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THIRD EDITION

Principles and Practice *of* GRIEF COUNSELING

Darcy L. Harris, PhD, FT | Howard R. Winokuer, PhD, LPC, NCC, FT

This core introductory text, with a focus on clinical application, combines the knowledge and skills of counseling psychology with current theory and research in grief and bereavement. The third edition is updated to address issues related to the developmental aspects of grief, including grief in children and young people, grief as a lifespan concept, and grief in an increasingly aging demographic. It describes new therapeutic approaches and examines the neurological basis of grief as well as trauma from disruption and loss. Also emphasized is the role of diversity, along with cultural considerations in grief counseling. Instructor's resources include a Test Bank, Instructor's Manual, and PowerPoint slides.

User-friendly, while grounded in the latest research and theoretical constructs, the text offers such pedagogical aids as learning objectives, practice examples, glossary terms, and questions for reflection in each chapter. Above all, the book addresses grief counseling and support in a way that is informed and practical. The content explores concepts relevant to complicated grief, while differentiating the normal human experience of grief from mental disorders. Purchase includes digital access for use on mobile devices and computers.

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- New theory, research, and practice for grief in non-death losses
- New information on diversity and grief, the role of grounding and contemplative practices, and grief and developmental perspectives across the lifespan
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- New case studies with additional case scenarios for real-world application
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KEY FEATURES:

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- Combines the knowledge and skills of counseling psychology with current theory and research in grief and bereavement
- Written in easy-to-understand language, with emphasis on practical application
- Includes learning objectives, practice examples, glossary terms, and questions for reflection
- Supplemental Instructor's Manual, Test Bank, and PowerPoints included

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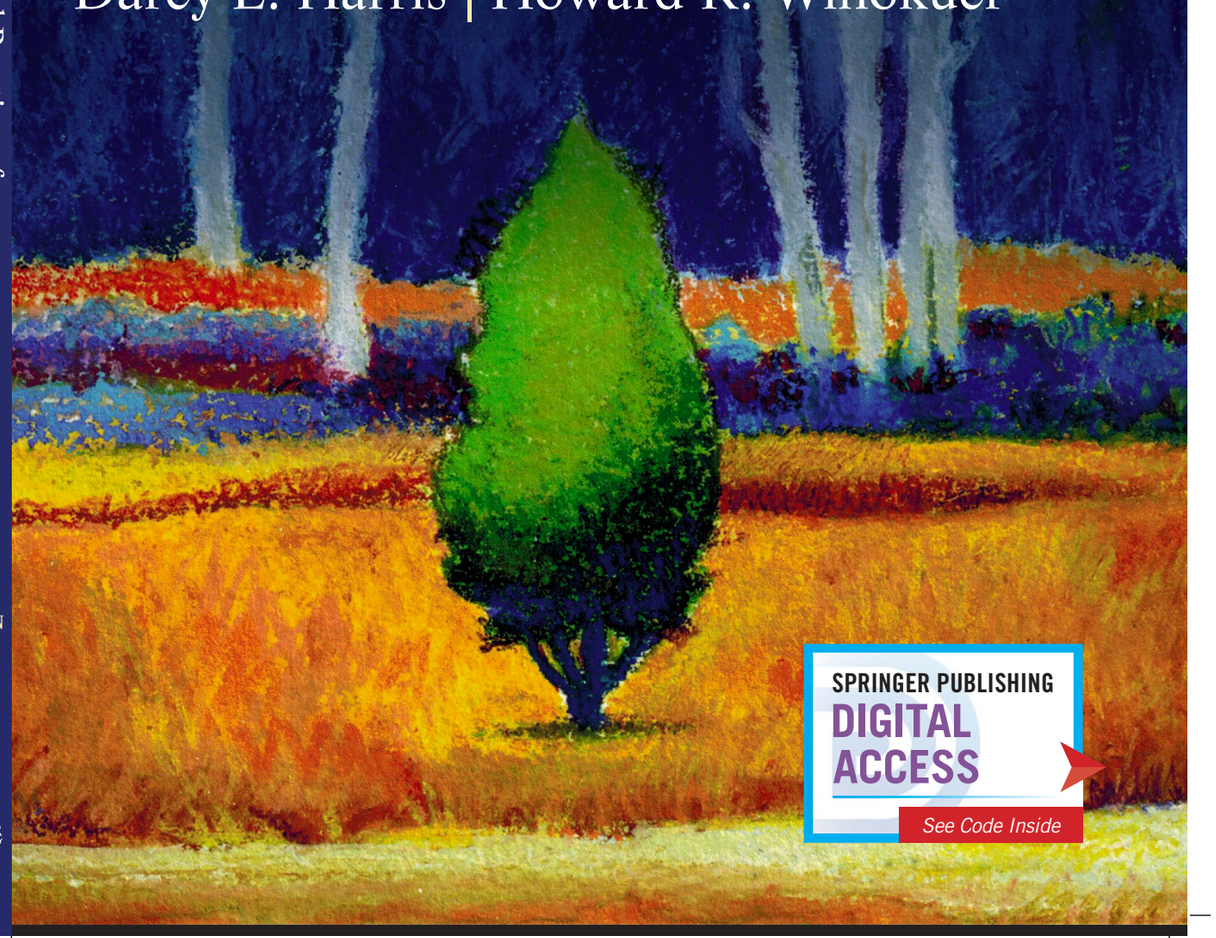

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Darcy L. Harris, PhD, FT, is an associate professor in the Department of Interdisciplinary Programs at King's University College at Western University in London, Ontario, Canada, where she is the coordinator of the Thanatology Program. She also maintains a private clinical practice with a focus on issues related to change, loss, and transition.

Dr. Harris planned and developed the undergraduate degree program in thanatology at King's University College, which provides students from around the world with the opportunity to study about death, dying, grief, and bereavement. She has implemented coursework in thanatology in the specific interest areas of critical theory, social justice, and the exploration of grief after nondeath losses. She is also adjunct faculty in the College of Graduate Studies at Western University. She has served on the board of directors for the Association for Death Education and Counseling (ADEC), and she is the recipient of the Death Educator award from this organization. She is also a member of the International Work Group on Death, Dying, and Bereavement (IWGDDB).

Dr. Harris has written extensively and is an internationally recognized speaker, providing presentations and workshops on topics related to death, grief, and loss in contemporary society. Topical areas include the social context of grief in Western society, compassion and mindful awareness in the context of loss and grief, and non-death loss and grief. Her books include *Handbook of Social Justice in Loss and Grief, Counting Our Losses: Reflecting on Change, Loss, and Transition in Everyday Life,* and *Non-Death Loss and Grief: Context and Clinical Implications,* and she is the co-editor of *Grief and Bereavement in Contemporary Society: Bridging Research and Practice*. She has also authored numerous book chapters and articles in related areas.

Howard R. Winokuer, PhD, LPC, NCC, FT, is the founder of the Winokuer Center for Counseling and Healing in Charlotte, North Carolina, where he maintains a full-time clinical practice. He completed his PhD in 1999 at Mississippi State University, where he developed the first course in grief counseling skills. As the founder of TO LIFE, a not-for-profit educational and counseling organization, he was the associate producer of seven PBS specials and helped pilot one of the first teen suicide prevention programs in the southeastern United States. He has taught numerous courses and has been a guest lecturer at many colleges and universities, including New York University, Rochester University, the University of North Alabama, Queen's University, Appalachian State University, and the University of North Carolina.

Dr. Winokuer has conducted workshops and seminars throughout the United States as well as nine foreign countries, including programs for St. Christopher's Hospice and St. George's Medical Center, London, UK; The National Assistance Board, Barbados; and the United States Embassy at The Hague, Netherlands. He wrote a bimonthly column in *The Concord Tribune*, "Understanding Grief," and hosted a regular radio show on WEGO, *Life Talk*. He was a consultant to WBTV, the local CBS affiliate in Charlotte, North Carolina, after the tragedy of September 11 and has been the mental health "professional on call" for Fox TV's news show *The Edge*. He has recently appeared on the radio show *Healing the Grieving Heart* and has been interviewed by the *American Counseling Association Journal* and *Counseling Today*, as well as in *the Staten Island Advance, The Houston Chronicle, The Charlotte Observer, The Detroit Free Press,* and *The Chicago Tribune*. He also led an international delegation of funeral directors to Russia and Holland to study death and funeral practices in those countries.

Dr. Winokuer has been actively involved in the field of dying, death, and bereavement since 1979. He has presented workshops and seminars to many organizations, including the National Funeral Directors Association, the University of North Carolina's Department of Neurological Surgery, the Tennessee Health Care Association, and the Presbyterian Hospital. He also developed the crisis management plan for the Cabarrus County School System. He has been an active member of the Association for Death Education and Counseling (ADEC) for almost three decades and is a past president of the organization. In his almost 30 years of membership, he has chaired the national public relations committee, co-chaired the 2000 and 2003 national conferences, served on the board of directors, co-chaired the 2011 international conference that ADEC co-hosted with the International Conference on Grief and Bereavement in Contemporary Society, served as president, and was one of the co-editors for *Grief and Bereavement in Contemporary Society: Bridging Research and Practice.*

PRINCIPLES AND PRACTICE OF GRIEF COUNSELING

Third Edition

Darcy L. Harris, PhD, FT

Howard R. Winokuer, PhD, LPC, NCC, FT

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For Brad and Lauren, and to my clients, students, and colleagues who are all my teachers and inspiration.
— Darcy L. Harris

I would like to dedicate this book to all my students, colleagues, clients, and friends who have influenced my life both personally and professionally. I would also like to dedicate this book to Dr. Darcy Harris, my co-author, whom it has been a joy, privilege, and honor to work with.
—Howard R. Winokuer

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Part III: Current Issues and Trends

PREFACE

This book grew out of our need to have a text for the university-based courses that each of us teaches to students who are interested in furthering their knowledge and skills in grief counseling and support. We found that there are many good texts that explore research and theory in counseling psychology and many other books that expound on grief and bereavement theory and research. However, we have been unable to find a book that combined both the practical aspects of counseling with the current research and the theory related to grief and bereavement. After years of piecing together articles, course reading packets, and chapters selected from different texts, we decided to design a book that would explore both the practical knowledge and skills that are available in counseling psychology with some of the current research and theory in the area of loss, grief, and bereavement. Both of us have been practitioners in this area for over 30 years, and we have drawn on our own clinical work to "flesh out" things that we think would be most helpful to clinicians who wish to work effectively with bereaved individuals.

We are often asked by clinicians who specialize in other areas of counseling, "How can you do this kind of work all the time?" We also smile at our students' surprised faces when they see that we are not (always) dressed in black, morbid, and void of humor, as those who work around individuals who are dying or bereaved are often stereotyped. We try to convey to our students our passion for this area, and the rewards that we find in our practice with bereaved individuals. We realize that every day is precious. Our clients continually remind us that life is a gift, and that our time is limited—so we make the most of it. We firmly believe that working with individuals who are dying and bereaved makes us live our lives more consciously, fully, and with a greater appreciation. In our work with individuals who have experienced all types of losses, we have had the privilege of sharing very personal time with people who are hurting, vulnerable, and broken. However, we also have the opportunity to see how people

are able to draw on their strengths and innate resilience, often re-entering the world later with a stronger sense of themselves and of the gifts that life has to offer.

We view the practice of grief counseling as a unique specialized area of practice, which is another reason why we wanted to write this book. Although counseling in general is meant to address issues that occur in everyday life, and loss is certainly a universal experience, we wanted to be able to focus on grief as a painful but adaptive process, with some unique features that separate it from other types of issues that are addressed in general counseling and therapy practice. We further expand on this idea later, but we want to state at the beginning that we believe a key aspect of grief counseling is that it does not focus on what is wrong, but rather on what is right about the grieving process, and our emphasis is on how we can facilitate the healthy unfolding of the adaptive aspects of this process rather than on its containment.

One other unique feature of this book is the discussion of grief as a response to losses that are death related and non-death related, tangible and intangible in their description. An individual does not have to lose a loved one to death in order to grieve; grief can occur after placing a loved one with advanced dementia in a long-term care facility, with the ending of an intimate relationship, with the loss of hopes and dreams, and with the loss of self that may accompany life-altering events. Grief is viewed as an adaptive response to experiences that challenge our assumptions about how the world should work, and how we view ourselves and others within that world. Although we devote an entire chapter to this topic, this broader view of grief will be woven through all of the material that is presented in the various chapters.

Because we make no assumptions about the background of the reader, we start with the basics of counseling and the therapeutic relationship. In Chapter 1, Thoughts About Counseling, and Chapter 2, Unique Aspects of Grief Counseling, we explore the purposes that counseling may serve, and the unique aspects and challenges that may occur in counseling individuals who have experienced significant losses. We then move into some basic material about current theories of grief and bereavement and how these understandings apply to clinical practice in Chapter 3, Theories and Orientation to Bereavement. In Chapter 4, The Social Context of Loss, we detail the ways that we are socialized to think about and respond to loss and grief. We then focus on issues that are salient to setting up the therapeutic relationship with clients, and specific counseling practices that we believe are relevant to working with bereaved individuals. We devote an entire chapter (Chapter 5, The Practice of Presence) to the cultivation of presence within the context of the counseling relationship, using this material to form the foundation on which grief counseling should occur. In no other form of counseling is the value of presence more relevant or timely; counselors who focus on trying to problem-solve and "fix" things with their clients may find working with bereaved clients to be an exercise in frustration and futility. We think it crucial for grief counselors to understand and embrace the gift of presence as the primary therapeutic stance in working with grieving individuals. We then take the material from the previous chapters and discuss basic concepts of counseling practice in Chapter 6, The Basics of Counseling Practice.

