relationships with others, the bereaved is understood to move through reorganization.

Bowlby's (1998) stages are reminiscent of what he recognized in children: they yearn and pine for their parent when separated. He theorized that the attachment style that the child exhibited (secure, anxious, avoidant [Ainsworth,

Blehar, Waters, & Wall, 1978]) would influence the impact of loss and that children who were less secure in their attachments would be more likely to exhibit anxious or detached feelings when experiencing a loss. He and others have speculated that these influences carry on into adulthood, with adults' grief reactions to loss influenced by their attachment styles. Additionally, as the quote illustrates, he recognized that anger acts as a barrier to processing grief and that the bereaved only begin to move through their grief once anger subsides.

Since Bowlby's observations about the direct relationship of the level of attachment to the loved object and the degree of loss, many researchers have explored the ways that attachment styles inform the grief process (Field & Wogrin, 2011; Zech & Arnold, 2011). For example, anxiety is said to be higher, with subsequent intensity to grieving and yearning, when the attachment styles of the bereaved are less secure. Insecure attachment styles are correlated empirically with difficulties in grieving, but the ambiguous validity of measures of conceptual categories such as degrees of attachment and nonattachment, and bonded versus nonbonded relationships makes research at the intersection of attachment and bereavement challenging (Shaver & Tancready, 2001). Regardless of attachment style, clinical experience indicates that the level of fondness and connection positively correlate with the level of grief and mourning.

As important as the attachment style of the griever and the degree of connection in the lost relationship may be, it is also true that the bereaved experience uncertainty about the future. This is understandable as many plans are abruptly changed through loss and separation. Uncertainty may provoke anxious behavior and a heightened sense of vulnerability. Sometimes this anxiety provokes attempts to defend against attachments and that may subsequently leave the individual isolated at the very time they are most in need of support.

Maciejewski, Zhang, Block, and Prigerson (2007) explored the stage theories of Kübler-Ross (1969) and Bowlby (1998) and found more support for Bowlby's stages, though aspects of Kübler-Ross's stages were present. They studied 233 bereaved individuals over the course of two years and concluded that stages of disbelief, yearning, anger, and depression all had discrete peaks over time. They found that "acceptance" ran as a concurrent trend in a linear, positive fashion. Almost immediately, their findings were questioned. Roy-Byrne and Shear (2007) asserted that the authors had "overstated their findings" and that they "drew oversimplified conclusions that reinforce formulaic, unhelpful ways of thinking about bereavement" (http://psychiatry.jwatch.org/cgi/content/full/2007/326/1?q=etoc). Concerns about stage theories remain: the idea that they are applicable to all and that they seem like recipes for grief are the more problematic of these concerns.

A recent classic comes from the work of Therese Rando (1993). Although framed as processes rather than stages, Rando argues that individuals move through similar phases (whether stages or processes) that are fairly universal. She identifies these as the Six "R" processes—a blend of stage (phase in her language) and task-centered models that she asserts lead to the outcome of a healthy grieving process. Her model (Rando, 1993, p. 45) is below and consists of phases and tasks for the mourner to accomplish in each phase. It is

prescriptive in that it describes a process the bereaved must experience if they are to proceed toward healing. Note that the titles of the phases and subphases are Rando's (1993), followed by our description of their meaning.

AVOIDANCE PHASE

1. Recognize the loss—The bereaved must acknowledge and understand the reality of the death.

CONFRONTATION PHASE

2. React to the separation—The bereaved must experience the pain of the loss, give it expression and mourn secondary losses.
3. Recollect and re-experience the deceased and the relationship—The bereaved is to review and remember the relationship realistically and also review and re-experience the emotions that arise as they remember the relationship.
4. Relinquish the old attachments to the deceased and the old assumptive world—The bereaved is to let go of previous bonds and beliefs and develop a "new normal" with new relationships and attachments.

