Therapy for grief resolution: accepted theories and new developments

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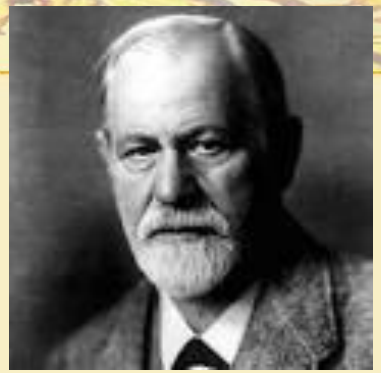
Ground rules

- Confidentiality. Things *said* stay with you.
- Professionals together, so
    i) Please ask questions.
    ii) Please share examples if you can do so ethically.
- I have to maintain responsibility for timing.
- If at any point, the session ‘presses your buttons’ feel free to take time out.

Historical perspectives



Sigmund Freud

- *Mourning and Melancholia* (1917, 1957)
- Melancholia not inevitable following bereavement.
- Grief a normal process. Melancholia in those of a ‘pathological disposition’.

Historical perspectives

Sigmund Freud

- Libido becomes bound to the lost love object. Only by breaking this bond can a person be freed from his grief. The process Freud called ‘grief work’.

Historical perspectives

Helene Deutsch

- Four bereaved patients for whom there was “a complete absence of the manifestations of mourning” (Deutsch, 1937, p. 12).
- Deutsch drew on Freudian concepts to explain her belief that these patients may have been avoiding grief, and that this avoidance was pathological.

The Cocoanut Grove Fire

Boston, 1942

1000 people were inside.

492 died, 160 were injured.

Historical perspectives

Erich Lindemann

- Boston psychiatrist and psychoanalyst Erich Lindemann treated many of the families of the victims.
- In 1944 he published a highly influential paper entitled *Symptomatology and Management of Acute Grief*.

Historical perspectives

George Engel

- In 1961 George Engel MD wrote an article which he entitled *Is grief a disease?*
- Engel listed the commonly observed symptoms of grief. If these were seen as a disabling syndrome then ‘yes’ he concluded, grief is a disease.
- If grief was seen as a disease, this validated clinical intervention

Historical perspectives

John William Worden

- From the idea of Stages of Grief, Worden developed *The Tasks of Mourning*. The various edition of his book all involve versions of ‘letting go’ of the deceased.

Worden's Task Model of Grief

Task 1 Accepting the reality of the loss,

Task 2 Experiencing the pain of grief,

Task 3 Adjusting to an environment in which the deceased is missing,

Task 4 Letting go.

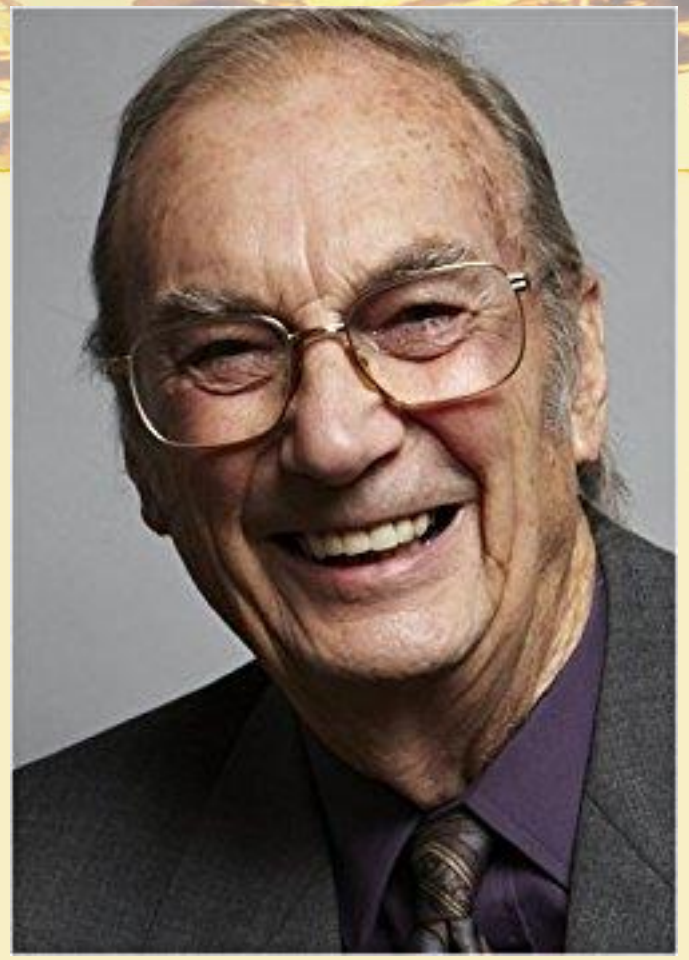
John Bowlby

Worked with Colin Murray Parkes at the Tavistock Clinic. Together they developed a four-phase model of grief:

1. Numbness
2. Yearning and searching
3. Disorganisation and despair
4. Greater or lesser degree of reorganisation.

(Bowlby & Parkes, 1970)

Parkes (2009) has since written that this phase model was theoretical, and never intended to be used prescriptively by counsellors



Bereavement counselling:
The issues for private practitioners:

1. Given appropriate reassurance, most bereaved people do not need counselling for their grief
2. Bereavement counselling has not been shown to be effective, except for the most severe cases of grief. It may also do harm
3. For some clients, there are benefits in avoiding emotions and keeping busy
4. There is no evidence that all clients need to do ‘grief work’ as part of their recovery
5. Arguably, working with a client’s grief when it is not needed and unlikely to bring benefits, is ethically analogous to a doctor prescribing antibiotics for a viral infection.

