Grief Treatment Certification Course: Clinical Tools for Building Resiliency and Moving Toward Post-Traumatic Growth

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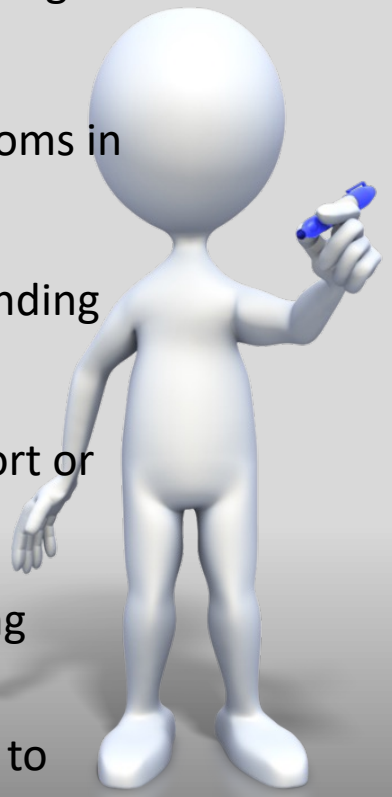
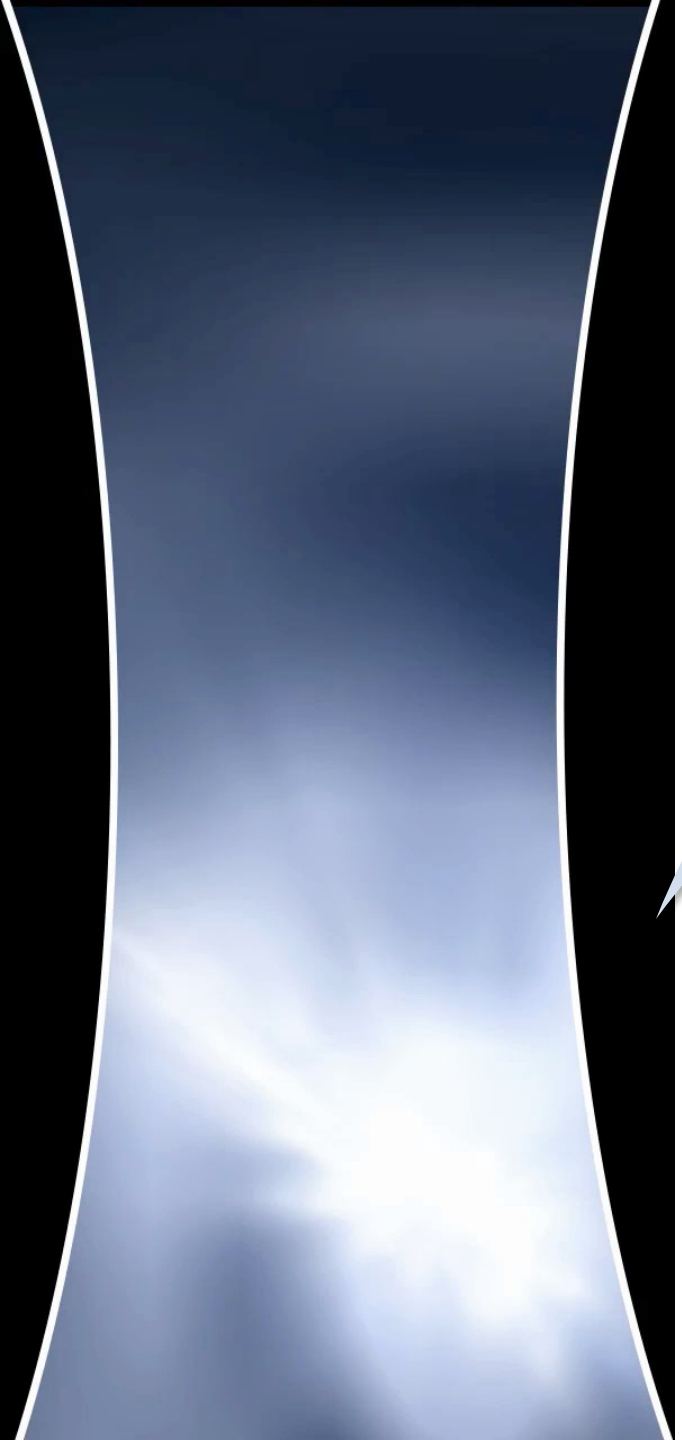
Objectives

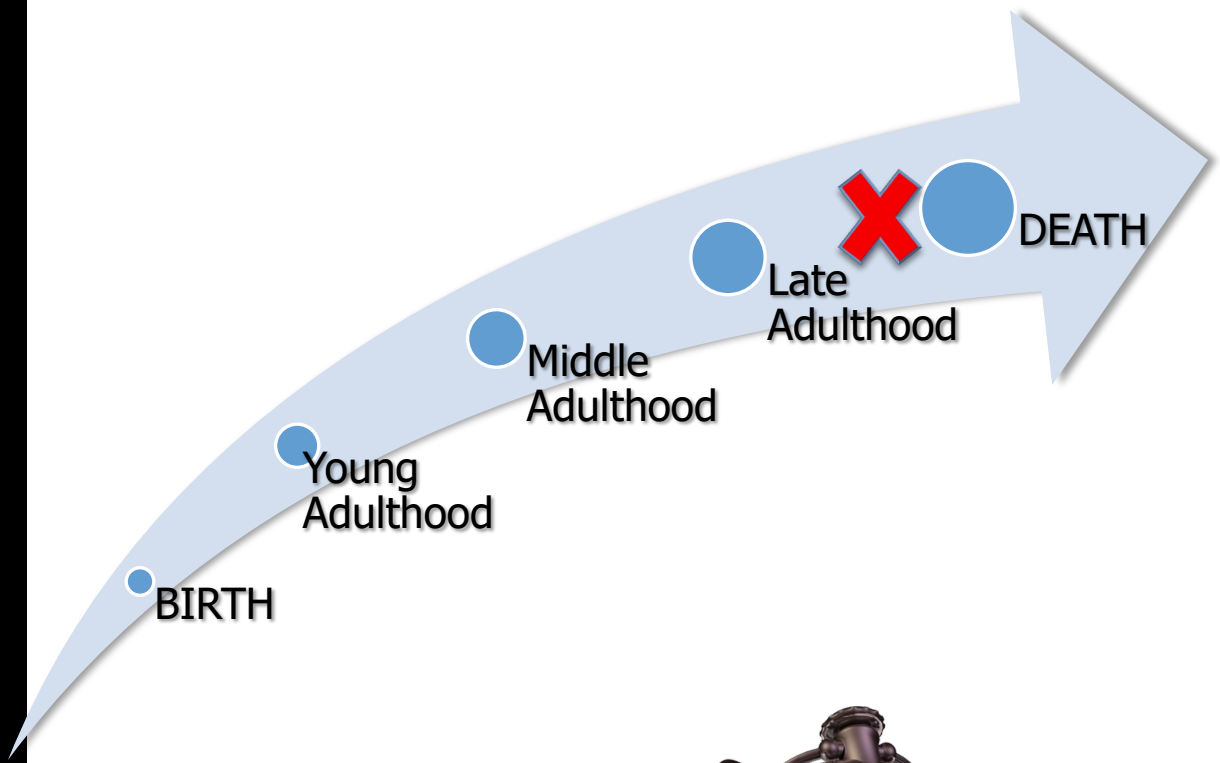
- Assess for trauma, depression, substance use and anxiety in grieving clients
- Utilize two assessment measures for gathering grief responses
- Distinguish how the experiences created by different types of loss impact assessment and treatment planning
- Evaluate contemporary models of bereavement as they relate to case conceptualization for grief therapy
- Assess the boundaries of professional competence in grief work and know when to refer out
- Investigate factors that can influence the grief process including the type of loss and support system
- Use the DSM-5-TR to diagnose/identify prolonged grief disorder
- Employ emotional regulation techniques to help calm clients who've experienced a traumatic loss