ACCOMMODATION PHASE

5. Readjust to move adaptively into the new world without forgetting the old—The bereaved is to revise his or her assumptive world; develop a new relationship with deceased; adopt new ways of being in the world and form an identity not predicated on the presence of the deceased.
6. Reinvest—This is a time to invest in new relationships and roles and indicates a resolution to active grieving.

Although Rando (1993) provides a model with more room for individualized tailoring of the treatment process, the model assumes that complicated grief is common and requires treatment when grief is deemed to be too extended, too brief (or absent), or when it does not follow the trajectory outlined in these various stage and process models. Despite Rando's obvious compassion and concern for bereaved people, her model is subject to some of the same criticisms noted above. These models are of the "modern" era: all progress is forward and the map is the same for all. The model is normal and deviation is considered abnormal. Yet pathologizing variation in a highly variable process like grief seems rather obtuse from the "postmodern" perspective that is skeptical of essences and "natural uniformities" in the social world.

THE GRIEF WORK HYPOTHESIS Task and stage-based theories imply a specific way to work on or "evolve in" one's grief. The primary activity is emotional processing and the good griever actively works on his or her loss. This is known as the Grief work hypothesis—and it was discredited in the early 1990s (Stroebe & Stroebe, 1991) although still cited in the late first decade of the 21st century (Costa et al., 2007). The grief work hypothesis assumes that emotional ventilation (crying, mourning, anger) needed to be expressed before one could begin to heal from a significant loss. The implication was that if this

type of ventilation did not occur and the person was seemingly healthy, the attachment to the lost one must not have been strong. Multiple studies have found this to be inaccurate (Bonanno, 2009; Carr, Nesse, & Wortman, 2006; Konigsberg, 2011; Wortman & Silver, 1989, 2001). Indeed, a significant group of bereaved people actually become worse if emotional ventilation is pushed upon them; this subgroup can do quite well without any professional intervention. We must thus attend to the particular experience of each griever and recognize that many will heal without professional help.

The Transition to Postmodern Grief Theory

Some theorists in the Foucauldian tradition critique grief theorists and counselors for "disciplining grief" (Foote & Frank, 1999). Grief counseling is viewed as a way of pathologizing grief in ways that allow therapeutic intervention to produce conformity to societal norms. This is "diffuse power" not overt coercion. It is a form of self-care and self-improvement (something Foucault calls "technologies of the self" [Martin, Gutman, & Hutton, 1988]) that functions to contain grief within a therapeutic context.

They comment:

> Grief, like death itself, is undisciplined, risky, wild. That society seeks to discipline grief, as part of its policing of the border between life and death, is predictable, and it is equally predictable that modern society would medicalize grief as the means of policing. (Foote & Frank, 1999, p. 170)

They also critique focusing on only the psychological aspects of grief, asserting that this deflects attention from the social and physical consequences of grief and mourning.

Walter (2000) too has recognized how policing grief can be destructive. He traces the evolution of policing grief from the Victorian era's enforcement of contained, formalized and time limited grieving to a current expectation of expressive grief with a tendency toward medicalization of the grief process. He asserts that mutual help support groups have evolved as a form of resistance to policing and medicalization, while themselves evolving norms that contain an expectation of grieving like other group members.

Postmodern theories of grief grow from a social constructionist understanding of the world (Berger & Luckmann, 1967) which asserts that humans construct their understanding of the world in ways that they then see as self-evident and true. This "true-ness" is deeply felt, yet differs from how others will construct their own truths. For example, in some traditions (Jewish and Amish) the dead are buried with little fanfare and usually within a day, whereas in others (Irish) the dead are "waked" with viewings and parties before burial takes place. Members of each group believe their traditions to be "natural" and others to be odd. Postmodern understandings hold that there are many truths, each created within historically specific social milieu. This approach is embraced by grief theorists and therapists (Neimeyer, Klass, & Dennis, 2014) who assert that "grieving [i]s a situated interpretive and communicative

activity" (p. 496) during which grievers work to make meaning of their loved one's life, to find their current place in a changed social context, and to perform (or resist performing) grief in ways consistent with the relevant cultural context.