In Chapter 7, Working With Bereaved Individuals, we begin to integrate counseling theory and practice directly with grief and bereavement theory. In this chapter, we explore some

of the "nitty-gritty" expectations of the counseling process with bereaved clients. We then expand on definitions and understandings of loss and grief in Chapter 8, Living Losses: Nonfinite Loss, Ambiguous Loss, and Chronic Sorrow, by exploring grief that may be present, but which may often be unrecognized or invalidated because it is not related to a death per se. We include a chapter (Chapter 9, Working With Emotions: Yours and Theirs) on working with strong emotions because many clinicians find working with clients who are experiencing such intensity to be intimidating or difficult, and their focus is often on containment of emotions rather than on the potential to use strong emotional content to deepen the client's therapeutic process. In this chapter, we discuss concepts such as emotional intelligence and specific ways that strong emotions can provide valuable grist for the mill in the client's process (and the counselor's self-awareness).

Chapter 10, When Grief Goes Awry, opens up the discussion of when grief goes "off track," and how to recognize when additional resources and referrals are indicated in complicated grief scenarios. Chapter 11, The Clinician's Toolbox: Therapeutic Modalities and Techniques in the Context of Grief, provides an overview of some of the therapeutic techniques and tools that we have found to be useful in working with bereaved individuals, adding to the clinician's "toolkit" some possible resources that may be helpful with specific types of clients and situations. In Chapter 12, Ethical Issues in Grief Counseling Practice, we explore ethical issues that may be particularly relevant to grief counseling, and we make recommendations for how grief counselors can ensure that they are practicing in ways that are competent and ethically sound. In Chapter 13, Caregiver Issues for Grief Counselors, we identify some of the common pitfalls that can affect grief counselors, and how the unique features of individuals who are drawn to this type of work can actually make the counselor more vulnerable to experiences such as burnout and secondary traumatization. In Chapter 14, we explore some of the current and upcoming issues that we see in our field, so that individuals who wish to specialize in the area of grief counseling can critically reflect and incorporate best practices into their clinical work. We include a section at the end of each chapter to allow the reader an opportunity to better absorb and reflect on the content with directed questions and exercises and a glossary of important terms. New to this edition are practice examples that are scattered throughout each chapter, which help to provide real-life application of some of the concepts that are discussed. In Chapter 15, we have provided sample case studies for the reader to analyze using the book materials.

We also wish to indicate our decision to make a grammatical change in our writing style in this edition; we have chosen to shift from the use of singular pronouns that are binary in nature (e.g., he, she, him, her) to the use of pronouns that are more inclusive (e.g., they, their, them). It is important to recognize that not everyone identifies with binary pronouns, and in the counseling profession, it is important to follow the lead of our clients and how they wish to be referenced.

We hope that you find this book both practical in its clinical content and stimulating in its theoretical underpinnings and philosophy. We find our work with grieving individuals challenging at times, but it is also highly rewarding, both professionally and personally. It is our desire that you learn some things that you might not have thought of earlier, and that you might feel better equipped to offer your healing presence to grieving individuals as a result

of reading the material in this book. We also hope that you find, as we do, that this work is an opportunity to appreciate the strength, innate resilience, and capacity of human beings. Finally, it is our wish that you find an affirmation of the gifts that are present in your ability to care about others as we encounter fellow travelers in our life's journey.

Darcy L. Harris, PhD, FT
Howard R. Winokuer, PhD, LPC, NCC, FT

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ACKNOWLEDGMENTS

For both of us, the decision to become counselors and then to write a book about counseling represents the culmination of many life experiences and relationships with people who encouraged, supported, and trusted each of us in many ways.

Dr. Harris would like to express her gratitude to the individuals in her life who supported her during her own times of upheaval and loss, and who encouraged her to use the strength she found at these times to embrace the concept of the wounded healer. She would also like to specifically express her thanks to the mentors and colleagues who have offered her inspiration and have served as models to her practice: Anne Cummings, Margaret Rossiter, Marg McGill, Derek Scott, and Robert Neimeyer.

Dr. Winokuer would like to express his thanks to his mentors, Robert Rieke, Mary Thomas Burke, Jonnie McLeod, Joe Ray Underwood, and Craig Cashwell, who guided him through the education process; and to Billie Thomas, his friend and colleague, who has been there through both the good times and the bad.

Both of us would like to express deep appreciation to our clients, who granted us the privilege of sharing deeply personal and vulnerable times with us. We feel honored by the trust that they have placed in each of us. In addition, we dedicate this book to the students who seek to learn more about this process and themselves in our grief counseling classes. It is a great joy to share this vocation with others who are traveling on the same path. This work constantly reminds us of the profound connection that we share with each other and of the common thread of human experience that binds us together in this world. It is with this awareness that we feel both humility and excitement in sharing this book with our readers.

PART I

THEORETICAL UNDERPINNINGS

CHAPTER 1

THOUGHTS ABOUT COUNSELING

LEARNING OBJECTIVES

1. Describe common misconceptions about counseling.
2. Differentiate between counseling and therapy.
3. Identify the components of the therapeutic relationship in counseling.
4. Define the goals of grief counseling.

INTRODUCTION

Most of the time, we find our own way through the difficult times in our lives without the need for a professional to assist us. Life is full of ups and downs, and we usually learn to adjust to change, cope with difficulties, and develop our own sense of resilience along the way. There are times, however, when some of our life experiences throw us into a place of great upheaval, severely taxing us and overwhelming our coping abilities. Many of the experiences that challenge us at this level involve painful and significant losses that force us to deeply question ourselves, others, and the world. It is at these times that we may choose to seek the assistance of a counselor. In this chapter, we explore what counseling is and examine some of the more common misconceptions about counseling. We also look at the therapeutic relationship that develops between the counselor and the client in the counseling setting, consider the different contexts in which counseling may occur, and briefly discuss the goals of grief counseling.

WHAT IS COUNSELING?

In its simplest form, counseling is about two people sitting down in privacy, with one of these individuals listening intently and responding in a helpful manner to the other person who is expressing his or her concerns about problems in everyday life (Feltham, 2010; Kottler & Carlson, 2014). The field of counseling psychology arose out of a grassroots movement of the 1960s in response to what were viewed as heavy-handed, elitist therapies that focused on the weaknesses and foibles of the client and that were seen as perpetuating client dependence and disempowerment.

Counseling is seen as a means to address everyday life concerns and issues related to daily living, not as a means to dissect an individual's deep psychic secrets and family dysfunctions. The philosophy of counseling is basically that human beings possess innate strengths and resilience that can be drawn upon during times of struggle and crisis. Counseling offers the opportunity to help identify these areas of strength within individuals. The counseling process provides an avenue for empowerment of individuals to draw from these inner resources in order to work through difficult situations. Goals of counseling may include the following:

- Assisting clients to gain insight and perspective on their situation, behavior, emotions, and relationships
- Providing a safe place for clients to express feelings and clarify their thoughts
- Offering a context for clients' experiences within a broader perspective (e.g., within a family context, social and political structures, existential viewpoint)
- Enhancing the development of clients' skills in dealing with painful and distressing situations
- Empowering clients to become their own best advocates
- Facilitating clients' process of finding and making meaning in their life experiences

Counseling is an experience, a relationship, and a process. The counseling process is highly dynamic and interactional between the client and the counselor, with the central focus on the client's needs and experiences. Counseling does not involve having an expert analyze the client with the goal to fix him or her. In the counseling relationship, the counselor and the client work together as a team to help the client to understand his or her experiences, and to develop awareness of what can be done do to work through the current issue.

It is important at this juncture to delineate between counseling and therapy. Counselors typically assist people with issues and problems that arise in everyday life that are causing angst and difficulty. Counselors typically engage with clients who are basically functional, but who are struggling with an issue that is having an impact on their lives in a significant way. Counseling is usually short term or limited in the time that the client needs this assistance. In contrast, therapy involves in-depth work with clients, aimed at long-standing struggles and unresolved deeper issues that may require longer, ongoing supportive work. In therapy, clients usually work on restructuring their core aspects. In counseling, clients focus on

reframing everyday life events and identifying the strengths and resources that they need to draw upon to work through these events.

MISCONCEPTIONS ABOUT COUNSELING

Popular media and culture perpetuate a negative view of counseling by frequently portraying a client who is loosely identified as "neurotic" sitting in an office with a gloating professional who acts like a condescending parent figure, talking to the client in a way that is belittling and demeaning. In addition, call-in radio and television shows that feature a guest psychologist or "doctor" of some sort who tells people how to solve their problems in 10 minutes or less for the sake of entertainment do not give a very accurate representation of the counseling process. Many people probably have a very unrealistic and stereotypical view of counseling as a result of these types of portrayals. In this section, we try to dispel some of the more common misconceptions about counseling.

Misconception #1: Only Individuals Who Are Weak Seek Counseling

Many people think of going to a counselor as a sign that something is wrong with them, or that seeking professional assistance is an indication of weakness. This commonly held thought is predicated on the belief that people seek professional help because they are somehow inadequate or needy. This misconception is most likely an extension of the value our society places on stoicism and rugged independence, which rewards us for denying and hiding our emotions at times of vulnerability, rather than supporting our healthy need to reach out to our communities and healers when we need to do so. Public expressions of the more vulnerable emotions, such as sadness or anxiety, do not necessarily result in offers of support; rather, their disclosure seems to serve as an invitation for criticism and judgment, along with lowered social status (Harris, 2009–2010, 2016).

Our society places a great deal of expectation for us to be "above" emotion and to "overcome" our humanness, and counseling is often associated with emotions that are socially stigmatized. Therefore, seeking counseling is seen as something that "weak" people do because they cannot control their feelings, or they are too weak to manage them according to social expectations. Seeing a counselor is not about whether one is weak, but rather it is more closely associated with our human need to reach out for support at a time when our ability to accommodate something that has happened is deeply challenged. We are social creatures who live in community with others, and yet there is a strong dichotomy in regard to needing to be close to others while not allowing others to see us when we are not strong and independent. Professional counselors understand the courage it takes for a client to be willing to confront his or her problems head on and to expose such vulnerability in order to work through these difficult times (Practice Example 1.1).

Misconception #2: The Counselor Is the Expert

Another misconception about counseling focuses on the role of the counselor as the expert. Certainly, professional counselors have usually completed a great deal of training and they

PRACTICE EXAMPLE 1.1

UNEXPECTED BENEFITS OF GRIEF COUNSELING

Debbie's husband died 3 months ago from a long, debilitating illness. Since his death, she struggled with feelings of guilt that she didn't do enough to help him when he was very ill. She also had difficulties sleeping because her grief intensified at night and she was overwhelmed by the feelings that surfaced at these times. One of her colleagues at work suggested that she see a grief counselor, but she thought, "I am not *that* bad off," and she never pursued it. Later on, one of her friends gave her the name of a grief counselor that she had seen after her mother died. Debbie decided to give it a try. After a few sessions, she noticed that while she still felt very sad at night, she was able to sleep better, and she had a more realistic appraisal of the events that surrounded her husband's illness. Debbie realized that the counseling gave her a place to talk about her feelings, along with tools to engage with her grief so that she could choose how she wanted to be with her grief rather than being triggered and overwhelmed as much by her grief.

usually have graduate-level degrees in their field. The natural assumption is that the counselor is in a position of being the expert, and the client comes to the counselor to find answers to problems by drawing from the counselor's expertise. We distinguish between the expertise of the counselor in the *process of counseling* and the expertise of the client in his or her *life and choices*. The client knows their values, beliefs, and life experiences better than anyone else, and the role of the counselor is not to give advice or figure out what the client *should* do. Instead, the counselor acts as a facilitator to help the client to find their own answers, solutions, and choices. We strongly believe that each person has his or her own best answers deep inside, and that the role of the counselor is not to solve the client's problems, but rather to help that person find what he or she needs to work through the painful times and problematic areas.

Misconception #3: People Who Need Counseling Are Basically Emotionally Unstable

Another misconception about the counseling process is that a person must be crazy or unstable if they are seeking help from a counselor. It is true that when someone is going through a difficult time, especially an acute grief reaction, there is a wide range of emotional responses that can be associated with that loss (Worden, 2018). Those emotions are often described by bereaved individuals as similar to riding a "roller coaster," with feelings changing rapidly and varying widely, and the sense of being out of control often highly distressing. Such feelings have led many of our clients to ask questions, such as, "Am I normal?"; "Am I going crazy?"

We often reassure these clients that although they are normal, the disequilibrium that they are experiencing can be the stuff of crazy making! It is not because people are going crazy or

that something is wrong with them that they seek counseling, but rather it is because they are experiencing a significant challenge (e.g., a death, divorce, grief, a personal trauma, and unresolved childhood issues), and they need to have a safe place to sort these things out with someone who can walk alongside them in an empathetic, yet objective, way.