Objectives

- Implement a bereavement plan of care for identified prolonged grief disorder
- Use CBT techniques to help bereaved clients manage guilt, blame and other maladaptive cognitions following loss
- Apply narrative approaches to help clients construct meaning following loss
- Utilize mindfulness interventions to reduce anxiety symptoms in clients with grief
- Evaluate the clinical implications of cultural beliefs surrounding mourning and continuing relationships with the deceased
- Utilize best practices to structure and facilitate grief support or treatment groups
- Develop strategies for self-care when working with grieving clients
- Analyze continuing attachment bonds and their relevance to clinical practice with bereaved clients across the lifespan






DEATH
Late Adulthood
Middle Adulthood
Young Adulthood
BIRTH

What is on your

What is "grievable?" What is a Loss?

We experience a sense of loss when someone or something, very dear to us, has been taken from our lives. This loss leaves a sense of emptiness and deprivation.

Loss is an experience of our own human condition. And…we experience different types of losses throughout our lives.

Types of Losses

Family members	Milestones	Jobs
Marriage/Partnership	Separation from primary caregiver	Retirement
Pet	Deployment	Incarceration
Friends	Moving	Health

Types of Losses

Independence	Earlier identities	Innocence
Significant relationships	Potential futures	Self-image
Abuse	Safety	Body parts
Connection to spirituality/religious community	Self-efficacy	Sense of generativity


Normative Grief

Grief: Isn't it Always Complicated?

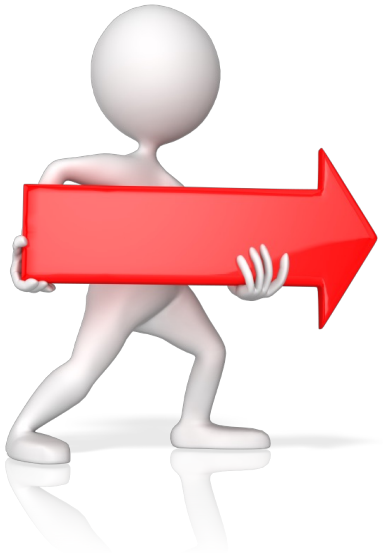
- **Yes, but not in the clinical sense!**
- **Reduction of grief reactions, separation distress, and intensity over time, with allowances for exacerbation (sudden transitory upsurge of grief - STUG) and *non-linear grieving processes***
- **Growing acceptance of reality of the death/loss and its implications. Gradual adaption and integration to new life without deceased**
- **Continued bond with deceased – a different relationship (if culturally appropriate)**
- **Life goals redefined**
- **Gradual return and reinvestment of new interests, activities, relationships, etc.**
- **"If only" thoughts diminish**
- **Meaning reconstruction/post-traumatic growth**

(Harris & Winokuer, 2016; Jamison, 2009; Neimeyer, 2016; Neimeyer, et al., 2019; Rando, 1993; Shear, et al. 2011; Worden, 2018)

Uncomplicated Grief

Acute Grief

- Shortly after loss
- Intense yearning, longing, sorrow
- All-encompassing, painful emotional, physical, cognitive, spiritual, and interpersonal reactions
- Natural adaptive reaction



Integrated Grief

- Lasting form of grief
- Feelings and behaviors are integrated into a "new" normal
- Reality of loss is accepted
- Bittersweet memories
- Grief does not dominate

(Doka & Tucci, 2017; Simon, et al., 2011)

7 Domains of Grief Responses


Prolonged
Grief
Disorder

When Grief Goes Awry

Acute Grief

- Shortly after loss
- Intense yearning, longing, sorrow
- All-encompassing, painful emotional, physical, cognitive, spiritual, and interpersonal reactions
- Natural adaptive reaction

Prolonged Grief Disorder

- Persistent form of intense grief
- Maladaptive thoughts
- Dysfunctional behaviors
- Acute grief does not end

Integrated Grief

- Lasting form of grief
- Feelings and behaviors are integrated into a "new" normal
- Reality of loss is accepted
- Bittersweet memories
- Grief does not dominate

(Doka & Tucci, 2017; Simon, et al., 2011)

The Missing Piece - PGD

Not a form of depression

Pathological and unique enough to have its own diagnostic disorder (PGD)

Psychobiological dysfunction of the brain, reduced heart rate, impaired autobiographical memory, and problem-solving

(Horwitz, et al., 2009; Shear et al., 2011; Zisook et al., 2010)

Characterized by severe separation distress, dysfunctional thoughts, feelings or behaviors related to the loss that complicate the grieving process and prevent the griever from adapting to the loss, acknowledging the reality of the loss, reconnecting with others, and moving forward with aspirational goals.