Bereavement counselling:
The issues for private practitioners:

Our challenge is to identify who we need to work with and how we go about it.

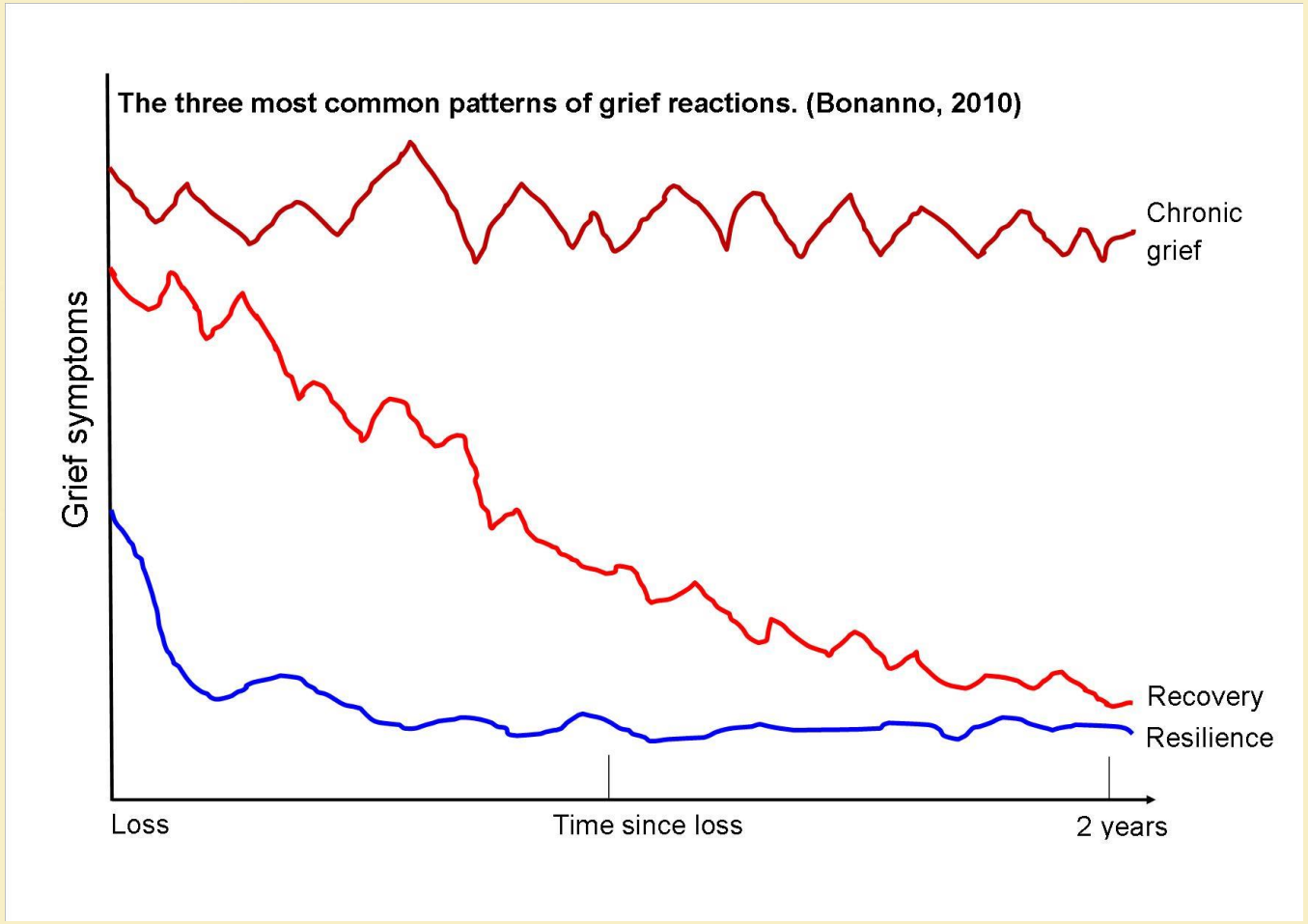
1. Given appropriate reassurance, most bereaved people do not need counselling for their grief

Chronic grief	16%
Recovery	11%
Resilience	46%
	73%

A further 18% exhibited pre-loss depression

9% were unclassified

Bonanno, Boerner & Wortman (2008)



2. Bereavement counselling has not been shown to be effective, except for the most severe cases of grief

- Schut, Stroebe, Van den Bout and Terheggen (2001), concluded that routine referral for bereavement counselling is highly unlikely to be effective. There is some evidence that counselling *may do harm*.