Misconception #4: People Who Have Good Friends Do Not Need a Counselor

Many individuals would say that they could get the same support from having a discussion with close friends or family members as they can by speaking with a counselor, and it is true that most of us have friends and family members who we rely on for support during difficult times. However, sometimes these individuals are also personally involved in the same difficult situations, or they are directly affected by them. As a result, these individuals may have their own opinions or strong feelings that may hinder our ability to openly share our difficulties or to seek their counsel.

In actuality, a counselor can provide a listening ear and trained support that a friend might not be able to provide. Lewis Aron describes the special type of listening in which counselors engage:

> That is what we offer: We listen to people in depth, over an extended period of time and with great intensity. We listen to what they say and to what they don't say; to what they say in words and to what they say through their bodies and enactments. And we listen to them by listening to ourselves, to our minds, our reveries, and our own bodily reactions. We listen to their life stories and to the story that they live with us in the room; their past, their present, and future. We listen to what they already know or can see about themselves, and we listen to what they can't see in themselves. We listen to ourselves listening. (Safran, 2009, p. 116)

This specific type of listening is unique to counseling and is unlike other types of interaction. Unlike a relationship with a friend, relative, colleague, or another caring human being, counselors do not just listen—they provide a means for clients to hear themselves more clearly and, hopefully, come to some awareness of what is causing them to feel the way that they feel. Although friends might have wonderful listening skills and a desire to help, there is often a problem with friends acting as counselors because it is very difficult to see a friend who is hurting, and the desire to "fix" or "rescue" may interfere with the client's ability to solve the problem or issue for himself or herself. Suffice it to say that most of our clients have good friends and family members available to them, but they usually find that the unique relationship with the counselor offers something important that these other relationships cannot provide during certain difficulties.

Misconception #5: Focusing on Problems Will Make Them Worse

The last misconception that we would like to address is the belief that we should just forget about our problems and move on in life. Although we readily agree that not everyone will find counseling helpful, especially if they are not prone to talking openly with others

about the more personal aspects of their lives, it is concerning that there is so much social pressure for people to ignore their feelings and act as if everything is fine when it is not. Unfortunately, this scenario is what commonly occurs, and in many instances, the problem festers and resides in the background, drawing energy away and resurfacing in unwanted ways throughout one's life. It is true that in counseling we tend to focus on client's feelings and their expression rather than supporting their suppression, which is more socially acceptable. However, focusing on feelings and actively working with strong emotions will not cause a client to lose control and have a "mental breakdown." Delving deeply into the difficult emotions that clients bring to the session does not cause depression or encourage the client to "wallow" in pain and self-pity. The contrary often seems to occur, as many of our clients will tell us that they feel lighter and more connected with themselves and others after they have been able to identify and share their feelings with someone who supported them in this way.

As a counselor, it is important to be aware of these common misconceptions and how they may influence your clients. Many people are very fearful of pursuing counseling mainly because of these misunderstandings about the purpose and process of counseling. However, if they were to understand what the counseling process is really about, they might view the process differently.

THE THERAPEUTIC RELATIONSHIP

Developing a range of skills and techniques is very important and useful in working with clients. However, no intervention is more important than first establishing the relationship on which the therapeutic encounter is founded (Horvath, Del Re, Fluckiger, & Symonds, 2011; Kottler & Carlson, 2014; Norcross, 2010). The relationship between a counselor and a client is both like and unlike any other kind of relationship. What makes this relationship unique? The following list gives an overview of what is unique about what we call the *therapeutic alliance* with a client:

- The relationship exists to meet the needs of the client; the client's needs and agenda are the primary focus.
- Although the counselor possesses training and experience that are unique to the process, there is recognition that the clients are the true experts, because only the clients have had direct experience with their lives and they are really the only ones who know what is best for them.
- The relationship is a real relationship; counselors will have real feelings about the process and the client, and the client's feelings and stories will most likely have an impact on the counselor. Because the relationship is a real relationship, issues of personality and goodness of fit may have an effect on the success of the therapy. It is important for counselors to recognize that they may not work well with everyone, and for clients to realize that finding a counselor who is a "good fit" is as important as finding a counselor with appropriate training and credentials.
- The relationship has specific, described boundaries that are in place to protect *both* the client and the counselor.

- The relationship exists within a framework of defined ethical practices for counseling.
- The relationship is not a friendship, a parental relationship, or a teacher–student relationship, although certain aspects of each of these types of relationships may, at times, be present within the therapeutic alliance.
- The relationship is built upon a model of respect and empowerment; the counselor follows the lead of the client and builds upon the inherent strengths that are present in the client.

The basic conditions for counseling were defined in person-centered therapy by Rogers (1995) as *accurate empathy, unconditional positive regard,* and *congruence*. *Accurate empathy* refers to the ability of the counselor to enter the client's inner world of private personal meanings and feelings "as if" it was that of the counselor, but without ever losing the "as if" quality. Entering the world of the client in this way conveys a deep sense of the message, "I am with you completely." *Unconditional positive regard* is the stance of the counselor to the client, indicating an attitude that, despite one's failings and faults, the counselor relates to the client with deep respect, with value, and without any conditions. It is not that the counselor "sugar-coats" problematic areas in the client's life and way of being, or that the counselor ignores negative or unskillful tendencies that are apparent, but the counselor chooses to focus on trusting in the innate tendency of human beings to grow and develop when given the right conditions for this to occur.

Finally, *congruence* is a little more complex in its description within the therapeutic alliance. Basically, when counselors are congruent, they are aware of their own thoughts and feelings within the encounter with the client and share these real thoughts and feelings with the client. A related term to congruence is genuineness, in which the counselor is not merely fulfilling a role within the therapeutic relationship, but is actively engaged as a *real* person in that relationship, and shares thoughts, feelings, and reflections with the client that are based within the counselor's personal experience with the client and not just drawn from theoretical knowledge and viewed through a diagnostic lens (Geller & Greenberg, 2012; Slife & Wiggins, 2009; Yalom, 2009). In this book, we repeatedly go back to these conditions as the foundation of the counseling relationship, with an understanding that the concept of engaged presence is the prerequisite to the counselor's being able to offer these necessary conditions to the client.

GRIEF COUNSELING

Now that we have discussed what counseling is and what it is not, it would probably be helpful to discuss the specific subset of counseling practice that focuses on grief and bereavement. In her book, *Necessary Losses*, Viorst (2010) states that loss is something that we cannot avoid and that loss experiences can be both difficult and transformative. Our lives are often shattered and shaped by the experience of various losses over time. The death of a loved one can certainly be one of the most crippling events that we encounter. Because we live in a society where we expect to live a long, healthy life, and there is little

exposure to death on a regular basis, most people do not have the opportunity to develop a repertoire of responses to death before being plunged headfirst into a major loss experience. We also do not have many good role models for how to walk the path of grief in a way that allows for much variation, other than the typical social messages that offer empty platitudes and reward bereaved individuals for being busy and distracted, and for "getting over it" as soon as possible. A counselor who understands the basic tenets of good counseling practice and who also has expertise in the grieving process can provide a highly specialized form of support to an individual who is struggling with a significant loss (Larson, 2014; Worden, 2018).

Individual Counseling

Perhaps the most common venue for grief counseling, individual counseling can provide the support and guidance to help a bereaved individual navigate through significant loss experiences. Clinicians who are trained in the unique aspects of grief counseling can help a person better understand this experience and place it into a sense of perspective in regard to normalcy and expectations. Grief counseling might also help the client to identify and develop effective tools to cope at this very time. In addition, the grief counselor is often the safe person who can hear about things that are difficult for the client to tell others within their friendship network and family circle. Grief counseling is directly related to general counseling practice because loss and grief are universal and everyday experiences, and counseling is aimed at helping individuals to get through times in everyday life that are especially challenging or difficult.

Marriage/Couple Counseling

When two individuals who share an intimate relationship experience a significant loss, there are often challenges to the couple in the form of disparities in grieving style. The most common scenario for couple counseling is after the death of a child (Finkbeiner, 2012; Rosenblatt, 2000). The death of a child is one of the most difficult losses that can be experienced; it is expected that we will inevitably bury our parents, and there is a 50–50 chance that we will have to bury a spouse, partner, or significant other. However, it is not the natural order for parents to have to bury a child. It is not unusual, even in healthy marriages, for conflicts to occur. Partners who are already in a great deal of pain after the loss of a child often do not have the energy to resolve conflicts with the other partner. There is also the compounding issue of differences in grieving style that often surfaces during this painful time (Doka & Martin, 2010). As a result, it is common to hear partners grieve the loss not only of their child but also of each other due to the deep, paralyzing grief that each experiences, and the disparities in how that grief is manifest. In this scenario, couple counseling can provide the grieving couple with an understanding of their grief and the tools to explore where they are stuck in their grief. As a result, they may be able to learn new behaviors and skills to break out of the destructive cycle of blame and isolation that can cause a great deal of damage to the relationship between them (Practice Example 1.2).

PRACTICE EXAMPLE 1.2

RECOGNIZING DIFFERENT GRIEVING STYLES

Bill and Alice's 19-year-old son died 5 months ago in a car crash in which his friend was driving and went through a red light and was hit by a truck coming through the intersection. Since the accident, Bill has been consumed by feeling anger at his son's friend, who came away from the accident with scratches, while his son died. He finds that staying busy with his work and projects is a welcome distraction from his pain. Alice has been despondent and withdrawn. She often sleeps in her son's room, wrapped in his sheets and clothing that still have his scent on them. Bill feels that Alice is wallowing in her grief, and he gets frustrated when he tries to get her to do things with him and she refuses. Alice is afraid of Bill's anger. She feels that he doesn't understand her feelings, and she also gets angry that he doesn't seem to be grieving at all.

At the recommendation of their family doctor, Bill and Alice seek assistance from a grief counselor, who explains their differences in grieving style, and who offers a safe place for them to begin to talk about their son with each other. In the counseling sessions, they realize that they are each grieving uniquely, and they no longer take each others' reactions to the death of their son personally.

Family Counseling

Although there is the expectation that family members will grieve together and provide support to one another, the reality is that dissimilar or incongruent grief often occurs and causes conflicts within the family system (Harris & Rabenstein, 2014; O'Leary, Warland, & Parker, 2011). People who experience a mutual loss within a family may be the least able to support each other, because the relational dynamic with each other and the deceased person may impede the ability to find common grief pathways. Loss of a family member disrupts the family system, and the family must reorganize after the loss. Family members may also be depleted after a long period of caregiving, and there may be a lack of available energy to deal with the underlying family dynamics and stresses that have built up over time, and often come to the surface after a family member dies. Counselors who are trained in family therapy and who also understand the complexities of grief within these family systems may be able to bridge the gaps in the family system that has been torn by caregiving burdens, losses, and dissynchronous or asynchronous grief.

GOALS OF COUNSELING

The purpose of grief counseling is to help individuals work through the feelings, thoughts, and memories associated with the loss of a loved one in a way that is congruent with the bereaved individual's personality, preferences, values, and goals. Understanding the goals of grief counseling can help clinicians to work more effectively with clients. Although most people associate grief counselors with assisting individuals who are grieving the loss of a loved

one, the scope of grief counseling encompasses supporting individuals through all kinds of change, transitions, and losses. As you look through these goals, think of how they may also apply to losses that may not be related to death, such as the ending of a relationship, the loss of employment, or the loss of functionality or health.

Some of the goals of grief counseling are as follows:

- Providing the bereaved a safe place to share their experiences and feelings
- Helping the bereaved to live without the person who died and to make decisions alone
- Helping the bereaved to honor the continuing bond with the deceased person while moving forward into life again at some point in the future
- Providing support and time to focus on grieving in a safe environment
- Recognizing the importance of important times, such as birthdays and anniversaries, and supporting the client through these dates and special times
- Providing education about normal grieving and the normal variations in grieving among individuals
- Assisting clients to integrate the loss into their assumptive world or to rebuild that world after a significant loss
- Helping the bereaved to understand their methods of coping
- Engaging clients to recognize their innate strengths in coping and adapting to significant loss experiences
- Identifying difficulties in coping that the bereaved may have and making recommendations for further professionals and resources in the community as needed
- Empowering the client in approaching life and others after experiencing a life-changing loss.

We have written this book in a way to hopefully provide you with a solid foundation in counseling and grief theory, interspersed with practical suggestions for your work with bereaved individuals. At its core, grief counseling is basically good counseling practice that is also embedded with the current research, theory, and clinical wisdom from those who have spent years in research and practice with bereaved individuals. We hope that the contents of this book help you to be a better informed and reflective practitioner with clients who have experienced significant, life-altering losses.

CONCLUSION

Counseling is a unique form of support that occurs within a relationship between the counselor and the client, occurring within specific boundaries with the goal of supporting and empowering the client through difficult times in life. Counseling may occur with an individual client, a family, or a group of individuals who share similar loss experiences. Grief counselors help individuals as they work through the grieving process in a way that is congruent with the grieving individual's personality, preferences, values, and goals.

GLOSSARY

Accurate empathy The ability of the counselor to enter the client's inner world of private personal meanings and feelings "as if" it was that of the counselor, but without ever losing the "as if" quality.

Congruence When counselors are congruent, they are aware of their own thoughts and feelings within the encounter with the client and share these real thoughts and feelings with the client.