Prolonged Grief and DERAILERS (Shear)

- **D**ifficulty letting go of doubts that you did enough for person who died
- **E**mbracing ideas about grief that make you want to change or control it
- **R**uminating about ways that the death was unfair or wrong
- **A**nger and bitterness you can't resolve or let go of
- "**I**f only" thoughts about imagined alternative scenarios
- **L**ack of faith in the possibility of a promising future
- **E**xcessive efforts to avoid grief and/or reminders of the loss
- **R**esistance to letting others help, feeling hurt and alone
- **S**urvivor guilt; it feels wrong or uncomfortable to be happy or satisfied

(Shear, 2020)

These are *normal* responses to loss, especially at the beginning of the grieving process. But if unrelenting, *could* lead to prolonged grief.

Risk Factors

I. Personal psychological vulnerability
   a. Pre-loss or co-morbid psychological disorders
   b. Extreme separation distress
   c. Non-integrated previous losses
   d. Low self-esteem
   e. Worry/anxiety
   f. High negative cognitions
   g. Poor coping skills
   h. Trauma history
   i. Tendency to avoid
   j. Intolerance of uncertainty
   k. High emotionality
   l. Women more than men

(Tofthagen, et al., 2017)

Risk Factors

II. Circumstances of death
a. Untimely
b. Unexpected
c. Violent/traumatic
d. Feels preventable
e. Stigmatized

III. Context in which the death occurs
a. Low social support/ problematic
b. Disenfranchisement
c. Concurrent stressors
d. Multiple losses

(Tofthagen, et al., 2017)

Risk Factors

IV. Relationship dynamics
a. Dependent relationship
b. Loss of child/spouse
c. Insecure attachment style

(Tofthagen, et al., 2017)

Disenfranchisement

Denied the right to grieve, social support essential to integrating their loss, and deprived of the social validation in order to heal

Significance of relationship is rejected, minimized, or not recognized

Loss is not recognized because it is non-human, abstract, or inanimate

Griever is not recognized as being capable of forming significant relationships or recognizing the loss (griever is excluded)

Circumstance of death or loss is stigmatized

Grieving style is unacceptable

(Attig, 2004; Doka, 2002)

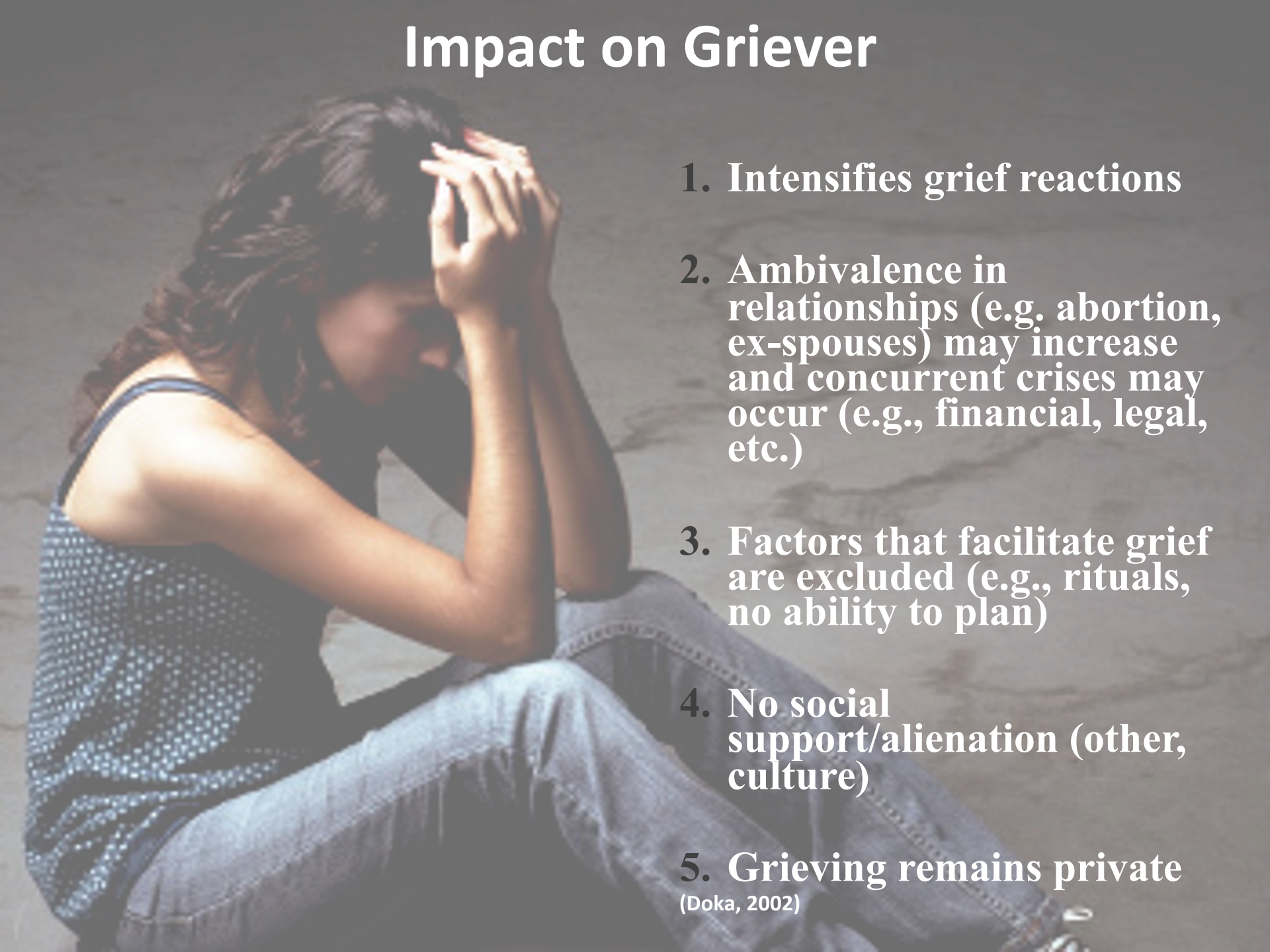
Self-Inflicted Disenfranchisement
"Auto-Oppress"

Influenced by culturally sanctioned grieving rules. Do not recognize:

1. Psychological indicators
2. Emotional indicators
3. Somatic indicators
4. Spiritual indicators
5. Behavioral indicators
6. Interpersonal indicators
7. Cognitive indicators