3. For some clients, there are benefits in avoiding emotions and keeping busy

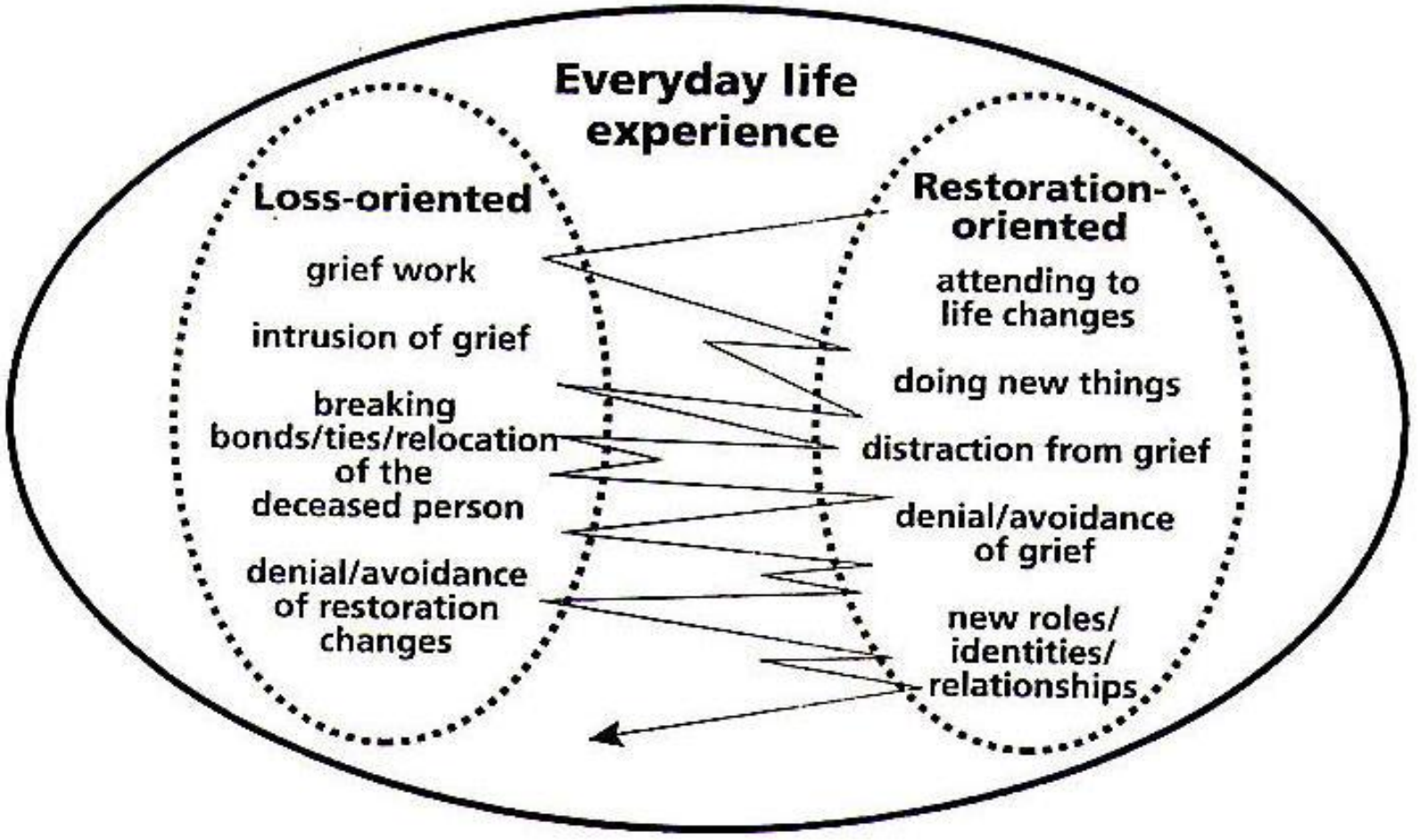


Figure 17-1. A Dual Process Model of Coping With Bereavement. Copyright Stroebe and Schut, 2001.

Does grief counselling help?

- On the other hand, they found that intervention offered to bereaved persons at risk of developing complications was found to be modestly effective, but only short term, while grief therapy for persons suffering from complicated grief was proven to be effective, also longer term (ibid).

4. There is no evidence that all clients need to do ‘grief work’ as part of their recovery

- From Freud to John Bowlby (1969) the concept of ‘grief work’ had become firmly established.
- Failure to do ‘grief work’ was seen as maladaptive, Bereavement counselling was about helping bereaved people to do their “Grief Work” (Stroebe 2002).