Core conditions of counseling Established by Rogers in person-centered counseling; these are the three conditions that must be in place for the therapeutic alliance to occur: accurate empathy, congruence, and unconditional positive regard.

Counseling Professional support that has defined boundaries with the intent of assisting individuals to effectively work through everyday life issues that cause difficulty or distress.

Therapeutic alliance The unique relationship with a client that is focused solely on the client's needs, whereby the client feels safe, supported, and understood by the counselor.

Therapy In-depth professional work with clients, aimed at long-standing struggles and unresolved deeper issues that may require long-term supportive work. In therapy, clients usually work on restructuring core aspects of themselves.

Unconditional positive regard The stance of the counselor to the client, indicating an attitude that, despite one's failings and faults, the counselor relates to the client with deep respect, with value, and without any conditions.

QUESTIONS FOR REFLECTION

1. Brainstorm about some of the media personalities and popular depictions of counselors that come to your mind. How are the counselors portrayed in these depictions? How do you think these portrayals influence the profession of counseling and the view of the general public about counselors and those who seek counseling? Based on the information in this chapter, how is the actual counseling process different from these portrayals?
2. In this chapter we discuss how counseling is different from receiving support from friends or family members. What do you think are the specific differences between support from a counselor and other types of support?
3. After reading this chapter, has your thinking about what counseling offers changed from what it was previously? If so, in what ways?
4. If you were to provide grief counseling to bereaved individuals, what do you think would be your biggest challenge personally?

REFERENCES

Doka, K. J., & Martin, T. (2010). *Mourning beyond gender: Understanding the way men and women grieve*. Philadelphia, PA: Brunner-Mazel.

Feltham, C. (2010). *Critical thinking in counselling and psychotherapy*. London, UK: Sage.

Finkbeiner, A. K. (2012). *After the death of a child: Living with the loss through the years.* New York, NY: Simon and Schuster.

Geller, S. M., & Greenberg, L. S. (2012). *Therapeutic presence: A mindful approach to effective therapy.* Washington, DC: American Psychological Association.

Harris, D. L. (2009–2010). Oppression of the bereaved: A critical analysis of grief in Western society. *Omega, 60*(3), 241–253. doi:10.2190/om.60.3.c

Harris, D. L. (2016). Social expectations of the bereaved. In D. Harris & T. Bordere (Eds.), *Handbook of social justice in loss and grief: Exploring diversity, equity, and inclusion* (pp. 165–176). New York, NY: Routledge.

Harris, D., & Rabenstein, S. (2014). Working with families who have experienced traumatic loss. In D. Kissane & F. Parnes (Eds.), *Bereavement care for families* (pp. 137–153). New York, NY: Routledge.

Horvath, A. O., Del Re, A. C., Fluckiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. In J. Norcross (Ed.), *Psychotherapy relationships that work: Evidence-based responsiveness* (pp. 25–69). New York, NY: Oxford University Press.

Kottler, J. A., & Carlson, J. (2014). *On being a master therapist: Practicing what you preach*. Hoboken, NJ: Wiley.

Larson, D. (2014). Getting grief working: A guide for the new grief therapist. *New Therapist, 90*, 25–29.

Norcross, J. C. (2010). The therapeutic relationship. In B. L. Duncan, S. D. Miller, B. E. Wampold, & M. A. Hubble (Eds.), *The heart and soul of change: Delivering what works in therapy* (2nd ed., pp. 113–141). Washington, DC: American Psychological Association.

O'Leary, J., Warland, J., & Parker, L. (2011). Bereaved parents' perception of the grandparents' reactions to perinatal loss and the pregnancy that follows. *Journal of Family Nursing, 17*(3), 330–356. doi:10.1177/1074840711414908

Rogers, C. (1995). *Counseling and psychotherapy.* Boston, MA: Houghton Mifflin.

Rosenblatt, P. C. (2000). *Help your marriage survive the death of a child*. Philadelphia, PA: Temple.

Safran, J. (2009). Interview with Lewis Aron. *Journal of Psychoanalytic Psychology, 26(2)*, 99–116. doi:10.1037/a0015679

Slife, B. D., & Wiggins, B. J. (2009). Taking relationship seriously in psychotherapy: Radical relationality. *Journal of Contemporary Psychotherapy, 39*(1), 17–24. https://doi.org/10.1007/s10879-008-9100-6

Viorst, J. (2010). *Necessary losses: The loves, illusions, dependencies, and impossible expectations that all of us have to give up in order to grow*. New York, NY: Simon and Schuster.

Worden, J. W. (2018). *Grief counseling and grief therapy* (5th ed.). New York, NY: Springer Publishing Company.

Yalom, I. (2009). *The gift of therapy*. New York, NY: HarperCollins.

CHAPTER 2

UNIQUE ASPECTS OF GRIEF COUNSELING

LEARNING OBJECTIVES

1. Identify the unique features of grief counseling.
2. Differentiate between grief counseling and other forms of counseling.
3. Describe the primary goal of grief counseling.
4. Define the concept of the assumptive world, and identify the three main assumptions that comprise one's assumptive world.

INTRODUCTION

Loss, change, and death are all universal human experiences, and each one of us will become intimately acquainted with the grieving process at many points throughout our lives. Most individuals who are trained in psychology and other counseling-related professions typically have an understanding of the process of therapy after significant life events occur. However, we venture further in this chapter to explore what makes grief counseling a unique form of therapeutic support, and how the practice of grief counseling may differ from counseling for other types of issues.

One of the most important aspects of grief that differentiates it from other issues that clients bring into the counseling relationship is that the grieving process itself is an adaptive response and not a form of pathology. Grief is the normal, natural response to loss. Grief is not something that we strive to "overcome" or to which there is "recovery," as one might

recover from an addiction or an illness. Counselors who work with bereaved individuals understand that although the grieving process may involve a tremendous amount of pain and adjustment, the goal of grief counseling is to facilitate the unfolding of the healthy and adaptive aspects of the process as it is manifest within each client, trusting that this unfolding will eventually help the bereaved individual to reenter life in a way that is meaningful.

GRIEF AND THE ASSUMPTIVE WORLD

At a basic level, our expectations about how the world works begin to be formed from birth, through the development of the attachment relationships of the infant and young child. Bowlby (1969, 1973) posited that early-life attachment experiences lead individuals to form "working models" of the self and of the world. We essentially learn whether the world is a safe or a threatening place from these working models. Bowlby's theory of attachment also suggested that significant losses can threaten these working models, resulting in a need to rebuild or restructure one's working models to fit the post-loss world. Building upon Bowlby's work, Parkes (1975) extended the concept of the "internal working model" to that of the "assumptive world," which he stated was ". . . a strongly held set of assumptions about the world and the self, which is confidently maintained and used as a means of recognizing, planning, and acting" (p. 132) and that it is ". . . the only world we know, and it includes everything we know or think we know. It includes our interpretation of the past and our expectations of the future, our plans and our prejudices" (Parkes, 1971, p. 103).

Parkes (1971) stated that the assumptions that individuals form about how the world works are based on their previous life experiences and attachments. He also emphasized that experiencing a significant loss can threaten one's assumptive world. Recent research that links attachment style to the way an individual navigates the grieving process after a significant loss would also support the role of early experiences with attachment figures as a template for how experiences are interpreted and integrated in later life (Burke & Neimeyer, 2013; Mancini & Bonanno, 2012; Mikulincer & Shaver, 2013). In her extensive work that explored the construct of the assumptive world in the context of traumatic experiences, Janoff-Bulman (1992) stated that expectations about how the world should work are established earlier than language in children and that assumptions about the world are a result of the generalization and application of childhood experiences into adulthood. Forming a belief that the world is safe is related to the sense of "basic trust" described by Erikson's (1968) model of human development. Our assumptive world provides us with a sense of predictability and coherence in our daily lives.

Although attachment theory was originally founded in the psychoanalytic tradition of psychology and the discussion here draws heavily upon attachment as a means of understanding how assumptions are developed, the broader context of the assumptive world goes far beyond the realm of psychological theory or cognition. Janoff-Bulman (1992) identifies three major categories of assumptions, which have been broadened and extrapolated for our reference here:

1. *Assumptions about how we expect other people and the world to work.* For example, many people probably assume that overall there is more good than bad in the

world and that people are generally trustworthy. It is important to keep in mind that this category/assumption will vary from person to person. The main point is that whatever an individual believes about how the world works, that belief is foundational to many choices, decisions, and expectations about the world and other people that are taken for granted in everyday life.

2. *How people attach meaning to the world and to their lives.* An example of this assumption might be that many people assume that the world is meaningful and that good and bad events are distributed in the world in a relatively fair and controllable manner. The category of meaningfulness emphasizes the ideas of justice and control over certain aspects of life. Most individuals tend to believe that misfortune is not haphazard and arbitrary; that there is a person-outcome contingency attached to negative life events. At a basic level, especially in Western-oriented cultures, negative events are often viewed as punishment and positive events are rewards. Janoff-Bulman (1992) states that this assumption is "that we can directly control what happens to us through our own behavior. If we engage in appropriate behaviors, we will be protected from negative events and if we engage in appropriate behaviors, good things will happen to us" (p. 10).
3. *How individuals view themselves, including their worth and how they fit into their social network and cultural context.* Most Western-oriented societies place a great deal of value on the individual's intrinsic worth and value and on individual accomplishments. Other societies may view the worth of an individual in relation to that person's place within a family system or a larger social context (Practice Example 2.1).

PRACTICE EXAMPLE 2.1

THE SHATTERED ASSUMPTIVE WORLD

Kaley always dreamed of being a mother. After she married Don, they decided they wanted to start a family right away. However, after 2 years of trying, Kaley had not become pregnant. They then proceeded to undergo medical treatments to try to conceive. The treatments were expensive, painful, and encompassed all of Kaley's time and energy. Kaley began to feel resentful of her friends who were starting families without any trouble. She began to withdraw from her friends because it was painful to hear them talk about their new babies.

One day, when Kaley was driving back from the medical center after another treatment, she saw a teenage girl with a baby in a stroller on a street corner. The girl was disheveled, smoking a cigarette, and paying no attention to the baby. Kaley yelled out loud in her car, "What kind of God allows this to happen?" She felt the weight of the unfairness of her situation, where a child would be welcomed and loved versus the scenario she had just seen on the street. At that moment, she felt that something deep inside her had broken.

Janoff-Bulman (1992) stated that these three categories of beliefs can be called world assumptions, and together they make up an individual's assumptive world.

Why are we discussing the development of our assumptive world? Because significant losses assault the assumptions that we have formed about the world from when we were very young. We learn that people can harm, even murder, those we love. We learn that our view of the world as a safe and predictable place, where good things come to those who work hard and where all human beings have value and worth, may not be what we actually encounter in our experiences later in life. Somehow, we then have to reconcile the world that we now know to exist with the world that we believed to exist, and the grieving process helps us to rebuild our assumptive world so that we can feel safe and functional again in this new experience of the world that differs greatly from our previously held beliefs about how that world should work.

At this point, a caveat about how our assumptive world works might be in order. Not everyone experiences a world that is basically safe or people as generally well meaning. In fact, for some individuals, their assumptive world may be built around surviving in a world that is chaotic or surrounded by unpredictability. What is important to consider here is that whatever a person's assumptions about the world might be, it is these assumptions (and the associated thoughts, feelings, and behaviors that extend from these assumptions) that serve to provide congruence and meaning to us, even when the "outside" world is anything but safe, secure, and predictable. For example, children in the foster care system are often taken from their parents due to concerns over their safety within that home. They are then placed in a home with foster parents to care for them. The children may have been acutely aware of the problems at home, but their parents are still attachment figures to them. In their awareness, a professional (usually a stranger) takes them away from their parents and the home they know. They are then placed with strangers, and they may even be separated from their siblings at this time. Many children in foster care are moved from one home to the next due to circumstances that are out of their control (Mitchell, 2016). They learn not to get too close to their foster families because of the pain experienced when they are transferred out of one home to another. They learn that they have no control over the events that happen to them. Some experience poor treatment in their foster homes as well.

As a result of these experiences, these children's assumptions about the world begin to change. Not all people are basically good or mean well. The ideas of justice and cause/effect have to change to accommodate unpredictability and randomness. Finally, their views of self and how loveable and valued they are will also be profoundly affected, as they are bounced from one situation to another with their personal feelings about what has happened not being included in the decision-making. After a few years in foster care, they may be unable to receive unconditional love if it was offered because they have learned to protect and guard themselves so deeply. In this scenario, the assumptive world has become built around experiences that support beliefs that (a) people are untrustworthy and can cause harm; (b) things do not happen for a reason— instead of expecting justice, there is an expectation of randomness and helplessness in situations of vulnerability; and (c) the view of self congeals around feelings that people around them do not want them or they are tainted by the events they have endured. There may also be a sense of being objectified as they are carted from one

family to another. In situations like this, exposing the child to unconditional love or to a family that cares is not going to be received openly; rather, the temptation to draw close will likely be tempered with an assumptive world that is built around lack of safety, inconsistency, and negative views of self. Ironically, grief may surface when these children are exposed to love and true caring.