(Zinner, 2002)

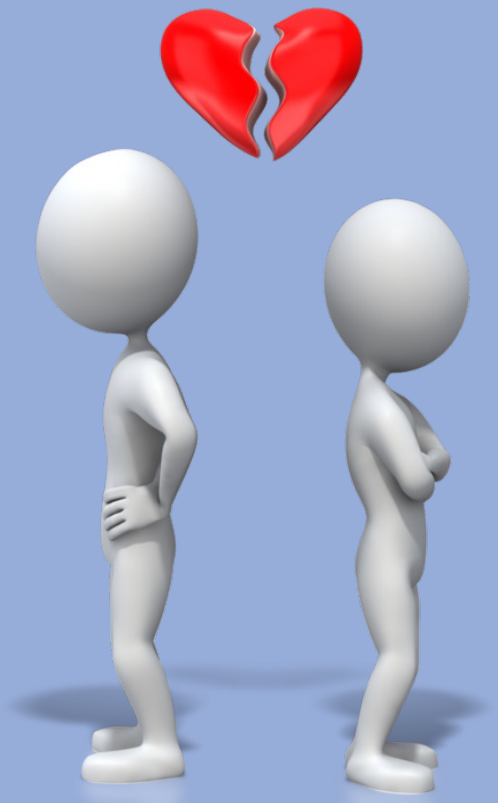
Impact on Griever



1. **Intensifies grief reactions**
2. **Ambivalence in relationships (e.g. abortion, ex-spouses) may increase and concurrent crises may occur (e.g., financial, legal, etc.)**
3. **Factors that facilitate grief are excluded (e.g., rituals, no ability to plan)**
4. **No social support/alienation (other, culture)**
5. **Grieving remains private**

(Doka, 2002)

1. Avoiding contact
2. Discouraging communication or expressing feelings
3. Giving unsolicited advice
4. Making rude or insensitive comments
5. Expressing inappropriate expectations about the person's grief responses



What to Say to the Bereaved

These feelings can be so painful.

I wish I had the right words. Just know I care.

I can't assume how you feel, but I am here to help in any way I can.

You and your loved one will be in my thoughts and prayers.

My favorite memory of your loved one is…

I am always just a phone call away

Give a hug instead of saying something

We all need help at times like this. I am here for you

I am usually up early or late if you need anything

Say nothing, just be with the person

There was no good reason for this to happen

It's OK to feel this way. It's OK to not feel OK

What *Not* to Say to the Bereaved

At least she lived a long life, many people die young

He is in a better place

She brought this on herself

There is a reason for everything

Aren't you over him yet? He has been dead for a while now

You can still have another child

She was such a good person. God wanted her to be with him

I know how you feel

She did what she came here to do, and it was her time to go

Be strong

It's good she is no longer suffering Now she is at peace

Maybe if you started dating again?

I know it's tough, but he wouldn't want you to suffer like this

You have to remember the good times. Those are what matter

Theories of Grief

Kübler-Ross' Stage Model of *Dying*

II. Elisabeth Kübler-Ross' (1969) five stage model

A. Denial - "it can't be"

i. Healthy way of dealing with the initial shock

ii. Used to mobilize other "less radical defenses" - a temporary defense.

B. Anger – "why me?"

i. Anger, rage, resentment and/or envy

ii. Often projected to the survivor's environment, one's higher power, or other people

Elisabeth Kubler-Ross

Kübler-Ross' Stage Model of *Dying*

C. Bargaining – "If you just…"
   i. Attempt to make agreement, often with one's higher power

D. Depression
   i. Full awareness kicks in
   ii. Numbness, stoicism, anger, and rage have worn off
   iii. Sorrow, helplessness, hopelessness, isolation, great loss

E. Acceptance
   i. Neither angry nor depressed about fate of death
   ii. Previous feelings have been explored and expressed
   iii. Not a stage of happiness, but rather one that is almost void of feeling

Stage Model Criticisms

- People do not move through stages in a fixed, linear progression. They are useful in describing *some* of commonly found reactions
- Little room for individual, family, religious, societal, cultural, and contextual factors (e.g., not everyone experiences anger/bargaining)
- Cannot apply theory of dying of terminal illness to theory of grieving process. This theory of dying process has now been discredited as well
- May unintentionally imply a fixed process that the individual should be at a particular place on a continuum despite intervening variables. Actually, the "stages" are more like defense mechanisms/responses and even those are simplistic
- Lack of empirical support, absence of clear research concepts, and not culturally sensitive. 200 interviews of terminally ill middle-aged people

(Corr, 2021; Friedman & James, 2008;Kelley, 2010: Metzger, 1979; Schultz & Adermna, 1974)

“The attempt to expand this model to what experts have learned is unjustified, potentially dangerous, and contrary to what experts have learned about loss, grief, and bereavement during the past 30 to 40 years…attempts to employ the five stages of grief (whatever they are thought to mean) in either education or practice should be promptly abandoned and never resuscitated.”