Doubts about ‘grief work’

- Camille Wortman and Roxane Silver (1980) questioned the validity of the concept.
- *The Myths of Coping with Loss* (Wortman & Silver, 1989). Questioned that failure to do *grief work* was indicative of a pathological condition.

Is ‘grief work’ really necessary?

Stroebe (2011) defined *Grief work* as:

“The process of emotionally confronting the reality of the loss, of going over events that occurred before and at the time of death, and of focusing on memories and working toward detachment from the deceased.”

Criticism of the ‘grief work’ hypothesis

- Margaret Stroebe, “lack of conceptual clarity” engendered by the term
- Lack of rigorous scientific evidence that *Grief Work* is effective
- “Benefits of denial” (Stroebe 2011)
- Accumulated evidence from empirical research on bereaved people in Western (c.f. Stroebe 2002) and Balinese (Wikan 1990) cultures suggests *Grief work* is neither nor beneficial

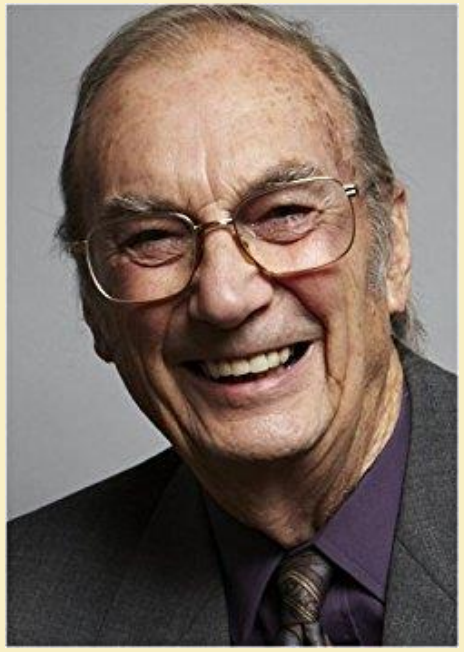
So where do we go from here?

Given the history of therapeutic interventions, and evidence we have considered so far, where do we go from here?

Exploration and appraisal of contemporary models of grief may help

Assumptive World Theory

- Conceived by Colin Murray Parkes (1971)
- Developed by Ronnie Janoff-Bulman (1992)



Finding meaning, Making sense

Thomas Attig (2001, 2011)

- Grief as the relearning of a complex world through the interplay between meaning making and meaning finding.
- The relearning involves *how to be and act*

in the world without the person we loved.

Finding meaning, Making sense

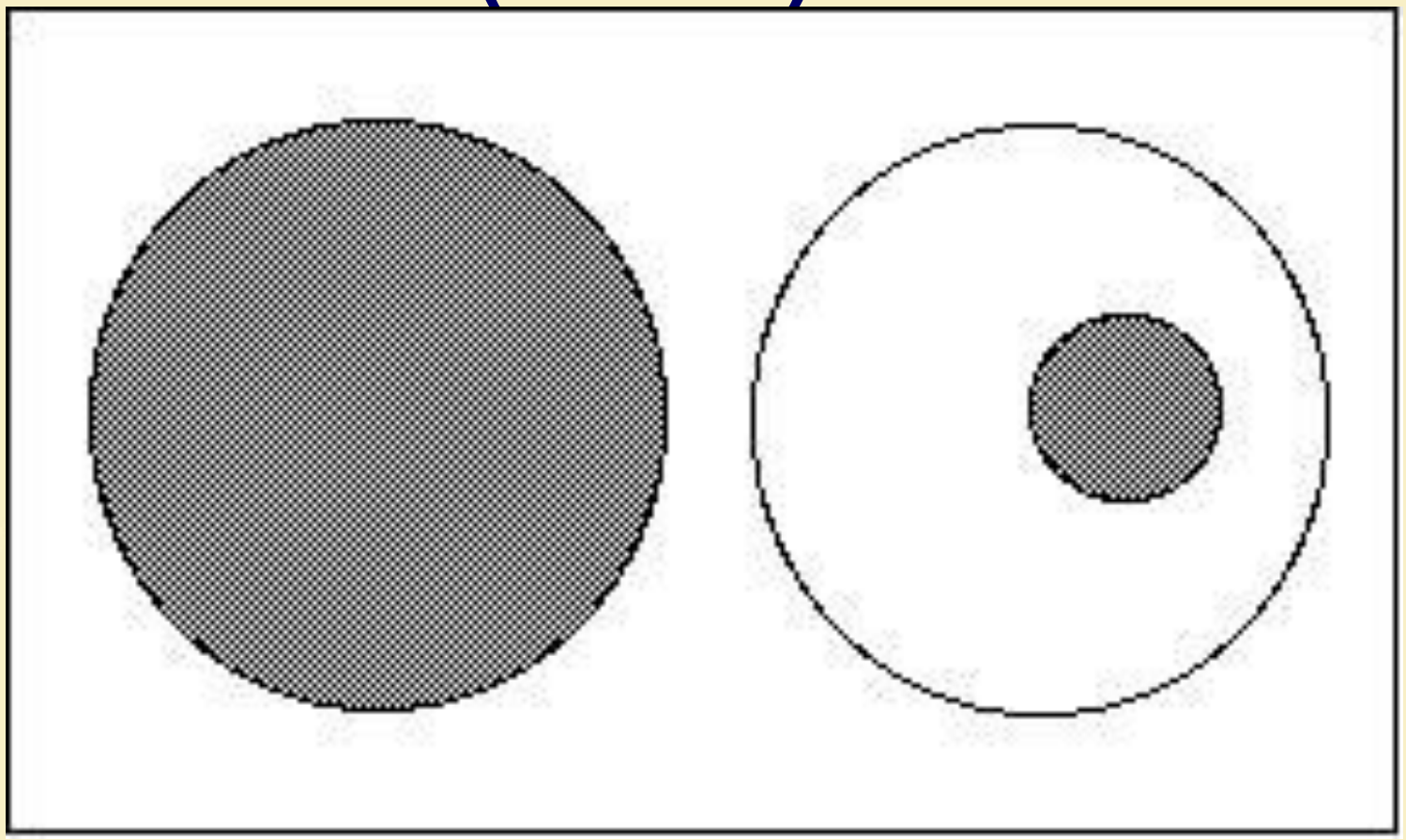
Bob Neimeyer's ideas are hugely influential