However the assumptive world is revised and rebuilt after a significant loss occurs, the revised assumptive world allows us to exist with a sense of safety in navigating through life. Rather than being a symptom of a disorder, the grief that accompanies the shattered assumptive world is a multifaceted adaptive response to the disorder and disorganization that can occur after our lives (and our assumptions about the world) have been upturned by a significant loss. Instead of attempting to inhibit grief, we recognize that grief needs to be allowed to unfold without hindrance so that the loss experience can be assimilated into one's existing assumptive world or the assumptive world can be rebuilt in a way that makes sense of the loss that has occurred.

COMING TO TERMS WITH CHANGE AND LOSS

There are many misconceptions about what is involved in grief counseling and the way that therapeutic support works with bereaved individuals. It is not uncommon for a grief counselor to receive calls from individuals who think that family members need grief counseling because they are not "over" the grief or progressing through the grief as they should. The common misunderstanding is that grief counseling will "fix" people or return them to the prior level of functioning. Some of these kinds of expectations that are placed upon bereaved individuals are rooted in social norms that reward productivity, stoicism, and materialism (the role of social pressures on bereaved individuals is discussed in a later chapter). It is impossible to reverse time and to control events that are out of our control. We cannot "fix" what has happened (e.g., we cannot bring back the deceased person to relieve the separation distress of the bereaved individual). We also do not focus on helping bereaved individuals to feel better necessarily, because we understand that the process of rebuilding one's world after a significant loss is naturally going to involve a painful time when the many layers associated with loss must be addressed, and the process of readjustment that occurs can be very difficult.

We crave predictability and stability in our lives. In fact, most of us operate on the assumption that we have a lot of control over the events in our lives (Heckhausen, Wrosch, & Schulz, 2010). As stated earlier, one of the basic assumptions espoused by Janoff-Bulman (1992) indicates that most people in Western societies believe that if you work hard, you will be rewarded. In our clinical work, we frequently see individuals who experience profound anxiety because they can no longer live under the illusion that things can remain constant and unchanging; this realization usually occurs as a result of the experience of a significant loss or dramatic change in their lives. Even though we attempt to function as if there is certainty and stability in everyday life, the world around us, including our bodies, serve as metaphors for the normalcy of loss, change, and transition. The seasons change. Living things are born, grow, reproduce, and die. Many of the cells that exist in our bodies today were not present a year ago and may not be present in our bodies in a month from now. This moment is gone

and replaced by another moment in time. We cannot stop the changing nature of life, just as we cannot stop time in its place or change the course of events, although this topic has frequently been the subject of fantasy.

Weenolsen (1988) speaks of our innate resistance to change and our belief that things can remain the same as the "fundamental illusion," functioning to allow us to feel safe and solid in the world. However, our clinging to this image causes us great difficulty when the illusion cannot be maintained, such as when a major loss event does indeed occur or when we come to the realization that we have very little control over ourselves and the people, places, and things that matter very much to us. For many of the bereaved individuals who seek counseling, the realizations that (a) we really have very little control over the events in our lives, (b) there is very little predictability and stability in the world, and (c) we will never be the same again form the foundation of the work that occurs in the counseling process.

UNDERSTANDING BEREAVEMENT THEORY IN COUNSELING PRACTICE

It is very important for counselors who wish to effectively support bereaved individuals to have a working knowledge of current theories of bereavement. The literature in thanatology is relatively new in comparison to other fields of study, and most of the current thinking in grief counseling is grounded in ways of thinking about grief, loss, adjustment, and coping that have been reported and published within the last 20 years. We will spend an entire chapter exploring some of the current research in bereavement, current bereavement theories, and ways of working therapeutically with bereaved individuals, but at this point it is important to recognize that there is a separate and unique body of literature in this area that has direct application to grief counseling.

One important aspect of the study of bereavement that we must keep in mind is that grief is not just a psychological issue that is experienced by the grieving individual in isolation. Grief can be experienced and expressed in many ways, which include thoughts, feelings, and emotions; however, it can also be experienced physically through bodily symptoms, socially through changes in interpersonal dynamics and social expectations for the bereaved individual, spiritually as a quest for meaning or as existential suffering, economically through changes in financial status and expenses incurred after a loss, and practically through the changes that occur in one's day-to-day routine as a result of a loss. Thus, we look at literature in many fields of study for an understanding of the grief process in all of its many facets and complexities.

Another unique aspect of grief counseling is an understanding of the complexity of the experience and the factors that shape an individual's response to loss. For example, when there is a loss within a family system, each individual family member will experience grief depending on his or her relationship to the deceased person and other family members, the age and developmental stage of the family members, who provided the caregiving if needed, and the grieving styles of the members (Kissane, 2014). Individuals tend to grieve

in ways that are congruent with their age and developmental stage, according to their personalities and attachment styles (Doka & Martin, 2010; Lai et al., 2014; Stroebe, 2002), in the context of social rules and expectations (Doka, 2002; Harris, 2016), and with the influence of other factors and concurrent stressors at that time (Worden, 2018). Thus, grief counselors need to have a good understanding of how many different areas intersect in this one experience. For example, to explore only the feelings associated with a loss without understanding the social underpinnings and the impact of the concurrent stressors that shape these feelings would provide an inaccurate and overly simplistic account of the client's full experience.

Understanding current bereavement theory and research allows the counselor to appreciate the normative aspects of grief that may inadvertently be labeled as pathological or abnormal to someone who does not have this awareness. For example, the dominant view of grief until recently was the "grief work" hypothesis (Stroebe, 2002), which stated that individuals must do the "work" of grief by talking about their loss and their feelings, and if a bereaved person did not do this, it was assumed that something was wrong with that individual or they were not grieving properly. The grief work model also posited that the goal of grief was to help the bereaved individual to "let go" of their loved one in order to move forward in life. However, in the mid-1990s, research with diverse groups of bereaved individuals demonstrated that although many individuals did, indeed, talk about their loss and their feelings as part of the grief response, many others did not have this same need, and these individuals seemed to cope just as well afterward. In addition, the *Continuing Bonds Theory*, derived from research by Klass, Silverman, and Nickman (1996), demonstrated the normalcy of bereaved individuals continuing a relationship with the deceased. These researchers found that the ability to find a way to remain connected to the deceased individual often helped bereaved individuals to move forward in their lives after a loss (Practice Example 2.2).

PRACTICE EXAMPLE 2.2

CHALLENGING THE "GRIEF WORK" HYPOTHESIS

Derek's wife, Shelby, died 3 months ago. At his daughter's insistence, Derek began attending grief counseling sessions. His daughter was concerned that he never talked about her mother. She felt he needed prodding to talk about his grief.

When he met with the counselor, Derek mentioned that he knew his daughter was worried about him because he didn't talk openly about Shelby's death and his grief but stated that he had "never been much of a talker." The counselor reinforced that not everyone needs to talk about their grief with others, adding that his not talking about his feelings didn't mean that something was wrong. The rest of the session focused mostly on how his daughter was coping with the loss of her mother. Derek thanked the counselor for her time and said he didn't think he needed another appointment.

WHO BENEFITS FROM GRIEF COUNSELING?

Most grief counselors assume that their work with bereaved individuals is effective. However, recent research into the efficacy of grief counseling provides more detailed information about who would benefit from, and who might actually be harmed by, grief counseling. Studies by Kato and Mann (1999) and Allumbaugh and Hoyt (1999) implied that professional bereavement support did not provide significant benefit to the bereaved participants. It is probably important to take a step back and to ponder the basic premise of many interventions for bereaved individuals. As we have stated earlier in this chapter that grief is a normal and adaptive process, we need to consider why professional intervention may be needed by bereaved individuals to assist an adaptive process that is at work. Indeed, Stroebe, Hansson, Stroebe, and Schut (2001) observed that the general tendency for many bereaved individuals is to improve with or without professional intervention. In addition, Kato and Mann's (1999) study revealed that many of the bereaved participants would have had a better outcome if they had been assigned to the control (nontreatment) group than to the treatment group. In another study, Jordan (2000) reported that for some bereaved individuals, professional intervention may actually do more harm than good. Neimeyer (2012) provided reflection on grief counseling research, stating that many studies did not capture the 10% to 15% of bereaved individuals who not only would benefit from grief counseling but also should receive intervention to prevent significant negative consequences that may occur as a result of their losses. In a review of research into the efficacy of grief counseling, Schut (2010) similarly concluded that although it is not effective to recruit bereaved individuals into grief counseling if they are not seeking support, professional support may be beneficial for those who do request it and for those who endure a crippling form of complicated grief.

In response to these findings, researchers in the area of bereavement have made some comments and suggested a few guidelines that would be applicable to clinical practice in grief counseling. It is generally agreed that most bereaved individuals are able to adapt to the loss that has occurred with the support of their families and friends and do not require professional intervention. Making the assumption that all bereaved individuals need professional assistance would be inconsistent with the awareness of grief as an adaptive process. It may be the case that although the grieving process is normative and adaptive, if one's grief does not fit into a socially acceptable or recognized pattern, the bereaved individual may be perceived as abnormal and referred for treatment; when in fact, the social norms that judge the expression of grief in such limited terms may be the issue, and not some dysfunction within the individual. Wolfelt (2005) suggests a model of "companioning" with the bereaved, emphasizing the relational component of therapeutic support, which may be especially helpful if a bereaved individual does not have other supports available to "walk alongside" him or her during the acute grieving process.

In their review of bereavement efficacy studies, Jordan and Neimeyer (2003) state:

> [G]eneric interventions, targeted toward the general population of the bereaved, are likely to be unnecessary and largely unproductive. Instead, interventions that are tailored to the problems of mourners in high-risk categories (e.g., bereaved mothers, suicide survivors, etc.), or showing unremitting or increasing levels of distress after a reasonable period of time are likely to be more beneficial. (pp. 778–779)

Parkes (2002), Schut and Stroebe (2011), and Neimeyer (2012) identified specific at-risk populations that may benefit most from grief counseling. These groups include older men who lose spouses, mothers who lose children, and survivors of sudden or violent losses with traumatic features. Other high-risk individuals may be those with pre-existing psychological disturbances, such as depression, substance abuse, posttraumatic stress disorder, and previous history of psychosis. In addition, individuals with high levels of distress early in their bereavement experience are more likely to benefit from professional intervention. Hoyt and Larson (2010) suggest that some of the research about the efficacy of grief counseling (and the lack of positive effects that have been found in many of the studies with bereaved individuals) may be a result of how participants are recruited versus how clients actually seek counseling for assistance when they feel that they need additional help. These researchers state that there is a big difference between individuals who respond to calls for participation in studies and bereaved individuals who contact a counselor for assistance with a grief-related issue.

CONCLUSION

Once you start into a clinical practice specializing in grief counseling, you will no doubt have clients with a diverse range of losses who also have very different ways of grieving, coping, and adapting to loss. Probably the most important aspect of your work will be your ability to "walk alongside" your clients as they share their experiences with you. It is important that you are able to normalize reactions that may be viewed as abnormal by social norms that are unrealistic, and that you are able to recognize when a client is in a high-risk category and in need of additional support. Having knowledge of current bereavement theory and research will help you in this process. Being informed and aware of good counseling practice is also essential to providing a safe place for your clients to journey through their grieving process in a way that allows for the integration of the loss experience into their lives in a way that is healing.

GLOSSARY

Assumptive world Fundamental beliefs that an individual holds regarding how the world works and how others and one's self are viewed. The assumptive world is thought to provide individuals with a sense of safety and security in everyday life situations.

Attachment The formation of significant and stable connections with significant people in an individual's life. This process begins in early infancy as the child bonds with one or more primary caregivers, and later extends to other significant relationships throughout the lifespan. Attachment is thought to be an instinctual construct with the purpose of ensuring safety and survival.

Fundamental illusion The belief that things will always remain the same; maintaining this illusion serves the purpose of allowing people to feel safe and solid in the world.

"Grief work" hypothesis View of grief that individuals must do the "work" of grief by talking about their loss and their feelings, and if a bereaved person did not do this, it was assumed that something was wrong with that individual. Also indicates that that the goal of grief is to help the bereaved individual to "let go" of their loved one in order to move forward in life.

QUESTIONS FOR REFLECTION

1. If grief is an adaptive and healthy process, why do you think we have such a great deal of difficulty acknowledging grief both personally and socially?
2. Think about the section on the assumptive world. What are some of the assumptions that you can identify personally that guide you in your life? What are some of the ways that your assumptions have been challenged by experiences that you have had in your life?
3. If, as the chapter states, change and transition are truly constant companions in life, why do most people have difficulty adjusting to change and loss in their lives?
4. You are a grief counselor and you receive a call from a woman who wants her father to come to see you for counseling after the death of his wife (her mother). She reports that she is concerned that her father does not seem to be grieving at all, and she thinks that he needs to talk with someone. How would you respond to her request?
5. Perform a search on the Internet with one of the well-known search engines using the key words of "grief counseling," "grief recovery," and "helping bereaved individuals." Read over some of the material that is presented in these links. How many of them still extol the grief work theory of bereavement? What audience do you think each site is trying to target? Based on your reading of this chapter, do you think there is any potentially harmful content on the sites for bereaved individuals?

REFERENCES

Allumbaugh, D. L., & Hoyt, W. T. (1999). Effectiveness of grief therapy: A meta-analysis. *Journal of Counseling Psychology, 46*(3), 370–380. doi:10.1037//0022-0167.46.3.370

Bowlby, J. (1969). *Attachment and loss: Attachment* (Vol. 1). London, UK: Hogarth.