~ Charles Corr

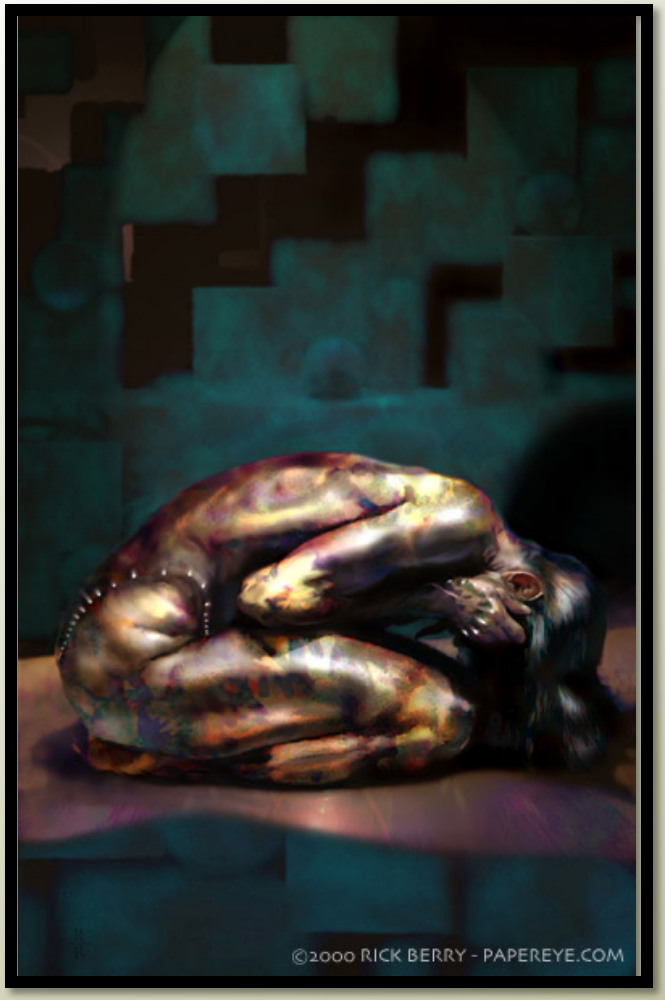
Phase Theories

- Models are more flexible than stage models

- Allows for symptoms of one phase to overlap the symptoms of the next—or even regress to a previous phase

Sanders' Phase Model

- Sanders' five-phase model states phases can co-exist, with one or more being more intense than others at different times
- Each phase has psychological, cognitive, and physical symptoms
- Recognizes individual nature of grief
- Individuals have choices in grief. Not just passive coping with little control



(Doka, 2005-2006; Sanders, 1999)

Sanders' Phase Model

1. Shock
   a. Feels impact of death
   b. Includes disbelief, confusion, restlessness, and feelings of unreality, regression, helplessness, preoccupation, and a state of alarm

(Doka, 2005-2006; Sanders, 1999)

Sanders' Phase Model

2. Awareness of the loss

a. Support has ebbed

b. Shock recedes

c. Experience full force of loss with intense emotional pain and cognitive arousal

d. Separation anxiety predominates

e. Bereaved knows death or loss has occurred, but on another level, not perceived as "real"

f. Becomes exhausted, which leads to phase 3

(Doka, 2005-2006; Sanders, 1999)

Sanders' Phase Model

3. Conservation-withdraw
   a. Long (sometimes never ending) phase
   b. Pain is chronic, not acute
   c. "Hibernation"
   d. Struggling to adapt
   e. Have three choices:
      i. Seek own death (consciously or unconsciously) rather than live without person
      ii. Maintain status quo (chronic grief)
      iii. Conscious decision to move forward

(Doka, 2005-2006; Sanders, 1999)

Sanders' Phase Model

4. Healing – The Turning In Point
    a. Concept of his/herself changes from being bereaved to being the survivor
    b. Assumes control of life
    c. Makes decisions for future
    d. Develops new identity, relinquishs old roles, and assumes new roles
    e. Restored physical and psychological health, increased energy

(Doka, 2005-2006; Sanders, 1999)

Sanders' Phase Model

5. Renewal
   a. Has dealt with social consequences of bereavement
   b. Increase self-awareness, reconnects socially
   c. Taken charge and responsibility for life and learned to live again with new levels of functioning and continued bond

** Sanders was making a sixth phase called Fulfillment, but she died before her work was finished. Doka (2006) published her work for her. **

(Doka, 2005-2006; Sanders, 1999)

Sanders' Phase Model

6. Sanders' 6th phase of Fulfillment
   a. Looks back at his/her life with a perspective that integrates loss into narrative
   b. Tends to be deeply spiritual in nature
   c. Finds benefit and meaning in loss

(Doka, 2005-2006)

Rando's Six R's of Mourning

Emotional Avoidance Phase

Recognize the Loss

1. Acknowledge death
2. Understand the death

Confrontation Phase

React to the Separation

1. Experience pain
2. Express loss
3. Mourn secondary losses

Recollect and Reexperience

1. Review/remember realistically
2. Revive/reexperience feelings

Relinquish Old Attachments/Assumptive World

Accommodation Phase

Readjust adaptive to new world

1. Revise assumptive world
2. Develop new relationship with deceased
3. Adopt new ways of being in world
4. Form new identity

Reinvest

(Rando, 1993)

Worden's Task Model

Worden's (2018) Tasks of Mourning approach

A. States stages and phases implies mourner *passes through* grieving

B. Completing tasks refers to the concept of the mourner can *actively* do something about his/her process

C. Tasks do not need to be accomplished in a particular order, but within definitions of each, some ordering is suggested

(Worden, 2018)

Worden's Task Model

1. Accept the reality of the loss
   - i. Becomes full face with reality of loss and will not return. Reunion is not possible
   - ii. Opposite of this task is denial (facts of loss, meaning of loss, irreversibility)
   - iii. Requires intellectual and emotional acceptance, and reduction of searching behaviors

(Worden, 2018)

Worden's Task Model

2. Work through the pain of grief
   i. Includes not only emotional pain, but also physical and behavioral pain
   ii. May avoid the work associated with the second task, including denial of the pain, only thinking pleasant thoughts about the decease/loss, addiction, refusal to believe loss
   iii. Those who do not successfully navigate this task are often found in counseling later

(Worden, 2018)

Worden's Task Model

3. Adjust to an environment in which the deceased is missing, relationship is gone, etc.
    - i. Three types of adjustments
        - a. External – everyday functioning
        - b. Internal – sense of self
        - c. Spiritual - sense of world, values, and fundamental beliefs, meaning making, existential issues
    - ii. Task is failed if adaption is not accomplished
    - iii. Remains helpless, withdrawn, or does not learn new skills. Leads to being unable to "complete" the mourning process

(Worden, 2018)

Worden's Task Model

4. Relocate the dead person, relationship, etc. within one's life and find ways to memorialize the person
   a. Not "living" indicates task is failed

"To find a way to remember the deceased in the midst of embarking on the rest of one's journey through life" (Worden, 2018, p.51)

Neimeyer's Meaning Reconstruction Model

- Constructivist model, narrative approach
- Active process of meaning reconstruction
- Loss assaults assumptive world:
    1. In day-to-day functioning
    2. Values and priorities
    3. Identity
    4. Social and interpersonal relationships
    5. Spiritual, religious, or philosophical views
- Holds that loss disrupts self-narratives and sets individual into a quest for meaning making

(Neimeyer, 2001; 2016)