The narrative tradition of therapy (White & Epston, 1990) grew from social constructionist and postmodern understandings and is predicated on each individual developing his or her own story with the help of the therapist. A narrative project, making meaning of the deceased's life, death, and relationships is viewed as critical to processing grief (Neimeyer, 2001). Along with the evolution of this meaning-making approach to grief work, grief theorists and practitioners began to question classic models and templates for grief. Social constructionism and postmodernism more generally imply that no individual's grief must follow a certain pre-set path; further, decathexis, resolution and/or acceptance should not be envisioned as desired outcomes for all grievers. This allowed Klass, Silverman, and Nickman (1996) to theorize what many mourners had been saying all along: the end of active grieving does not have to entail a detachment from the deceased. Most often, it entails continuing bonds, which change in quality. Foote and Frank (1999) assert that postmodern meaning-making approaches provide a basis for resistance to disciplining grief—at least until those strategies too are institutionalized and become a form of policing grief.

Another construct often used in the context of grief, and which must be challenged for many reasons, is the notion of "closure." In connection with the stage of "acceptance" that Kübler-Ross proposed, many have come to believe that closure is necessary for grievers to heal. Even if one sets aside the idea that acceptance is the desired outcome of grief, the construct of closure is knotty when explored through a sociological lens (Berns, 2011). "Closure" arose in the popular narrative during the 1990s and developed multiple meanings, all of which reflected the hope of grievers to be relieved of pain and suffering after a loss. Perhaps most insidious (if predictable), closure came to justify myriad commercial endeavors from "burials" in space to "diamonds" made of cremains (Berns, 2011). Berns notes that the word "closure" is used to mean closing a chapter, remembering, forgetting, getting even, knowing, confessing, and forgiving; such broad usage allows many services and products to be sold—and laws to be made—in pursuit of closure. Yet as a concept, closure is as slippery and suspect as most other "natural" outcomes of grief. Just as Klass (2013) recently cautioned not to assume all grief leads to growth (2013), we emphasize that not all loss experiences (nor even most) will or should lead to closure.

The following postmodern, conceptual approaches to grief work allow grievers and supporters to tailor their interventions, avoid thrusting uniform models on grievers, and support therapeutic or informal healing strategies without insisting on closure or acceptance.

Dual Process Model

A deceptively simple grief theory came from the work of Stroebe and Schut (1999): their theory met the criteria for a postmodern grief theory that is not

prescriptive and can be tailored to individual grievers. Their theory drew from Bowlby's ideas (1998) about disorganization and reorganization. Although Bowlby conceptualized these as discrete stages, Stroebe and Schut (1999, 2010) envisioned ongoing oscillation between loss orientation (LO) and restoration orientation (RO). This differs from Bowlby's stages of disorganization and reorganization in that the bereaved person has times of mainly experiencing the grief actively and focusing on the loss (LO), and others of (mainly) moving toward building a new life. These usually alloyed orientations both have value. One allows for distraction and restoration time that frees the mourner to move into new roles and activities while the other allows processing time for the loss. Both are necessary.

Notably, rumination (a typical aspect of early LO) is often portrayed as the *sine qua non* of grief work (Bonanno, 2009), yet Stroebe et al. (2007) developed the DPM theory to show how excessive rumination is actually a mode of avoidance, not accomplishing the work of LO or RO (although they frame this differently within their explication of rumination and its problematic nature in grief over time [Stroebe et al., 2007]). They identify excessive rumination, particularly focused on one's own emotions and a refusal to believe one can recover, as antithetical to healing and a form of avoidance that is not part of the fruitful work that occurs in LO or RO.

Stroebe and Schut (2010) built on their original model to show how it can be used as both an assessment tool (How much of the bereaved's time is spent in each orientation? How does the proportion gradually change toward more RO?) and also as an intervention (therapeutic guidance can help grievers move into whichever orientation the griever might be avoiding). Different developmental stages may also affect this process as it seems that children spend more time in RO (particularly utilizing distraction) and seem to oscillate naturally between orientations more quickly. Research is necessary to explore whether these impressions are generalizable and useful.