Finding meaning, Making sense

Neimeyer (2009) “The storied nature of human life”.

- Life is accompanied by a continuing self-narrative, by which we organise our understanding of day-by-day events.
- Significant loss or trauma disrupts the self-narrative process so that it may become totally disorganised.
- The grieving person may even dissociate from their self-narrative.
- Unhelpful self-narrative can lead to rumination and depression.

Grief and Growth. Lois Tonkin (2007)



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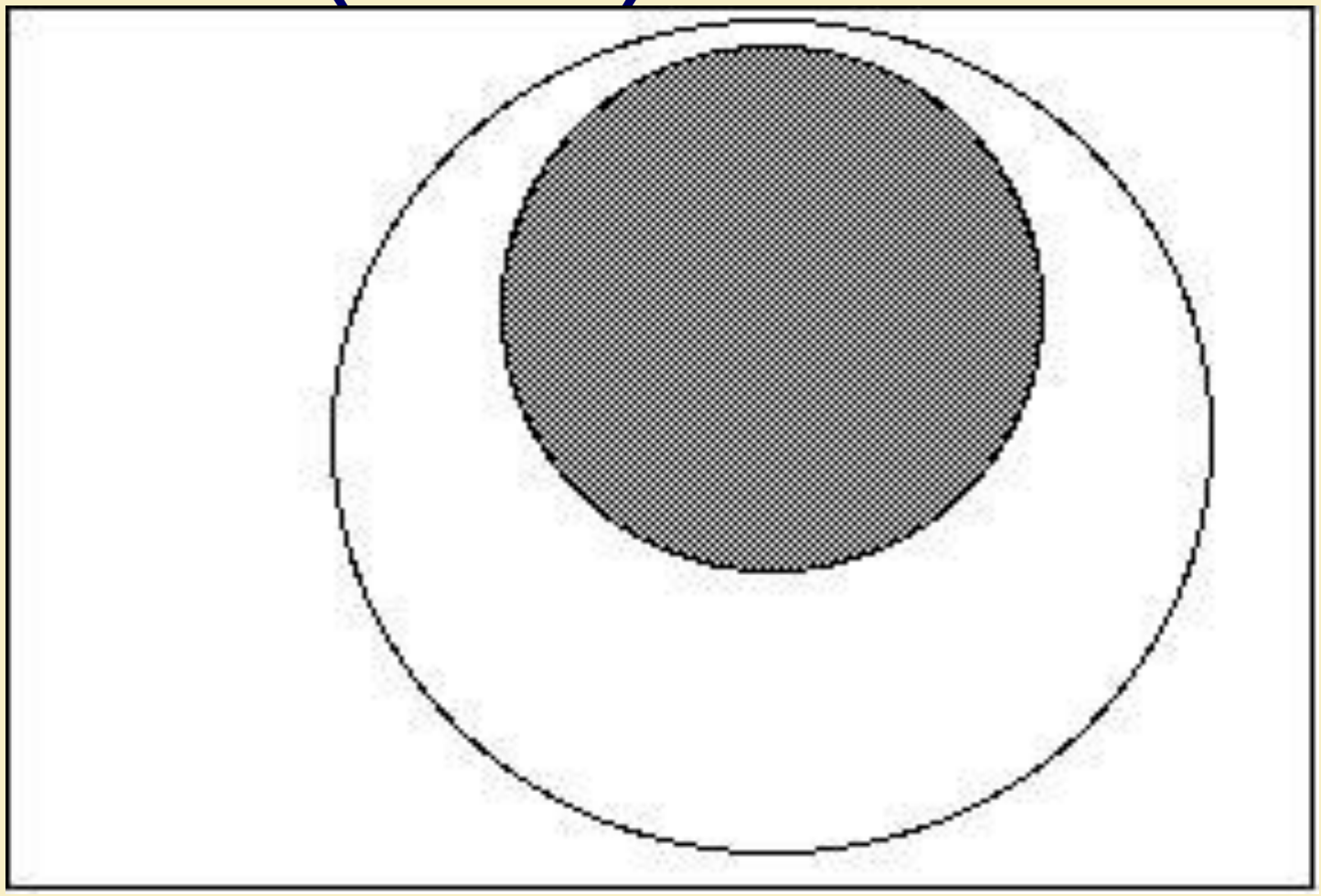