Neimeyer's Meaning Reconstruction Model

- The inability to make sense, find benefit, and readjust identity resulting from loss associated with severity of complicated grief
- Three activities to reconstruct meaning
  1. Sense making – Comprehending the loss; find benign explanation (e.g., spiritual reason)
  2. Benefit finding – "Silver lining" (e.g., increased empathy)
  3. Identity change – Reconstruct self, especially when response to loss is adaptive

(Neimeyer, 2001; 2016)

Neimeyer's Meaning Reconstruction Model

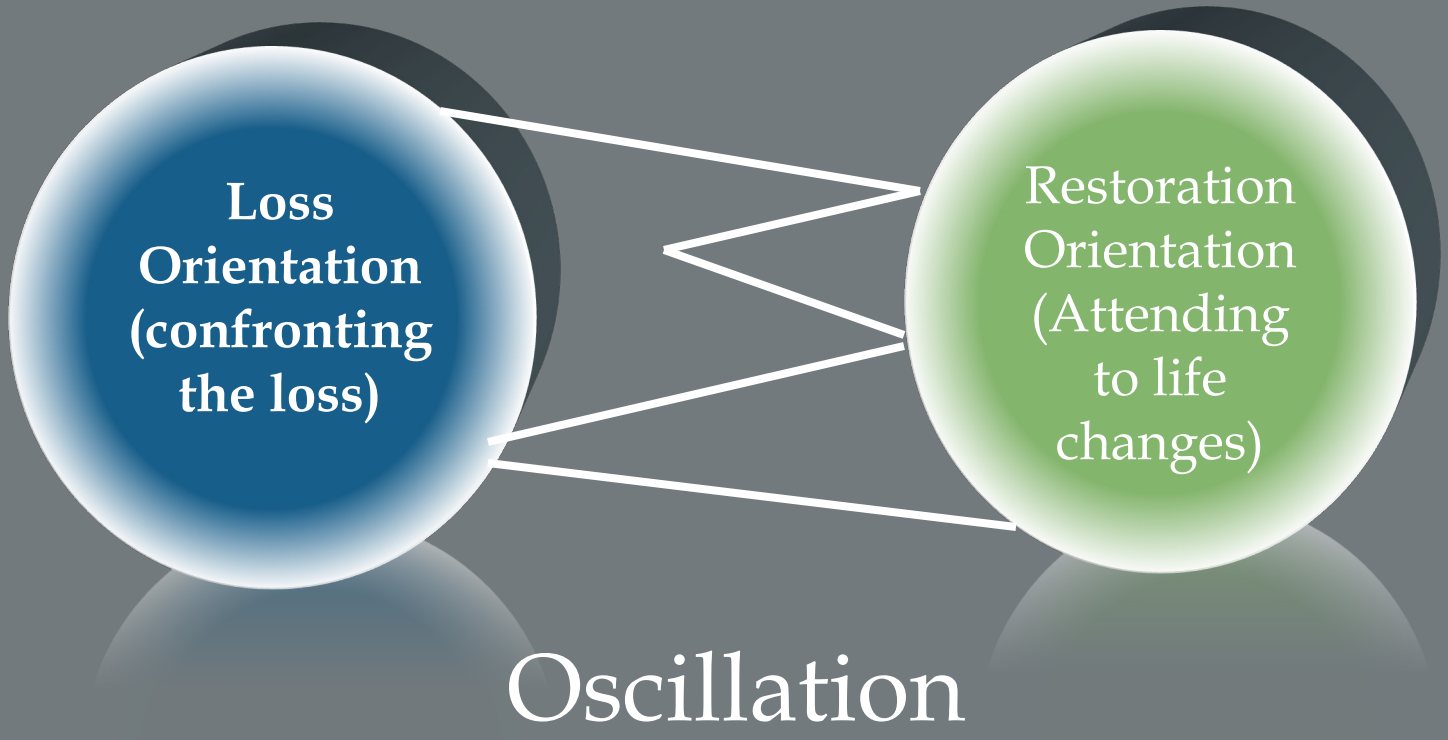
- Identity seen as successful narrative achievement established through stories we tell ourselves and others ("live in stories, not statistics") where meaning is woven in
- Author our own stories as we reflect, interpret, and reinterpret what happened
- Emphasizes the idiosyncratic nature in each griever's reactions – each person writes his or her own story
- Therapist comes from place of "not knowing"

(Gillies & Neimeyer, 2006)

"Perhaps the most important contribution to the current conceptualization of grief reactions is the recognition of the uniqueness of the grieving process to each individual and family. The empirical literature has not supported the concept of linear stages or phases in mourning. Bereaved individuals often experience contrasting emotions at the same time and oscillate between them. Instead of focusing on ensuring individuals are grieving the *correct* way, the emphasis now is on recognizing the multiple variables that affect the grieving process, as well as the particular individual style of expressing grief. Thus the main goal of grief and bereavement care is to support the individual's unique and personal grieving process without a preconceived notion of how that process should present or develop."

~ Strada, 2016

Dual Process Model of COPING



(Stroebe & Schut, 1999)

Definitions of Guilt, Regret, And Shame

Guilt

- "Remorseful awareness stemming from a perception of having *done* something wrong or failing to have done something" (Baugher, 2009, p. 2)
- Feeling tension, regret, and remorse
- Other focused, assesses impact of actions on other people
- Can lead to constructive engagement, empathy, and reparations
- Negative evaluation of behavior
- Can be adaptive or maladaptive
- Can be excessive
- Can lead to depression, low self-esteem, anxiety, suicidality, etc.
- Assessed retroactively – skewed memory bias

(Duncan & Cacciatore, 2015; Tangney, Miller, & Barlow, 1996)

Regret

- Unfulfilled desire or action that could/ should have done/not done (e.g., “I should have…”)
- Wishing one had made different decision because consequences of decision were unfavorable
- Related to perceived opportunity
- ”A profound desire to go back and change a past experience in which one has failed to choose consciously or has made a choice that did not follow one’s beliefs, values, or growth needs” (Lucas, 2004, p. 59)

Shame

- Event brings disgraces, dishonor, or condemnation
- Impacted by how others think of us
- Can lead to feelings of negative self-image (e.g., “I am a failure”)
- Focuses on “self” and moral character
- “Associated with sense of exposure along with lack of trust, feelings of worthlessness, powerlessness, and a desire to hide ” (Duncan & Cacciatore, 2015, p. 314)
- Threatens attachment system and sense of belonging
- Related to avoidance of relationships, anger towards others, depression, substance abuse, PTSD, suicide, and many other difficulties
- Maladaptive
- Change or remediation may seem impossible
- Control related – cannot be modified because it reflects global self-appraisal and character