In a volume of *OMEGA* devoted to empirical examination of the DPM, Carr (2010) synthesized the studies and observed that some did not find the expected response to DPM interventions (e.g., those involved in DPM groups fared no better than those involved in typical loss oriented support groups). She speculates that grief groups may meet the more universal needs of LO, but that RO requires new skills that are more individual. She also raises Shear's (2010) hypothesis that a certain amount of avoidance of active grief is adaptive; however, predicting optimal times for avoidance is elusive. Carr (2010) concludes that the optimal balance between RO and LO remains relatively unresolved.

Revision of the assumptive world also is implicit within the DPM. As discussed above, the assumptive world is the set of fundamental beliefs carried as schema, often without awareness until they are violated. The death of a loved one jolts the belief that the world is a fair and just place, violates the belief that one will not have to live without the loved one, and challenges the griever to revise and relearn assumptions about the way the world works. This activity occurs in RO as grievers work to understand what their assumptions were and to restore a sense of safety, predictability, and continuity by adopting new assumptions and defenses against fears evoked by the loss itself and the associated loss of the assumptive world. These new assumptions indicate that

one has found some meaning in the call to move forward into life. Attig has clarified how "relearning the world" differs from revision of the assumptive world (Janhoff-Bulman, 1992) in that the assumptions revised are all cognitive, whereas relearning the world requires relearning a sense of safety and belonging along with a new way of negotiating life (Attig, 2015).

Meaning-Making and Grief

Although Viktor Frankl is most associated with *Man's Search for Meaning* (1984) and White and Epston (1990) with meaning-making and story-telling via narrative therapies, Robert Neimeyer has most notably applied these concepts to grief theory and intervention. He traces this back to

> Kant (1787/1965) who emphasized that the mind actively structures experience according to its own principles and procedures. One contemporary extension of the argument is that narrative—the distinctly human penchant for storytelling—represents one such ordering scheme (Bruner, 1986) . . . Significant loss—whether of cherished persons, places, projects, or possessions—presents a challenge to one's sense of narrative coherence as well as to the sense of identity for which they were an important source of validation. . . . Bereaved people often seek safe contexts in which they can tell (and retell) their stories of loss, hoping that therapists can bear to hear what others cannot, validating their pain as real without resorting to simple reassurance. Ultimately, they search for ways of assimilating the multiple meanings of loss into the overarching story of their lives, an effort that professionals can support through careful listening, guided reflection, and a variety of narrative means for fostering fresh perspectives on their losses for themselves and others. (Neimeyer, 1998, 2001)

This is quoted at length because Neimeyer's (2001) explanation fits with our view that understanding grief and working with people in grief therapy is a mutual project. Grief therapy is a respectful process of hearing and witnessing the stories people tell of their lives and their losses, questioning them in ways that allow them to open themselves to other perspectives while also leaving room for them to reject those possibilities. At its best, grief work encourages mourners as they construct and reconstruct stories of meaning that enable them to move into their new lives and their new assumptive worlds in the physical absence of the lost entity.

It is important that clinicians working with grieving people recognize that their stories will take multiple forms and the task of the therapist is *not* to force adherence to a "true" or "real" one. Instead, we are to help the client create their own coherent story while illuminating blind spots. New understandings can enable a story that fits the client's evolving worldview in evermore useful and function-promoting ways that create meaning in the griever's life. This is a relational project involving a willingness on the part of the therapist to engage with the client in an authentic and caring manner, exhibiting genuine curiosity about the way the client is telling the story. Successful grief therapists convey realistic hope that this process will help the client return to full engagement with life and loves.