Dual Process Model

Stroebe & Schut 1999

Figure 17-1. A Dual Process Model of Coping With Bereavement. Copyright Stroebe and Schut, 2001.

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Continuing Bonds

- Klass et al (1996) suggest that, in many instances, the grief process does not end but rather undergoes ongoing adaptation and change.
- Memorializing, allowing lost loved ones to influence the present.
- Not living in the past, but recognising how past bonds can inform our present and future.

John’s research:

The research is predicated on the Meaning-making paradigm, which posits that clients make sense of their situation/environment by constructing meaning in the form of schemas, through a process of assimilation and accommodation.

Thus the role of the counsellor is to foster and encourage this process.

The role of the researcher is to observe, analyse and chart the development of meaning-making schemas.

John’s research:

The process of change is observed and charted on The Assimilation of Grief Experiences Scale, AGES (Wilson 2017), a refinement of The Assimilation of Problematic Experiences Scale, APES, devised by Bill Stiles (2001).

Assimilation of Grief Experiences Scale

Stage	
0 Warded off	Numbness from pain. Dissociation from reality of death. Reluctance to abandon the body.
1 Unwanted thoughts	Reminders of the death are avoided. Unwilling to discuss the death. Pretence that relationship remains unchanged.
2 Vague awareness	Loss of identity and purpose. Distress when discussing the death. Magical thinking.
3 Problem Statement/ clarification	Beginning of periods of respite from pain. Able to discuss the death, although usually upsetting. Rituals become less magical and more symbolic.

Assimilation of Grief Experiences Scale

Stage	
4 Understand-ing/insight	Acceptance of the pain: 'going with the flow'. Greater understanding of circumstances surrounding death. Magical thinking diminishes. The deceased is relocated symbolically.
5 Application/ working through	Comfortable oscillation between loss and restoration. Clearly discusses the death with reduced negative affect. Negotiation and renegotiation of relationship with deceased.
6 Problem solution	New meaning in life. New identity. May find meaning in the death. Fully symbolic continuing bond with deceased
7 Mastery	The bereavement is integrated into other life experiences. Resilience equips client for future losses. Open attitude to new close relationships.

John’s research:

My research points to the fact that that usually resilient experiencing problematic grief are helped if they can:

i) accept the reality of the death, including being able to talk about it in detail,

ii) make sense of the death,

iii) acquire and practice coping strategies. At best this involves oscillating between grief and restoration orientation (Distraction and avoidance can play an important part in this),

iv) accept that for a time, sadness will be ‘as good as it gets’,

John’s research:

My research points to the fact that that usually resilient experiencing problematic grief are helped if they can:

v) find meaning in a life without the deceased,

vi) anticipate (eventually) a positive future without the loved-one. This may include an individualised and creative continuing bond with the deceased: moving forward in a continuing *symbolic* relationship, rather than hankering for and clinging onto a lost past.

Complicated grief

Nothing exercises grief theorists and to some extent practitioners, more than the thorny subject of complicated grief.

The pros and cons of accepting or rejecting the concept are complex, and to a degree academic.

The concept may be helpful in some fields of health economics.

Many practitioners see the concept as medicalising grief

- Many theorists claim that its existence as an observable phenomenon has yet to be proven.

A working definition

A clinically-significant deviation from the (cultural) norm (i.e. that could be expected to pertain, according to the extremity of the particular bereavement event) in either (a) the time course or intensity of specific or general symptoms of grief and/or (b) the level of impairment in social, occupational, or other important areas of functioning.

(M.S. Stroebe, Hanson, Schut, & Stroebe, 2008, p. 7).

Features of normal, healthy grief

- sadness, shock, disbelief, pangs or waves of grief, yearning, obsessive thoughts, rumination, changed sleep patterns, confusion, difficulty in concentrating, anger, anxiety, guilt, changes in appetite, social withdrawal, vivid dreams, sensing the presence of the deceased, hallucinatory experiences.