Bowlby, J. (1973). *Attachment and loss: Separation* (Vol. 2). New York, NY: Basic Books.

Burke, L. A., & Neimeyer, R. A., (2013). Prospective risk factors for complicated grief: A review of the empirical literature. In M. Stroebe, H. Schut, & J. van den Bout (Eds.), *Complicated grief: Scientific foundations for health care professionals* (pp. 145–161). New York, NY: Routledge.

Doka, K. J. (2002). *Disenfranchised grief: New directions, challenges, and strategies for practice*. Champaign, IL: Research Press.

Doka, K. J., & Martin, T. L. (2010). *Grieving beyond gender: Understanding the ways men and women mourn*. New York, NY: Routledge.

Erikson, E. (1968). *Identity: Youth and crisis*. New York, NY: Norton.

Harris, D. L. (2016). Social expectations of the bereaved. In D. Harris & T. Bordere (Eds.), *Handbook of social justice in loss and grief: Exploring diversity, equity, and inclusion* (pp. 165–176). New York, NY: Routledge.

Heckhausen, J., Wrosch, C., & Schulz, R. (2010). A motivational theory of life-span development. *Psychological Review, 117*(1), 32–60. doi:10.1037/a0017668

Hoyt, W. T., & Larson, D. G. (2010). What have we learned from research on grief counselling? A response to Schut and Neimeyer. *Bereavement Care, 29*(1), 10–13. doi:10.1080/02682620903560841

Janoff-Bulman, R. (1992). *Shattered assumptions: Towards a new psychology of trauma*. New York, NY: Free Press.

Jordan, J. R. (2000). Research that matters: Bridging the gap between research and practice in thanatology. *Death Studies, 24(6)*, 457–467. doi:10.1080/07481180050121444

Jordan, J. R., & Neimeyer, R. A. (2003). Does grief counseling work? *Death Studies, 27(9)*, 765–786. doi:10.1080/713842360

Kato, P. M., & Mann, T. (1999). A synthesis of psychological interventions for the bereaved. *Clinical Psychology Review, 19*, 275–296. doi:10.1016/s0272-7358(98)00064-6

Kissane, D. (2014). Family grief. In D. Kissane & F. Parnes (Eds.), *Bereavement care for families* (pp. 3–16). New York, NY: Routledge.

Klass, D., Silverman, P. R., & Nickman, S. L. (1996). *Continuing bonds: New understandings of grief.* New York, NY: Routledge.

Lai, C. Luciani, M., Galli, F., Morelli, F., Cappelluti, R., Penco, I., . . . Lombardo, L. (2014). Attachment style dimensions can affect prolonged grief risk in caregivers of terminally ill patients with cancer. *American Journal of Hospice and Palliative Medicine, 32(8),* doi:10.1177/1049909114547945

Mancini, A. D., & Bonanno, G. A. (2012). The persistence of attachment: Complicated grief, threat, and reaction times to the deceased's name. *Journal of Affective Disorders, 139*(3), 256–263. doi:10.1016/j.jad.2012.01.032

Mikulincer, M., & Shaver, P. R. (2013). Attachment insecurities and disordered patterns of grief. In M. Stroebe, H. Schut, & J. van den Bout (Eds.), *Complicated grief: Scientific foundations for health care professionals* (pp. 190–203). New York, NY: Routledge.

Mitchell, M. B. (2016). The family dance: Ambiguous loss, meaning making, and the psychological family in foster care. *Journal of Family Theory & Review, 8*(3), 360–372. doi:10.1111/jftr.12151

Neimeyer, R. A. (2012). The (half) truth about grief. *Illness, Crisis, & Loss, 20*(4), 389–395. doi:10.2190/il.20.4.g

Parkes, C. M. (1971). Psycho-social transitions: A field for study. *Social Science & Medicine, 5(2)*, 101–115. doi:10.1016/0037-7856(71)90091-6

Parkes, C. M. (1975). What becomes of redundant world models? A contribution to the study of adaptation to change. *British Journal of Medical Psychology, 48*, 131–137. doi:10.1111/j.2044-8341.1975.tb02315.x

Parkes, C. M. (2002). Lessons from the past, visions for the future. *Death Studies 26*(5), 367–385. doi:10.1080/07481180290087366

Schut, H. (2010). Grief counseling efficacy: Have we learned enough? *Bereavement Care, 29(*1), 8–9. doi:10.1080/02682620903560817

Schut, H., & Stroebe, M. (2011). Challenges in evaluating adult bereavement services. *Bereavement Care, 30*(1), 5–9. doi:10.1080/02682621.2011.555240

Stroebe, M. S. (2002). Paving the way: From early attachment theory to contemporary bereavement research. *Mortality, 7*(2), 127–138. doi:10.1080/13576270220136267

Stroebe, M., Hansson, R. O., Stroebe, W., & Schut, H. (2001). Future directions for bereavement research. In M. S. Stroebe, R. O. Hansson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement research: Consequences, coping, and care* (pp. 741–766). Washington, DC: American Psychological Association.

Weenolsen, P. (1988). *Transcendence of loss over the life span*. New York, NY: Hemisphere.

Wolfelt, A. (2005). *Companioning the bereaved: A soulful guide for counselors and caregivers*. San Jose, CA: Companion Press.

Worden, W. R. (2018). *Grief counseling and grief therapy* (5th ed.). New York, NY: Springer Publishing Company.

CHAPTER 3

THEORIES AND ORIENTATION TO BEREAVEMENT

LEARNING OBJECTIVES

1. Define grief and describe common factors that affect the grief response.
2. Describe the main features of attachment theory and the relationship between attachment and grief.
3. Explain the Dual Process Model of grief and the overlap of attachment style onto this model.
4. Review current theories and models of the grieving process.
5. Discuss the process of meaning making after significant losses.

INTRODUCTION

In this chapter, we briefly look at models and theories of bereavement that help us to understand the grieving process a little better. Models and theories serve as descriptors for us and for our clients. They help us to "map out" what may occur after a significant loss in someone's life. They may also give us a framework for knowledge and insight into the various ways in which people experience grief and adapt to loss, or how bereavement professionals have observed grief responses in their clients. Research-based theories and models may ground our clinical practice in empirical knowledge, and descriptive models may give us practical insights from the anecdotal accounts of other clinicians who do similar work. It is important

to keep in mind that no one theory or model can fully encompass all of the manifestations, expressions, and experiences of grief and loss. However, becoming well versed in these descriptions may be of benefit to both the counselor and the client.

Before we embark on our exploration of various theories and models of bereavement, it is important to keep some thoughts in mind. First, although loss and grief are universal experiences, shared by all human beings, the grieving process is highly diverse and variable among individuals. Second, grief is not just an emotional response. Many individuals experience grief in ways that are dominated not by their emotions but by cognitive processes, somatic (bodily) changes, spiritual challenges, and/or changes in their social circles and patterns. In addition, a person who is grieving a loss exists within a broader social and cultural context, and we do a great disservice to individuals by assuming that they exist as separate entities from these spheres of existence. Finally, we tend to think in terms of adapting to losses and integrating these experiences into our assumptive world rather than focusing on "recovery" from grief or "overcoming" a loss, which tend to oversimplify the way loss and grief shape and change us in often very significant ways.

DEFINITIONS AND ANALOGIES

For the purposes of this book and our study of bereavement, *loss* can be defined as an experience where there is a change in circumstance, perception, or experience where it would be impossible to return to the way things were before. A loss can be death related or nondeath related, with the key element being the inability to return to some aspect of life we have cherished or valued that is no longer possible. An image that helps to describe a loss experience is that of a shattered pane of glass. While it might be possible to use glue to put the broken pieces of glass back into place, the glass that once existed as a whole, single pane will never exist in that form again. And so it is with a significant loss experience. There are times when you will not be able to undo what has happened, unknow what you now know, unsee what you have seen, and you will no longer be naïve to an experience that you have now endured. *Grief* is defined simply as the normal and natural response to loss. However, the use of the word "normal" implies that there is a defined expectation of what normal grief should look like, and that is far from true. Although grief is a universal experience that is shared by all human beings, the actual grief response in each individual is very unique, and the expression of grief can vary greatly from one person to another. Many factors, such as personality traits, the presence of concurrent stressors and previous losses, the nature of the loss(es), and the social expectations that are present, have a great deal of influence in shaping the course of grief for an individual, and these are discussed in later chapters.

Sometimes, analogies are helpful to share with bereaved clients to help point out the highly individual and unique nature of grief, especially when these individuals are told by others that somehow their grief response is abnormal.

- The grief response can be compared to snowflakes, where we can look at the flakes and identify them as "snow," but when you look closer, the crystalline structure of each individual flake is highly unique and there are an infinite number of patterns that can be found.

- The grief response is like a fingerprint; all human beings have fingerprints, but each person is identified by a unique fingerprint pattern that is unlike anyone else's.
- A significant loss can be seen like a deep wound that will heal with proper care and attention. After a deep wound heals, there is usually a scar in its place. So, although the "wound" is healed, the skin is never the same as it was before. (Another aspect of this analogy is that scar tissue tends to be thicker and stronger than the skin surrounding it.)

ATTACHMENT AND THE GRIEF RESPONSE

As we discussed earlier, a key aspect of bereavement theory is the concept of attachment. In humans, attachment is based on our most deeply rooted needs for safety and security (Bowlby, 1969, 1973). Attachment bonds exist at a level in the human experience that is usually not in a person's conscious awareness (Parkes & Weiss, 1983). When we speak of attachment in this context, we mean something more than a relational bond. Attachment relationships are linked to our primary, instinctual need to be close to significant others in order to feel safe and to feel a sense of "anchoring" in our world. In infants, the attachment system is formed around the primary caregiver who is present to meet the basic needs of the infant and who responds to the infant's cries and beginning attempts at social interaction. Later, we form attachments to individuals who tend to be closest to us, or to whom there is significance identified for us. It is important to note that the presence of an attachment bond in a relationship is not necessarily dependent on the quality of the relationship or the personality or temperament of the individuals involved in the attachment bond.

Attachment in humans was first described by John Bowlby, a psychoanalytically trained psychiatrist who worked with young children in postwar England. In his position at the Tavistock Clinic, he observed children who had been separated from their parents (their primary attachment figures), and he made note of some commonalities in the responses of these children, which he termed "separation distress." Bowlby was also influenced by the work of Hinde (1992), who, like Harlow (1961), studied the effects of infant–mother bonding in rhesus monkeys. Bowlby noted that in the works of both researchers, there were comparable behaviors demonstrated by primates that were separated from their mothers and human infants who were separated from their human mothers. He termed these consistent behaviors "attachment behaviors" and suggested that their function was to ensure that the primary caregiver stayed within close proximity to the needy, helpless infant in both species (Cassidy, 1999).

Bowlby later postulated that attachment between infants and their mothers is an ethologically based[1] construct, which serves to ensure the protection and survival of the infant. Thus, attachment theory was initially born as a merging of the psychoanalytic school of thinking

[1] Ethology is concerned with the adaptive, or survival, value of behavior and its evolutionary history. Ethology emphasizes the genetic and biological roots of development; thus, attachment is seen as an instinctual drive in humans and most mammals (Hinde, 1992).

and ethology, the study of animal behavior. Attachment was defined as an instinctually mediated response of an infant to its mother, and this response is delineated in the infant's developing mind through object representation and maintained through the attachment behaviors (Bretherton, 1992). Bowlby's later work, which is now known as *attachment theory*, became an eclectic model that incorporated elements of psychoanalysis, ethology, experimental psychology, learning theory, and family systems to describe the psychological and emotional development of the child.

Colin Murray Parkes, a psychiatrist based in London, United Kingdom, worked at the Tavistock Clinic with John Bowlby. He postulated that the attachment behaviors observed in infants upon separation from their mothers were the same behaviors that grieving individuals display upon the loss of a loved one through death (Parkes & Weiss, 1983). Parkes (1996) conducted extensive longitudinal research with older widows, documenting their behaviors, thoughts, and feelings after the death of their spouses. He found common behaviors between the separated infants in Bowlby's research and the widows in his own studies. Examples of these common behaviors were searching, pining, and protest upon the disappearance/loss of the attachment figure. Weiss (1975) explored attachment behaviors in the situation of divorce and obtained similar findings.

In addition to comparisons between the separation of infants from their mothers and the separation of adults from attachment figures through death, further studies examined the attachment behaviors of adults in various relationships (Ravitz, Maunder, Hunter, Sthankiya, & Lancee, 2010). The role of attachment in adult relationships has now been explored in longitudinal studies (Fraley, Roisman, Booth-LaForce, Owen, & Holland, 2013). Stable patterns of attachment behavior in children up to the age of 10 were documented by Sroufe, Egeland, and Kreutzer (1990). Clulow (2012) examined the identification of adult attachment styles with specific interactions in married couples, concluding that there are significant correlations between attachment security and marital quality. Simpson and Rholes (2012) explored the role of attachment style to adult intimate relationships. These authors stated that adults demonstrate the same types of attachment style in their current relationships that were originally present when they were much younger. Thus, their premise was that adult coping strategies and behaviors in intimate relationships are governed by attachment style, as determined by childhood attachment experiences.