Early in the development of grief theories of meaning-making, Davis, Wortman, Lehman, and Silver (2000) questioned whether it could be assumed that most bereaved individuals find meaning in loss. In their sample, only about half reported finding meaning in the loss. They suggested that grief workers might intervene more effectively by helping the bereaved to understand (a) the risks of staying stuck in their grief, (b) how to use the therapist as a "container" during the early phases of intense grief, (c) the benefits of using rituals and traditions that have meaning and comfort for them, (d) any ruminations/obsessions and how to move them into a flowing narrative rather than a recurrent thought, and (e) how to set attainable goals that allow grievers to make choices and sense accomplishment. Neimeyer, Baldwin, and Gillies (2006) have continued to build on these and other suggestions for interventions to assist meaning-making while incorporating continuing bonds and other postmodern concepts. Even more promising, these ideas are expanding into related fields like genetic counseling (Douglas, 2014) in ways that may allow more people struggling with loss to receive the support they need (in this case, the diagnosis of a child with a genetic disorder).

Continuing Bonds and Grief

A pivotal understanding in contemporary grief theory came when Klass et al. (1996) each examined data from their disparate research populations and realized that "Rather than letting go, they [the bereaved] seemed to be continuing the relationship" (1996, xviii). They challenged the notion that disengaging from the deceased or lost one is the goal and illuminated the concept that "the bereaved remain involved and connected to the deceased, and . . . actively construct an inner representation of the deceased that is part of the normal grieving process" (p. 16). In the Introduction to their important book they noted:

> When we discuss the nature of the resolution of grief, we are at the core of the most basic questions about what it is to be human, for the meaning of the resolution of grief is tied to the meaning of our bonds with significant people in our lives, the meaning of our membership in family and community, and the meaning we ascribe to our individual lives in the face of absolute proof of our own mortality. The book challenges the idea that the purpose of grief is to sever the bonds with the deceased in order for the survivor to be free to make new attachments and to construct a new identity. . . . [T]he constant message of these contributions is that the resolution of grief involves continuing bonds that survivors maintain with the deceased and that these continuing bonds can be a healthy part of the survivor's on-going life. (Klass et al., 1996, p. 22)

Again, this is quoted at length because it clearly defines a major shift in how grief theorists and therapists approach the nature and goals of grief. Aside from the implication that as with meaning-making, each individual will have a highly personal outcome to their grief, this also carries a caution. Just as bereaved people were "policed" into nonexpression of their grief (or more recently into full expression even when this did not fit their needs), we must remain cognizant that while some grievers may find comfort in continuing bonds, others will find them unnecessary.

Recent work on grief after traumatic loss differentiated types of continuing bonds. Field and Filanosky (2010) indicated that externalized continuing bonds (hallucinating the deceased loved one; hearing voices of the deceased) are associated with poorer adjustment over time. Internalized continuing bonds (having an internal sense of the deceased still comforting and caring) seemed protective (from complications of grief) and comforting.

Cultural understandings are important here. Mexican "Day of the Dead" celebrations and Buddhist worship at shrines of deceased loved ones are only two of many rituals that foster continued bonds. Japanese ancestor worship (Shinto and Buddhist) also maintains continuing bonds with the deceased (Valentine, 2010). Individualized assessment of the client, discussion of cultural aspects of the grief process and customs, the intuitive and respectful stance of the therapist, and the awareness of the wide range of ways people move through and process their grief are imperative for sensitive, competent grief work.

Disenfranchised Grief

Doka (1989, 2002) coined the term disenfranchised grief to conceptualize grief that is not recognized, validated, or supported in the mourner's social world. Essentially, the concept means that the grief does not meet the norms of grief in the griever's culture. Hochschild (1979, 1983) has referred to norms that guide "appropriate" emotions in a given situation as "feeling rules." Disenfranchised grief comes as a result of breaking the feeling rules, or of living in a time when feeling rules are not established or are discrepant (McCoyd, 2009a). The lack of norms leaves the griever uncertain about being "allowed" to feel sad about a loss not recognized by social peers. Further, it may leave grievers wondering if they are even "allowed" to call their experience a loss. Doka (2002) defines five categories of disenfranchised grief: (a) grief where the relationship is not recognized, such as gay and lesbian relationships, extra marital relationships and other relationships that lack social sanction; (b) grief where the loss is not acknowledged by societal norms as a "legitimate" loss, as when abortion, relinquishing a child for adoption, pet loss, and other losses are not viewed as worthy of sympathy; (c) grief where the griever is excluded as is often the case for individuals who are children, who are aged, or who are developmentally disabled and are (inaccurately) not believed to experience grief; (d) grief where the circumstances of death cause stigma or embarrassment, such as when a person dies of AIDS, alcoholism, crime, or in other ways that are viewed as the result of moral failures; and (e) grief expressed in nonsocially sanctioned ways, as when a griever is deemed to be either too expressive, or not expressive enough, reminiscent of the policing of grief discussed above.