Features of prolonged grief disorder

- sadness, shock, disbelief, pangs or waves of grief, yearning, obsessive thoughts, rumination, changed sleep patterns, confusion, difficulty in concentrating, anger, anxiety, guilt, changes in appetite, social withdrawal, vivid dreams, sensing the presence of the deceased, hallucinatory experiences.
- Lasting more than 6 months

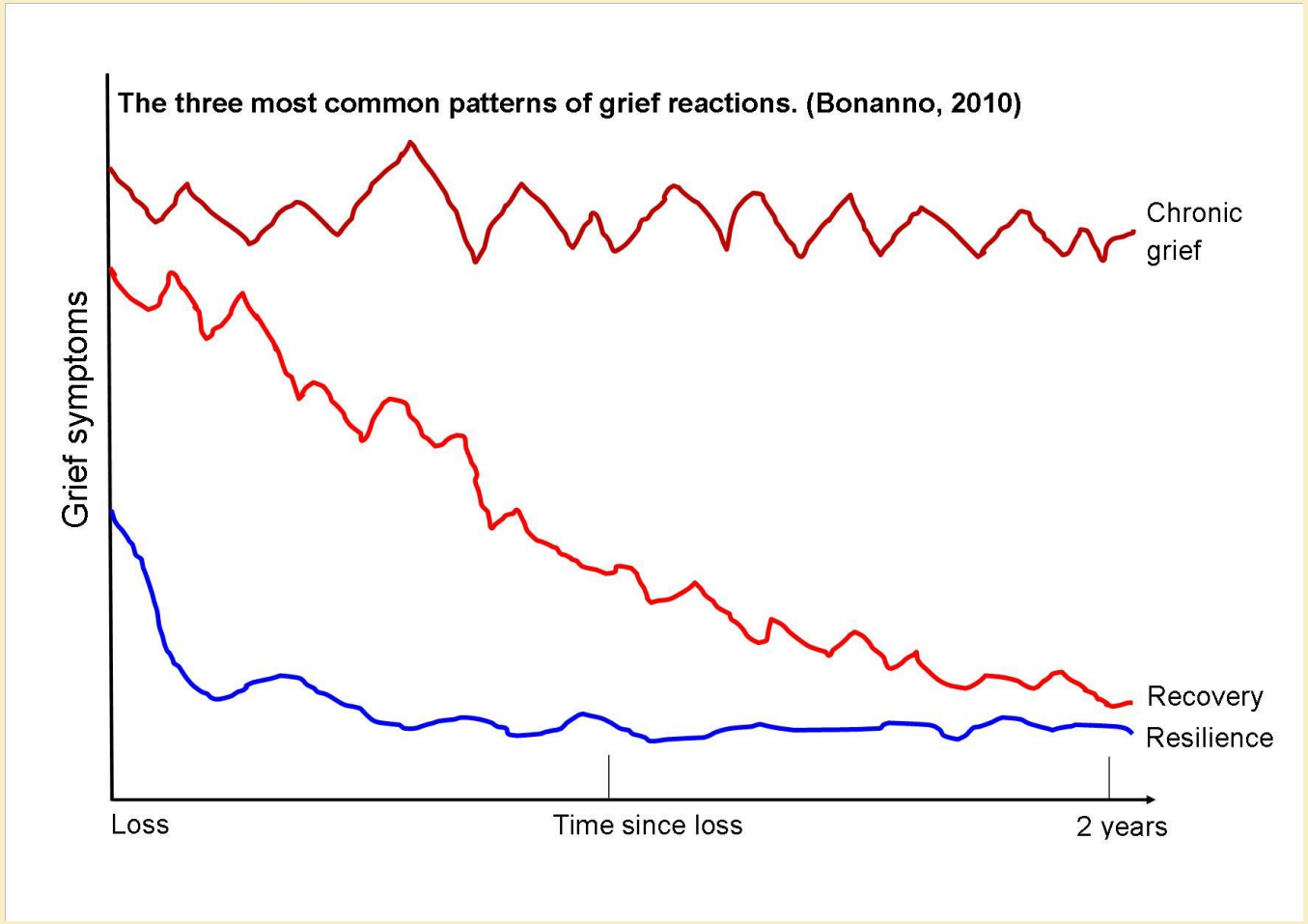
Bonanno's trajectories revisited

Chronic grief	16%
Recovery	11%
Resilience	46%
	73%

A further 18% exhibited pre-loss depression

9% were unclassified

Bonanno, Boerner & Wortman (2008)



Complicated or complicating?

- A consideration of the factors complicating grief may be a better guide.
- Many practitioners and some researchers consider that it may be better to talk about **normal grief**, or **common grief,** *complicated* by circumstances.
- Although the difference could be considered semantic, it can avoid the risk of medicalising grief reactions.

Inventory of Complicated grief

- Invasive thoughts that disrupt day to day life,
- Upsetting memories,
- Disbelief and difficulty in accepting the reality of the death,
- Longing for the deceased,
- Being drawn to places associated with the deceased,
- Feeling angry about the death,
- Feeling stunned or dazed, experiencing a loss of trust in others,
- Exhibiting a loss of empathy for, and distancing self from others,
- Suffering pains similar to that experienced in the deceased's final illness,
- Avoiding reminders of the lost person,
- Feeling that without the deceased, life is empty and pointless.