The "take home" messages for this discussion are understanding that:

- Grief is part of an instinctually mediated response that is based on our attachment system. Our attachment system typically exists outside of our conscious awareness unless it is threatened.
- The loss of an attachment figure will be experienced as a threat to most individuals.
- An attachment relationship is one that is significant, but the attachment bond itself is not necessarily dependent on the quality of the relationship. Infants form attachments to mothers who are not attentive; however, the *quality* of the attachment bond that is formed will most certainly be affected by the interaction between the infant and mother.

- Attachment relationships are present throughout life and do not only involve parental figures from early life and development. That being said, patterns of attachment style/orientation that are established early in life tend to continue in similar ways in close relationships through adulthood.

An additional perspective is to view grief as a wound to our attachment system; as a result, attachment plays a foundational part in our experience of grief. Perhaps this is why the presence of attuned support is such a pivotal aspect of how we grieve. Bowlby (2005) viewed bereavement as a time when attachment needs are intensified. As a result, the relationship that a client has with the counselor is particularly important. The therapeutic relationship is often seen as the most important element of the counseling process. Kosminsky and Jordan (2016) emphasize the necessity of flexible accommodation to the relational/attachment needs of the client for the client to be able to navigate through the grieving process. Attachment is described as the primary mediator in the capacity to tolerate intense emotions and the distress that often accompany the significant losses in our lives. In addition, the counseling relationship can provide a secure base from which clients can venture into emotionally laden territory that they might otherwise avoid (van Wielink, Wilhelm, & van Geelen-Merks, 2019). This anchoring may foster emotion regulation, distress tolerance, and a place of safety within a time when the client's world has been shattered by loss.

THE DUAL PROCESS MODEL OF GRIEF

Research by Stroebe (2002) and Stroebe, Schut, and Stroebe (2005) combined the work of all of the researchers in the area of attachment to acknowledge (a) the role of attachment in grief and bereavement, (b) the presence of consistency in adult attachment styles related to childhood attachment style, and (c) the specific coping strategies and appropriate expectations and interventions for grieving adults based on identified attachment patterns. These authors proposed the *dual process model* of bereavement, which allows for an understanding of diverse responses to separation and loss by examining the underlying attachment issues that are present in grieving individuals. The dual process model (Figure 3.1) posits that bereaved individuals will spend time in acute, active grief over the loss and its implications (loss orientation), and they *also* will spend time tending to their everyday life and returning to the world of the living that distracts them from their grief (restoration orientation).

According to Stroebe et al. (2005), individuals identified as basically secure in their attachment style will demonstrate a more balanced approach to emotion regulation in grief and will tend to "oscillate" more evenly between loss orientation (overt grief) and restoration orientation (daily functionality and activities of daily living). Individuals who display avoidant attachment patterns will tend to focus more on restoration orientation and will restrict their expressions of distress and avoid seeking emotional support. Individuals whose attachment style is anxious–ambivalent will tend to focus more on loss orientation, and they are more likely to become preoccupied by their grief and will tend to ruminate more about the deceased individual. Individuals who display patterns of disorganized attachment tend to present in ways that are similar to individuals who have suffered from traumatic experiences

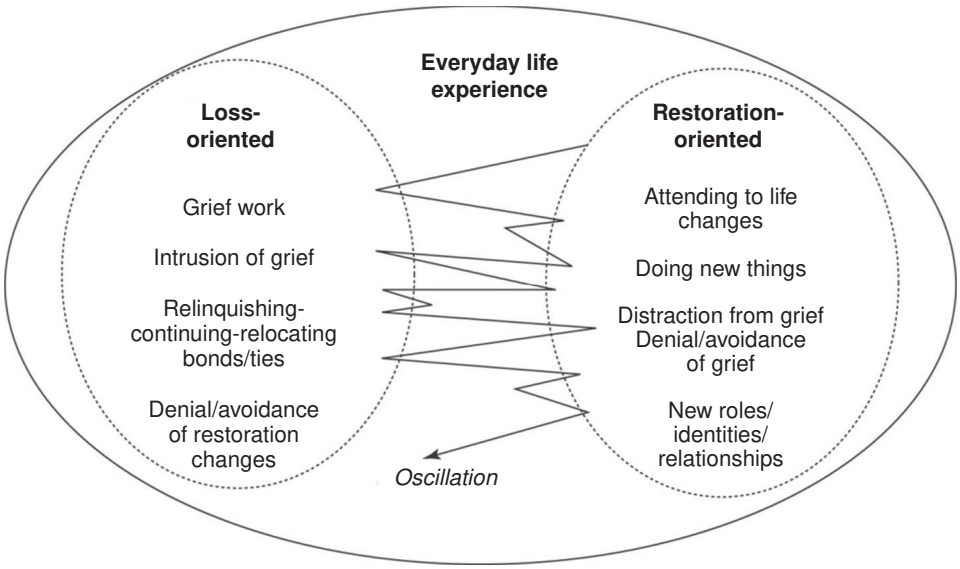

FIGURE 3.1 The Dual Process Model of bereavement.

Source: From Stroebe, M., Schut, H., & Stroebe, W. (2005). Attachment in coping with bereavement: A theoretical integration. *Review of General Psychology, 9*(1), 48–66. doi:10.1037/1089-2680.9.1.48

and have difficulty integrating their experiences into a relational context. The conclusion of these authors is that attachment style influences the course, intensity, and pattern of grieving after the death of an attachment figure (Table 3.1).

The use of attachment theory with its terminology, background, and associated predictions offers some interesting possibilities. For instance, when the concept of attachment theory as an ethological construct is applied to the grieving process, there is an implication that the grieving process itself is an adaptive mechanism that also functions to ensure the survival of the individual after the loss of a significant attachment figure. Grief, as we know it, may thus be a response that is instinctually programmed into us as a result of natural selection. If this statement is true, then the grieving process itself must be allowed to unfold without hindrance for the assistance in adaptation to significant losses that grief may afford to the bereaved individual. The grieving response would also be seen as separate from the quality of the relationship to the deceased individual, and more of an extension of the attachment pattern of the remaining bereaved survivor, although certainly the quality of the relationship would likely have an impact on the grief process.

TWO-TRACK MODEL AND THE CONTINUING BONDS THEORY

In research and clinical work with bereaved parents in Chicago, and later in Israel, Rubin, Malkinson, and Witztum (2012) proposed that the response to loss can be more effectively assessed when *both* the behavioral–psychological functioning of an individual and the internalized relationship to the deceased are considered. This model addresses grief

TABLE 3.1 **Attachment Style and the Experience of Grief**

ATTACHMENT STYLE	EARLY EXPERIENCES	ADULT EXPERIENCES	GRIEF RESPONSE
Secure	Home life felt generally safe; needs were mostly met by parents or significant adults.	Able to create meaningful relationships that are reciprocal in nature; empathetic and able to set healthy boundaries.	Able to navigate through grief with supports and normal coping mechanisms.
Avoidant	Often experienced parent or significant adults as unavailable, dismissive, or rejecting. Learned to be self-sufficient and independent early.	Tends to avoid closeness or emotional connection; often comes across as critical, rigid, resistant, or intolerant. Compulsive self-reliance and somatization common.	Often uses distraction or busyness to cope and avoid emotional pain; may focus on analyzing details and gets stuck asking questions. Usually uncomfortable with feeling vocabulary.
Ambivalent	Parental figures or significant adults inconsistent or intrusive. Availability and attention mixed with periods of rejection or violation of normal boundaries.	Tends to be anxious and insecure; often ruminates about relationships and may become heavily dependent and "needy" of others.	Rumination about loss; loss experience takes over all aspects of life and ability to cope and function. Grief may continue unrelentingly.
Disorganized	History of trauma, abuse, or significant lack of safety in childhood. Parental figures/significant adults often are frightening to child.	Ongoing, chronic vulnerability present, often accompanied by personality, psychiatric, and substance abuse disorders; tend to dissociate or "go blank" when triggered by perceived threats.	Loss often triggers previous trauma and any psychiatric or substance abuse disorders; often "seesaw" between wanting support and needing distance.

through a multidimensional lens, exploring both (a) the bereaved individuals' ability to function and navigate the world after a significant loss (track I) and (b) the tendency of bereaved individuals to continue in an ongoing and meaningful, but intangible, relationship with a deceased individual over long periods of time, and even indefinitely (track II; Rubin, Malkinson, & Witztum, 2011). Rubin and colleagues strongly urge clinicians working with bereaved individuals to identify which "track" appears to be more problematic or prominent for the bereaved person and to focus on that aspect of the grief in the support that is offered. For example, if a widow describes a great deal of stress as a result of the financial matters that were associated with her husband's estate, the counselor would serve her more

readily by focusing on these issues (track I) rather than engaging in therapeutic work that is focused more on the memories and feelings associated with her deceased husband at that time (track II).

When first describing the two-track model of bereavement, Rubin emphasized that the relationship with the deceased person often remains a focal point for the rest of the lifetime of the bereaved individual. In tandem with this model, Klass, Silverman, and Nickman (1996) described what they termed the bereaved's *continuing bond* with the deceased individual. It was clear from the data presented in these authors' research that the bereaved maintains a link with the deceased that leads to the construction of a new relationship with him or her. This relationship continues and changes over time, typically providing the bereaved with comfort and solace. Most mourners struggle with their need to find a place for the deceased in their lives and are often embarrassed to talk about their ongoing relationship with a person who has died, afraid of being perceived as having something wrong with them. The idea of a continuing, ongoing relationship with a deceased individual was a very novel proposition after so much of popular thought (based on Freud's writings) had been focused on the need to let go of the deceased loved one in order to move forward in life. The work of these researchers actually demonstrated that individuals who were more highly functional and had adapted better after a significant loss were those who were able to maintain a sense of connection (a continuing bond) with their deceased loved ones. Obviously, there will be some complications to this process, as when the relationship with the deceased was difficult or complicated (Field & Wogrin, 2011), or if the bereaved individual displays symptoms of prolonged grief disorder rather than developing an adaptive continuing bond with the deceased individual (Prigerson et al., 2009), which is discussed further in Chapter 10, When Grief Goes Awry.

The Continuing Bonds Theory has very important implications for grief counselors. First is that bereaved individuals may be well served to find ways to reconnect to their deceased loved one in ways that are meaningful. In the course of clinical practice, you will hear a myriad of stories about how bereaved individuals "connect" with their deceased loved ones—through having conversations with them, journaling to them, dreaming about them, feeling a sense of guidance from them or a sense of their presence with them in an abiding way, or finding "signs" that they believe are from the deceased individual to them. We have had clients tell us about hearing significant songs on the radio at opportune times, birds appearing on their porch, seeing patterns in carpeting, electronic devices turning on by themselves, dream encounters and symbols seen in dreams, hearing a deceased loved one's voice, feeling a brush of air, finding something that was lost a long time ago now being found in an obvious or significant place, and numerous other ways that are experienced by bereaved individuals as a form of connection with their deceased loved ones. The implication here is clear, as Morrie instructs Mitch in *Tuesdays With Morrie*: "Death may end a life, but not a relationship" (Albom, 1997, p. 174). It is very important as counselors to normalize this aspect of grief and to recognize its significance for the bereaved individual's process. It would make sense that if a loss creates a wound to our attachment system, then the ability to reconnect with a deceased loved one in a real but intangible way might provide a form of healing to the wounded attachment system (Practice Example 3.1).

PRACTICE EXAMPLE 3.1

FOSTERING A CONTINUING BOND

John's 14-year-old daughter was diagnosed with acute leukemia. She underwent aggressive treatment, which was unsuccessful, and she died within a few months of the diagnosis. John sought assistance with a grief counselor at the suggestion of his minister several months after his daughter died.

In his first counseling session, John admitted that he felt ambivalent about wanting to feel better, as he saw his grief as a way to remain connected to his daughter. Many people had given him advice about learning to "let go" so that he could be more functional in his everyday life. The counselor gently suggested that just as John felt that part of him died when his daughter died, perhaps a part of his daughter continued to live with him. They then began to work on finding ways to "invite" his daughter back into his life through letters that he wrote to her, journaling, and sometimes in conversations that he would have with her at her gravesite.

Gradually, John began to feel that his daughter was with him, sometimes as a presence, or a thought that would come to his mind, or an overall feeling that she knew how much he loved her. At one point, he had a powerful dream about her where she was happy and healthy, which was comforting to him. John told his counselor that it had never occurred to him that he didn't have to "let her go" in order to continue living his life.

In our clinical practices, we often notice that bereaved individuals seek out support at a time when they have lost the physical and tangible presence of their loved one, and have not yet been able to establish a link to their deceased loved one in an intangible way. There are obviously many other factors that contribute to a decision to seek support after a significant loss, but this is one area where we actively work with clients to assure them of the normalcy of their experiences, and to let them know that in some way, they may need to find a way to "hold on" to their loved one in order to "move on."

This is a good time to bring up the controversy that surrounds what is known as the "grief work hypothesis." This belief about grief was that it was necessary for bereaved individuals to talk about their loss and to express emotions in order to work through their grief, and that once painful emotions were worked through, grieving persons could resolve their feelings of grief (Stroebe et al., 2005). We now realize that not everyone grieves through feeling and expressing emotion, and, in fact, insisting that someone grieve in this way when it is not that person's propensity may induce more harm than good. The grief work hypothesis also posited that the goal of grief work was to eventually let go of the deceased person and relinquish the relationship to that person in order to move forward in life. We now know from the previous discussion that this "letting go" is not supported as the way that many bereaved individuals typically move forward in their lives after losing a loved one.