(Duncan & Cacciatore, 2015; Tangney & Solovey, 1999; Tangney, 1996)

Types of Guilt

1. **Death Causation**
   Ranges from intentionally to nothing committed/omitted
2. **Illness-Related**
   Time period prior to and including the illness that led to death (not believing illness, not taking action, feeling grateful for not being ill)
3. **Moment-of-Death**
   Not being present when person died
4. **Role**
   What “I should” done to prevent death based on expected role (e.g., parent)
5. **If-Only (Failure)**
   Feels could have done something to change outcome (Hindsight bias)

(Baugher, 2009)

Types of Guilt

6

Moral

Linking past behaviors and choices to reasons for death (punishment)

7

By Proxy

Take on guilt of another person (if actual guilty party is incapable to unwilling to feel guilt)

8

Survival

Outliving loved one or others who died from catastrophe

9

Inducing Pain in Others

Helplessly watching others die. Causing distress to dying person by expressing upsetting emotions

10

Benefit

Gratitude for benefitting from death (e.g., financially)

(Baugher, 2009)

Types of Guilt

Grief

Grieving “wrong” or anger towards person who died

Unmentionable

Secrets are too terrible to talk about (e.g., suicide)

Getting Better

Improving after the person died (e.g. being happy, new relationship)

Relief

Deceased had caused suffering in others while alive or relief after long illness

(Baugher, 2009)

Considerations for Non-Death Losses

Non-finite, Ambiguous, and Living Losses

Nonfinite Loss

- Five Hallmarks of nonfinite loss:

1. Ongoing uncertainty
2. Feeling disconnected from larger world and/or what is considered "normal"
3. Disenfranchised
4. Enduring powerlessness and hopelessness about loss
5. Chronic despair and dread as a person comes to terms of what was before and what it is now ("I thought he was sober, but now I realize he never was")

(Bruce & Shultz, 2001; Jones & Beck, 2007)

Nonfinite Loss

- Enduring effects in everyday life
- Loss and reaction are ongoing: may follow a particular event (e.g. trauma, assault)
- Interferes with normal development and gets in way of meeting life expectations
- Leads to other intangible losses (e.g., loss of safety, potential, etc.)

(Winokuer & Harris, 2012)

Ambiguous Loss

- Lacks clarity and definition of a permanent loss such as a death
- Is not finite (e.g., feelings of being safe again)
- Makes it hard to move forward
- Grieving a “living loss”
- Often not seen by others (e.g., loss of identity)
- Examples are addiction, divorce, immigration, health, pandemics

Ambiguous Loss

Two Types:

1. Physically absent, but psychologically present (e.g., someone is missing) leaving bereft in limbo, uncertain, and unsure

2. Psychologically absent (e.g., TBI, dementia, addiction)

End of Relationship

(Trolley, 1993-94)

- Disruption of family relationships
- Dissipated protection of nuclear family
- “Normal” predictable life lost
- Changes in familial roles
- Dissention between parents played out with children, visitation-custody battles
- Stigma of divorce and/or being single
- Struggles with religious beliefs/leaders
- New situations arise, making mourning difficult and lack of closure
- Children may feel reconciliation is option because parents alive
- Guilt, failure, familial and societal role expectations, norms compound grief
- No societally prescribed rituals
- Divorce is voluntary, unlike death

Job Loss

(Brand, 2015; Ramsey, 2014)

- Circumstances for involuntary job loss impacts person differently (e.g., economic recessions vs. closing of business vs. poor performance vs. health)
- Stigma: depression, anxiety, shame, isolation, apathy, lower self-esteem
- May not have colleagues experiencing same loss to which to turn for support
- Economic uncertainly, secondary losses
- Transition to new employment may be prolonged
- Lower social status, self-confidence, self-acceptance, morale, structure, life satisfaction, creativity, identity, meaning and purpose (shared goals), sense of control, social connection
- People who consider role at work central to self-concept suffer more
- Psychological consequences more disruptive in low unemployment areas

Reproductive Loss

- Infertility, miscarriage, abortion, fetal death (stillbirth), infant death, sterility, ectoptic pregnancy, adoption, loss of spouse/no relationship, hysterectomy, chosen childlessness
- Lost part of self, self-blame, blame of medical system, emptiness, shock, disbelief, numbness, denial, chronic apprehension, lack of security, overwhelmed, trauma, rage, guilt, innocence, repression, sexual dissatisfaction/disconnection
- Predictable world collapses

(Gray & Lassance, 2003; James, S., & Singh, A., 2018; Lee, et al., 2010)

Reproductive Loss

- Loss of possibility, couple to a family
- Contradictory to religious beliefs (esp. abortion)
- Increased divorce rate, drug/alcohol use, car accidents
- Intergenerational trauma
- Poor bonding with subsequent pregnancies and existing children
- Extremely disenfranchised, esp. men
- Medical personnel tend to not recognize the grief
- No rituals in most cultures

(Gray & Lassance, 2003; James, S., & Singh, A., 2018; Lee, et al., 2010)

Spirituality and Religion

- Crisis of faith – once perceived God/Higher Power providing care and comfort, now feels being punished or abandoned by distant, controlling, or authoritative deity
- Complicated spiritual grief (CSG) – loss of relationship
- Questioning Higher Power's character (goodness, caring, intentions, reasoning)
- Anger and confusion
- Possible disconnection from faith community; stigma, disenfranchisement, ostracism
- Reduced spiritual sense-making: assumptions about Higher Power shattered
- Higher levels of CSG for violent death
- Negative perceptions of spiritual community; disenfranchisement; selective sharing
- Betrayed and robbed; spiritual community lied; community abandoned them

(Burke, et al., 2021)

Spirituality and Religion

- Desire to hurt Higher Power in return
- Participation in faith related activities changes
- Afterlife concerns
- Spiritual reconnection struggles
- Fury, reduced trust, existential crisis
- Reduced sense-making
- Increased meaning struggles
- CSG highest with young, male, loss of partner
- No prescribed rituals (e.g., miscarriage, abortion, ambiguous losses, etc.)
- Spiritual anguish: ways life devastated by loss of spiritual beliefs
- Not all religious and spiritual beliefs are studied. Might be different for variety of beliefs
- Negative religious coping related to heightened reactivity and prolonged recovery, especially punishment and abandonment