Prigerson 1995

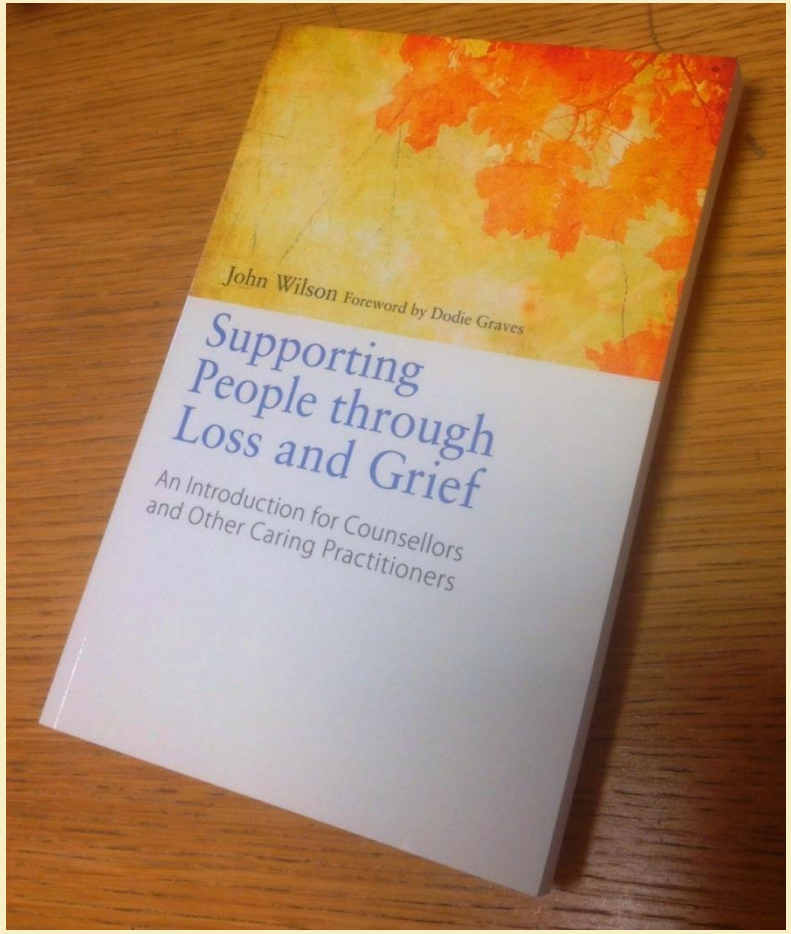
Complicated grief & ICD-11

- The World Health Organisation (WHO) International Classification of Diseases (ICD) Edition 11, classifies Prolonged Grief as a disorder. The Diagnostic & Statistical Manual of Mental Disorders, 5th Edition, published by the American Psychiatric Association in May 2013, rejected pressure from some quarters, to include prolonged grief as a disorder. As in DSM-IV, grief is recognised as a possible trigger to a major depressive episode.

Complicated grief & DSM-6

- Word on the bereavement counselling grapevine is that prolonged grief disorder will be recognised in DSM-6.

A detailed discussion on the nature of grief and grief counselling, including complicated grief, can be found in my book.



QUESTIONS ?

Thanks for participating

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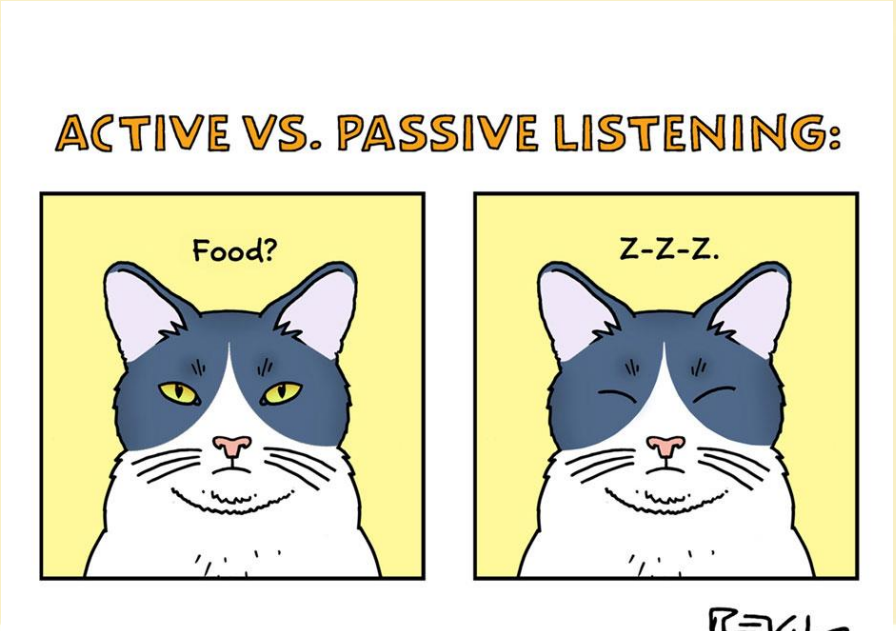

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