STAGES, PHASES, AND TASKS

If you were to ask the average person in casual conversation about grief and what it looks like, you would most likely be quoted *The Stages of Grief*, as set out by Kübler-Ross (1969). This book was a seminal piece of work that openly addressed the needs and feelings of dying individuals in a society that had become increasingly death denying. In her book, Kübler-Ross identified five stages in facing death and in being confronted with a significant loss: (a) denial, (b) anger, (c) bargaining, (d) depression, and (e) acceptance. Earlier proponents of this model suggested that the stages occurred in a more stepwise and linear fashion. However, Kübler-Ross later stated that these stages were more like descriptors rather than a prescription to follow, and an individual could fluctuate from one to another readily. Although these stages have been heartily embraced in popular (and academic) thinking, it is important to recognize the fact that the five stages were never actually empirically proven to occur in dying or bereaved individuals (Maciejewski, Zhang, Block, & Prigerson, 2007). The primary usefulness of this theory has been exactly what it did—promote a springboard for beginning discussions about this topic in a society that was generally avoidant and thus relatively uneducated about death and grief (Corr, Corr, & Doka, 2019).

There are also many theories of bereavement that suggest bereaved individuals go through "phases" in the grieving process. Bowlby (1982) described the "processes of mourning," in which he listed first yearning and searching, then disorganization and despair, followed by reorganization. Parkes (1996) later expanded on these phases by adding an additional phase of numbness at the beginning of grief. Sanders (1999) proposed her five phases of the grief process as (a) shock, (b) awareness of loss, (c) conservation/withdrawal, (d) healing, and (e) renewal. Rando (1993) put forth her description of the process of the "six Rs" of bereavement as (a) recognize the loss, (b) react to what has happened, (c) recollect and review memories associated with the loss, (d) relinquish the world as it once was, (e) readjust to life after the loss, and (f) reinvest and reenter the world. It is apparent that there are many ways of describing the grief process and many different perspectives from which these descriptions are drawn.

Worden (1991, 2018) developed a task-based model of grief, in which the grieving process is compared to the developmental tasks that individuals must master in order to move forward in life. These tasks are as follows:

1. *Acknowledge the reality of the loss.* The mourner needs to cease denying that the death has occurred and come to recognize that the loved person is truly dead and cannot return to life. The mourner needs to examine and assess the true nature of the loss and neither minimize nor exaggerate it.
2. *Process the pain of grief.* Sadness, despondency, anger, fatigue, and distress are all normal responses to the death of a loved person; people should be encouraged to experience these feelings in appropriate and supported ways, so that they do not carry them throughout their lives.
3. *Adjust to a world in which the deceased person is missing.* A full awareness of the loss of all of the roles performed by the deceased in the life of the mourner may

take some time to realize. Challenges to grow are presented to the bereaved as they assume new roles and begin to redefine themselves, often by learning new coping skills or by refocusing attention on other people and activities.

4. *To find a way to remember the deceased while embarking on the rest of one's journey through life.* It is important for the bereaved individual to find an appropriate place for the deceased person to occupy in a spiritual or nontangible sense. This task involves creating and sustaining an appropriate relationship with the deceased based on an ongoing emotional connection and memory, so that the person will never be wholly lost to them. This task was revised by Worden (2018) over the earlier versions of his model, and it is now very similar to the process that is described in the Continuing Bonds Theory discussed earlier.

Each description of phases, stages, and tasks may point to important aspects of the grieving process and may provide some realistic expectations for bereaved individuals, provided the phases and stages are not seen as necessary scripts for all bereaved individuals, or as a "map" of how grief *should* be for everyone. However, the downside of these models is that they tend to be seen as placing the grieving process in a linear flow (even if not intended by the model's originators), and there seems to be an emphasis on the sameness of the grief experience by all bereaved individuals, rather than an appreciation of the diversity that is present within grief. It is very important to remember that no individual's grief experience will neatly fit into a single model, because there is much variation in how losses are perceived and also in how grief is expressed and worked through.

MEANING RECONSTRUCTION AND GROWTH

The experience of a significant loss will often pose a strong challenge to an individual's sense of equilibrium. Coping, healing, and accommodation after such experiences are part of a greater process that individuals undertake in an effort to "relearn" their world (Attig, 2011) in light of confrontation with a reality that does not match one's expectations or assumptions. As we discussed in an earlier section, how we see the world (and our lives) as meaningful is based on the assumptions we have formulated about the world from our earlier life experiences and interactions. A significant loss can shatter the assumptions we have about how the world should be, and we can experience a high degree of distress when we cannot make sense of what has happened, or when we no longer feel a sense of safety or equilibrium in our lives.

Challenges to one's assumptive world are usually met through the process of *assimilation* (where events are interpreted through the lens of the assumptive world satisfactorily) or *accommodation* (where assumptions are gradually revised somewhat in order to explain a new set of experiences). However, there are times when something may happen that defies belief, or overwhelms one's ability to integrate the experience with any known way of how the world should work. The phrase "loss of the assumptive world" is used when a negative life event has challenged one's basic assumptions about the world in a way that these assumptions no longer make sense, and there is no acceptable alternate way of seeing the world that will reconcile previously held assumptions and beliefs with a new reality that does not

fit these assumptions (Attig, 2011; Janoff-Bulman, 1992; Harris, in press (a); Parkes, 1971). Pre-existing assumptions that are no longer viable in describing the world and one's inner working models or schemata must somehow be reworked in order for the person to feel safe in the world again, but this process can be very difficult. Janoff-Bulman (1992) uses the term "shattered assumptions" to describe when a negative life event overwhelms an individual's core assumptions so completely that reconciliation of reality with one's existing assumptive world is not possible.

Tedeschi and Calhoun (2004) speak of "seismic life events" that "violate" an individual's schemata about how the world should work. It is important to note in this discussion that the individual's subjective appraisal process is very important. How one interprets and perceives an event determines the significance of its impact on the assumptive world. Meaning making is the focus of many authors who explore responses to trauma, loss, and negative life events. Making sense of an event involves a process of attempts to reconcile the occurrence of the event with one's working models of the assumptive world (Davis & Nolen-Hoeksema, 2001; Harris, in press (a); Neimeyer & Krawchuk, in press). Frankl (1963), a concentration camp survivor and the developer of logotherapy, asserted that one can survive all forms of harm and harshness by finding meaning and purpose through what one has experienced. By choosing to reflect on the possibility of something positive occurring after a negative life event, individuals may be able to assign meaning to their experience, which helps to rebuild the foundation for one's assumptive world that is once again relevant and coherent. Janoff-Bulman (2004) describes the existential issues that must also be addressed and assigned meaning after experiencing a critical event. Survivors are interested not only in why an event happened but also in why an event happened *to them* in particular. She cites Sartre (1966) in her discussion of existential issues, stating that individuals must create their own meanings through a deliberate choice in the face of meaninglessness. She concludes that we may not be able to prevent misfortune, but we have the ability to create lives of value in the wake of misfortune.

Searching for meaning after significant loss appears to be an almost universal phenomenon and an important part of the grieving process (Davis, 2001; Gillies, Neimeyer, & Milman, 2014; Park, 2010). The trauma, shock, and anguish of a major loss assault an individual's fundamental assumptions about the world. Meaning making can result from reinterpretation of negative events as opportunities to learn new lessons about one's self or life in general, as a means of helping others, or contributing to society in some way that is related to the experience that occurred (such as the formation of an advocacy group or efforts to help others in similar situations). Perhaps this description offers an explanation as to why many bereaved individuals undertake the founding of trusts, advocacy organizations, and public awareness groups. Mothers Against Drunk Driving (MADD) is one example of how bereaved parents made meaning by educating the public and advocating for stricter enforcement of laws related to driving under the influence of substances after they experienced the loss of their children from accidents that involved drinking and driving (Practice Example 3.2).

Neimeyer (2001) and Neimeyer et al. (2002) discuss the social constructivist view of meaning making through the use of narrative reframing in individuals who have experienced significant losses. In these writings, the description of the "master narrative," which is an

PRACTICE EXAMPLE 3.2

VALIDATING GRIEF AND FINDING MEANING AFTER LOSS

Denesha and her husband were elated to find out that they were going to have a baby. They had been trying to conceive for over a year when the pregnancy test came back positive. Denesha's pregnancy progressed normally without any concerns. However, just before the end of her first trimester, she began bleeding. Tests confirmed that she had miscarried. Denesha was crushed. She tried to talk with people about her loss, but most dismissed her grief because she never "held" her baby in her arms, and it was assumed that she could readily get pregnant again. Nobody seemed to understand how much she wanted *this* baby, and that she already felt that she *knew* this baby that had spent these past several months inside her body.

Denesha began reading about miscarriage and pregnancy loss. She realized how many women go through this painful experience, and she knew that most would never have their grief validated by others. Through her doctor's office, she connected with other women who had lost their babies and had indicated they wanted to speak with others about their experience. Together, they supported each other in their grief. Finally, they decided to start a project for women who never got to hold their babies in their arms. They created "in my heart forever" memory boxes for women who experienced miscarriages, where they could store ultrasound pictures, keepsakes, and write in a special journal to the baby that they lost.

While Denesha continued to feel deep grief over the loss of her baby, she was comforted in knowing that other women who had a similar experience would have their grief validated rather than dismissed through the gift of the memory box project that she had created.

"understanding of one's life and experiences, along with meanings attached to these" (p. 263), is very similar to earlier descriptions of the assumptive world by other writers. Neimeyer states that significant losses disrupt taken-for-granted narratives and strain the assumptions that once sustained them. Individuals must find ways to make meaning of the life events that have been disruptive through a "reweaving" process that incorporates the new experiences into the existing narrative of one's life so that it is once again coherent and sustaining.

Searching for meaning in what seems to be a meaningless event is how human beings attempt to re-establish a sense of order and security in the world and to minimize the high degree of vulnerability that occurs after basic assumptions are shattered. Davis, Nolen-Hoeksema, and Larson (1998) focused on two aspects of meaning in their research: meaning as the ability to find a benefit in what had happened and meaning as a way of making sense of the loss. Attig (2001) further delineates the various conceptualizations of the search for meaning by distinguishing between meaning making and meaning finding. *Meaning making* refers to the conscious and active process of reinterpreting and bringing new meaning to one's experiences, actions, and suffering, and *meaning finding* refers to becoming aware of and accepting meaning that arises spontaneously out of grief and suffering. These two processes mix together as one rebuilds the assumptive world after a significant loss.

POSTTRAUMATIC GROWTH AND RESILIENCE

Research published by Calhoun and Tedeschi (2014) suggests that there is potential for more than adjustment after exposure to "seismic" life events. These authors cite numerous instances in their research where individuals encountered tragic bereavement, catastrophic illness, violence, or political oppression, and their exposure to such events led to significant personal accounts of positive growth and development. These authors' use of the term *posttraumatic growth* describes the potential that individuals may have for transformation after exposure to trauma, highly stressful events, and crises. Growth in this sense is not a direct result of exposure to these types of events, but rather from the struggle that an individual engages in with the new reality in the aftermath of these events. Posttraumatic growth may also coincide with ongoing distress related to the negative event, because it can be viewed as both a process and an outcome, but not necessarily an acceptance of the event.

Resilience and hardiness, which are two related concepts, speak to a potential for a positive outcome after the experience of significant losses. Resilience tends to focus on an ability to go on with life after hardship and adversity (instead of being paralyzed or destroyed by it). Resilience represents more of a "return to baseline" in regard to functioning and views about life. Hardiness is a concept that describes certain individuals' innate tendencies when confronted with challenge (Harris, in press (b); Maddi, 2008; Mathews & Servaty-Seib, 2007). "Hardy" people are those who tend to anticipate that life will bring challenges and they expect to be able to develop and become stronger as they rise to meet these challenges. Individuals who experience posttraumatic growth may or may not have these characteristics, although individuals who score high on hardiness would be very likely to experience posttraumatic growth after a significant loss.

Perhaps most salient to this discussion are the aspects of posttraumatic growth, which reflect on personal strengths that are developed when some individuals face an assault on their deeply held assumptions about the world. Personal strength may include descriptions of greater self-reliance, fortitude, and self-respect. Janoff-Bulman (2004) gives an account of a client that survived a debilitating accident, who, after months of intense rehabilitation and therapy, stated, "I guess I really am strong . . . I never knew I had it in me" (p. 30). She also quotes a rape survivor who stated, "I feel stronger now. . . . I came through with my integrity—I got through those months of hell and I know myself as a strong person now" (p. 31). In these descriptions, survivors of traumatic loss events often recognize that they have gone through agony and that they have become stronger as a result of these experiences. In the backdrop of suffering, pain, and adversity, individuals may recognize the preciousness of life and be able to identify what is truly "most important" in their lives, which may not have been as easy before the experience.

CONCLUSION

Through the work of bereavement researchers, clinicians, and academics, the present-day thinking about the grieving process has been extrapolated. It is generally thought that the grief process has evolved as part of our survival instinct to enable us to integrate the experience