The nature of disenfranchised grief means that grieving individuals do not receive the social support and degree of sympathy from others that they desire to enable processing grief and moving on in healthy ways. The very core of grief (for most) is to actively process the pain. Yet, many have that pain exacerbated by social isolation or rejection with little support (if any). Many of the losses discussed in the following chapters fall into some of these

categories, particularly losses that are not recognized as worthy of support by others. In these cases, the mere validation of the event as a loss and normalizing the grief response can allow the griever to move through the loss response without the complications that may occur otherwise.

Recently, Robson and Walter (2012) challenged the notion of disenfranchised loss as not reflecting the hierarchical nature of loss found in most situations (particularly as it relates to who is considered entitled to support and sympathy). They noted that the language of disenfranchisement implies a binary nature: One has freedom and legitimacy as a voting citizen or one does not. They developed a tool for measuring the levels of grief allowed those in different relationships to the deceased (e.g., the mother, the husband) and found substantial agreement that this is a hierarchical set of relationships. They observed: "Our contention therefore is that disenfranchisement is not a norm, but a feeling experienced by mourners whose personal grief exceeds their position in the hierarchy either as generally perceived or as perceived by one or more significant condolers" (Robson & Walter, 2012, p. 109). They noted that clinicians tend to work with grievers whose grief outstrips the sympathy allotted to them. The clinicians may assume their work is to enfranchise all grief, an assumption Robson and Walter question. They note that the language needed to research these areas involves norms, legitimacy, and validation—language that most grief work practitioners have likely used anyway. We will often talk about validating the grief of those whose loss is viewed as "disenfranchised." Validating grievers' sense of loss is likely to continue to evolve as more nuanced expressions of grief, relationship to the lost entity/person, and types of loss remain the focus of research within varied social contexts. To emphasize the point yet again: Grief is social.

Ambiguous and Nonfinite (or Chronic) Grief

Ambiguous loss (Boss, 1999), also called "frozen grief," is difficult to process because of the uncertain definition of who or what is lost. In ambiguous loss, the lost entity is

- Physically present but psychologically absent—for instance, a loved one with Alzheimer's or head trauma/brain injury or
- Physically absent but psychologically present—such as when someone is kidnapped or missing in action during a war.

It is unclear how to adjust to such losses. Without a death (the first case), it seems premature and even cruel to grieve as if there has been one; in the second case, grieving would remove the hope of return. Boss points to the following difficulties with ambiguous loss:

- Adjustment to the loss cannot occur as it is uncertain what one is supposed to adjust to.
- Rituals are not available and there are few social supports.
- The irrationality of life is on display. It is hard to feel that there is a rational world when nothing seems clear or rational; it is seemingly unending. The

uncertainty drags out and there is little ability for resolution and no end in sight.

These losses also confuse support people, who are perplexed about whether to express sympathy or maintain a stolid sense of normalcy and hope. Because the loss has not fully happened (yet), people lack social support, yet they struggle with the fact that their loved one is slipping away bit by bit. Boss reports a case where the mother of a veteran of the Iraq war with significant head trauma struggles with the fact that her son is alive, yet certainly not the same son she raised and loved (Boss, Roos, & Harris, 2011). Learning to live with a life that has become incomprehensible (unpredictable and utterly different from what one planned) is a key to managing ambiguous loss: as the loss is relational, the treatment must be relational (Boss et al., 2011, p. 165).

This may be why peer support groups seem so efficacious with grievers such as these. Group members share a similar experience of confusing loss over a protracted period. Although similar loss does not guarantee similar response, the group can discuss obstacles to social recognition and strategies for coping with the lack of support.

A similar type of grief, chronic sorrow (sometimes referred to as nonfinite grief), reflects the living nature of the loss (as in ambiguous grief). This type of grief is characteristic of parents whose children are born with (or contract) disorders that affect their development and ability to participate in typical society. This grief tends to be "permanent, periodic, and progressive in nature" (Boss et al., 2011, p. 165) and reflects the losses parents experience when they see other children accomplishing goals their children have not or cannot. Riesz (2004) describes her experience of mothering a 30-year-old daughter with developmental delays and details the experience of nonfinite loss. Boss et al. (2011) suggest a form of intervention that may provide guidance for many forms of ambiguous and nonfinite grief.

ISSUES OF INTERVENTION

Grief theorists tend to identify phases (and associated tasks) through which the mourner must move in order to heal. Newer theories avoid the prescriptive nature of many of the earlier ones, yet the onus remains on the bereaved to move through some process. Interestingly students and others who want to assist those who are grieving, often ask "What can I do?" not "What should the bereaved do?" Asking what we can do is actually the much more important question.

Therapist Activity in Intervening With Grief

Lloyd (2002) provides a general intervention strategy for customary grief after death loss. The practitioner is to (a) explore attitudes toward death and dying from psychological, sociological, and philosophical/religious perspectives; (b) explore and analyze the bereaved's constructions of life; and (c) explore the processes of adjustment to the world without the lost entity. Within each area for exploration, attention is to be paid to how the bereaved is redefining roles,

rebuilding identities, negotiating transitions, surviving trauma, and maintaining morale.

Boss, Roos, and Harris (2011) suggest intervention to assist those with ambiguous and nonfinite loss. The clinician is to: (a) name and validate the loss; (b) help the client find meaning in their new role; (c) address trauma when it is present; (d) temper mastery—by which they mean tempering the mourner's expectations to have control of, or overcome the situation; (e) help the griever reconstruct identity; (d) normalize ambivalence—recognizing that having both love and hate for the person who is changed from their previous persona is normal; (e) revise attachment; (f) discover new hope; and (g) identify resources for support.

Walter (2003), in her research with people adapting after the loss of a life partner, also emphasized the issue of validation. She recognized that gay and lesbian couples often had little recognition and validation of the loss of their life partner. Mourning a disenfranchised loss, and often denied access to the usual rituals of support after death, such an individual benefits from having someone with whom to reflect on how his or her identity is changing and has changed. Further, Walter notes the "two incompatible urges" (p. 245) of wanting to cling to the pain of the loss, but also to move on to the new life ahead. Seldom do people have social contacts ready and able to provide the nondirective approach necessary to accompany bereaved individuals as they review these opposing urges and reflect upon prior experiences. Grief counselors are called upon to patiently be with and witness the pain and possible growth that comes from loss.

Mindfulness as an Intervention for Grief

Mindfulness has become widely known and accepted as a practice for becoming more attuned to one's own internal sensations, emotions, and responses, as well as to tune in with others. Starting as mindfulness meditation, popularized in Jon Kabat-Zinn's (1982, 1990) work, mindfulness has many new iterations that apply to practitioner's own practices as well as to the work we do with grievers. Cacciatore and Flint (2012) synthesized much of this movement in their ATTEND model of bereavement care, making the point that it is for use by the practitioner/therapist; it is for use within the therapeutic relationship; and it is for the client's use. The pillars of the ATTEND model are: attunement, trust, therapeutic touch, egalitarianism, nuance, and death education. Attunement comes first and is likely the integrating principle of mindfulness. Attunement requires attending to oneself and others' well-being and being. It entails empathy, responsiveness, intentional attentiveness, and allowing each person to observe and accept pain and suffering as well as positive emotions. Dan Siegel puts this at the heart of being a mindful therapist (2010b) and notes that "presence" is a sense of being open to the other (the client) while attunement requires presence but also includes "focused attention and clear perception" (Siegel, 2010b, p. 35).

Cacciatore and Flint (2012) define trust as compassionate communication that allows the client to know there is safety and care within the relationship. The second T in ATTEND is therapeutic touch, which they acknowledge is controversial. Nevertheless, therapeutic touch conveys caring with a gentle

touch on the hand or shoulder, or a willingness to sit side by side as a griever cries. Egalitarianism focuses on the idea that the mindful relationship is humble and takes place between equals in a collaborative and safe relationship. "Nuance" reflects all the unique aspects of the client and the practitioner as they come together to work on the client's challenges; they note that nuance rejects assumptions and one-size-fits-all answers and means that all work together is tailor-made within the mindful relationship. Death education encompasses both psychoeducation to assist the dying and the grieving to know what to expect of the dying or grieving process. It demands that the practitioner remain up-to-date on new aspects of death education and counseling.

Similarly, the acronym SIFT (Epstein, Siegel, & Silberman, 2008) helps practitioners be mindful within the therapeutic relationship. SIFT refers to how the practitioner must review sensations, images, feelings, and thoughts. By doing so, the practitioner gets in tune with concerns about how the client is feeling, what responses the practitioner is having that may create barriers to staying attuned, and allows the practitioner to stay fully engaged with the person with whom they are working. In psychodynamic education, we refer to this as attending to our countertransference so as to avoid "bringing our own stuff" into the relationship in harmful ways. Siegel also uses the acronym COAL to reflect the importance of curiosity, openness, acceptance, and love, which infuse the mindful therapeutic relationship. Regardless of which acronym frames the work one does with grievers, mindfulness requires intense connection and attunement with one's client and with oneself in the service of the client. Such intense work can only be done well when the practitioner attends to his or her own self-care. Whether practicing mindfulness exercises on one's own, engaging in contemplative practices, or finding routines that help one stay healthy, it is imperative that practitioners be aware of their own well-being and responses. Throughout this text, we will describe varied mindfulness and other practices for use with clients. Here, we urge our readers to become familiar with mindfulness practices and to utilize them day to day. Kabat-Zinn's *Full Catastrophe Living* (1990) is a great place to start and many of Siegel's works involve mindfulness practices as well (2010a; 2010b).

A FINAL WORD ABOUT GRIEF WORK

In 1991, Stroebe & Stroebe asked the question "Does 'Grief Work' Work?" Their answer was "maybe." Findings that widowers who avoided emotional expression had worse outcomes than those who did not suggested tepid support for grief work; however, widows did not exhibit this same association. This led the authors to suggest that "the view 'everyone needs to do grief work' is an oversimplification" (p. 481). Indeed, Bonanno, Wortman and Nesse (2004) found that the majority of widows and widowers did well after spousal death (see "Older Adults" chapter for more detail). In short, most feel pain, but are able to cope, even after major losses.

Here, we raised the concern that classic theories may create a tendency toward policing grief. We also raised questions about the efficacy of grief work. Nevertheless, reflective practitioners must avoid the paralysis that can

result from giving so much weight to these concerns that we neglect to provide support for those who ask for our assistance. Remaining open, mindful, and reflective about new understandings in grief theory, while also using empirical data derived from one's interaction with clients will guide us toward meaningful work with grievers. Whether the grievers perceive the work to be useful (or not) will allow us to modify our work to fit that particular griever's developmental and mourning needs. These are requirements of ethical and sensitive practice in the world of grief support.

DISCUSSION QUESTIONS

1. What rituals do you typically engage in after a death in your family and how do you believe this helps or hurts the mourners?
2. Consider disenfranchised losses you have experienced in your lifetime. If each one was actively mourned, how might that change the way you feel about those losses?
3. How would you approach a client who comes in to a first session and says "My spouse just died and I know I'm in anger right now but I want to get to acceptance."
4. In light of the tepid support for grief work for all losses, how do you think most death losses of close people should optimally be managed?