(Burke & Neimeyer, 2014; Burke et al., 2014; Lee et al., 2013)

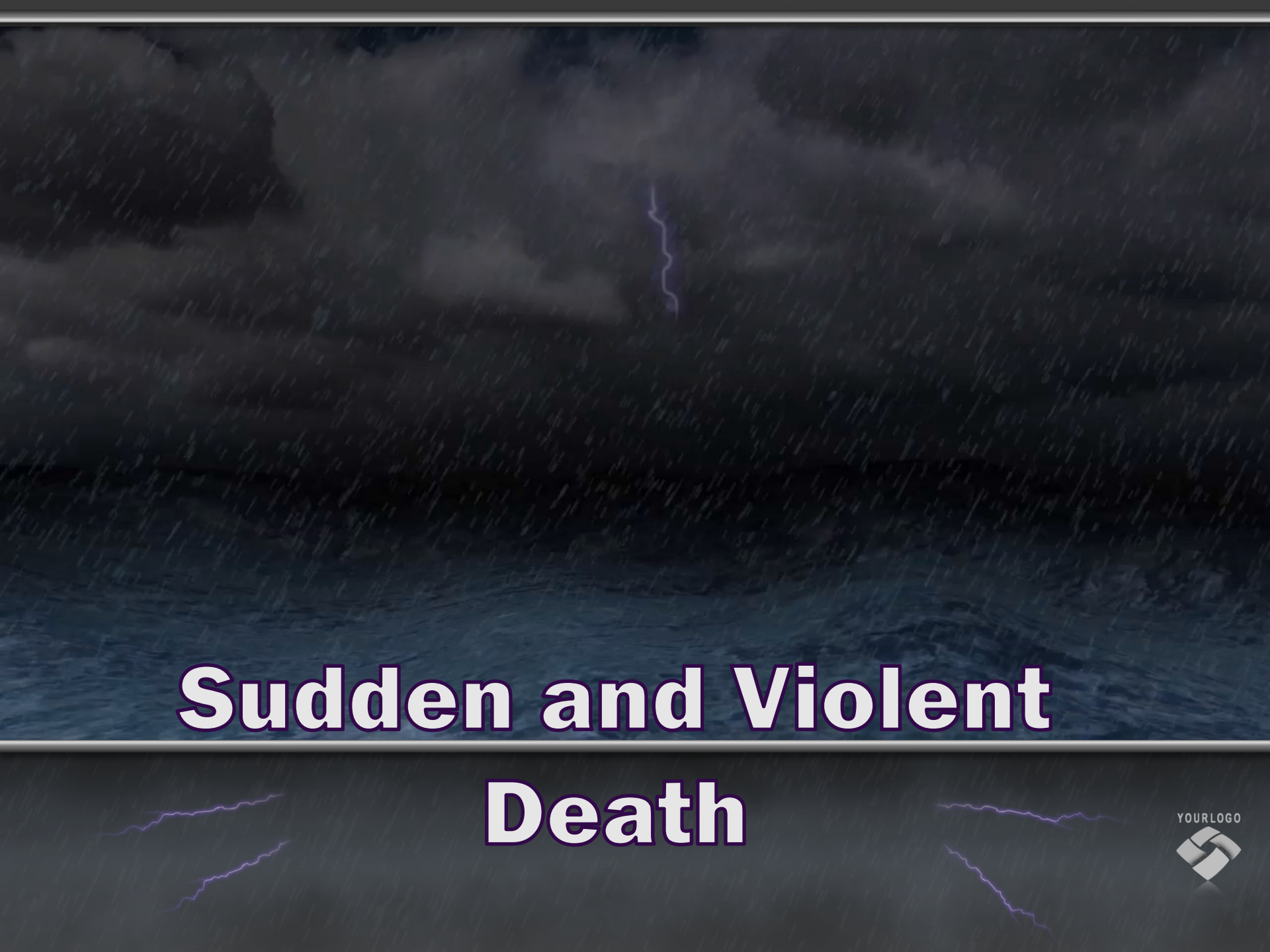
Chronic Illness

- “Dyings along the way”
- Grieves loss of control
- Medications can lead to sense of loss of control of body and emotions - may be exacerbated by side effects
- Sexual identity lost to“chronically ill identity” (“I am illness”)
- Job loss?
- Medical system and government funded financial systems
- No immediate end, closure, or resolution (non-fin loss)
- Remission – denial response?
- Flares – Overwhelmed with hypersensitivity and acute awareness
- Bereavement overload
- Acceptance, adjustment & coping are high priorities
- Regressions common
- Self-image may cease to exist or not have meaning
- Especially at diagnosis: non-compliance, denial, disbelief, shock of loss of wellness, hopelessness

(Lewis, 1993; Pereira, 1984)

“Because chronic illness can strip away many of the characteristics that form identity at the same time it causes disability and loss of livelihood, the totality of the losses is potentially enormous. Since these losses aren’t tied to one event but are multiple and repetitive, the ill person may live with perpetual grief, known as chronic sorrow or sadness…The most prominent component is fear: fear of pain, disability, recurrence or death.”

~ Mila Tacala


Sudden and Violent
Death
YOURLOGO

Grief Related to Sudden and Violent Death

- Examples include:

1. Suicide
2. Homicide
3. Accidents (e.g., car accidents, falling, fire)
4. Overdose
5. Natural causes (e.g., heart attack)
6. Reproductive loss (e.g., SIDS, miscarriage)
7. Tragedy (e.g., natural disasters)
8. War

While sudden deaths have different causes, united because are unexpected, unanticipated.

Higher risk for PGD

No time to prepare for loss or say goodbye.

Loss is often traumatic. Horrific details are difficult to assimilate (violence in which the person died, unanswered questions, and social consequences that is stigmatized)

Stigma

- “A set of individual attitudes and beliefs substantiating a perception that one is discredited by society and condemned to an undesirable social status, minimizing the individual from a whole and usual person to a tainted, discounted one” (Keller, et al., 2021, p. 2)
- “A process involving labelling, separation, stereotype awareness, stereotype endorsement, prejudice, and discrimination in context in which social, economic, or political power is exercised to the detriment of members of a social group” (Keller, et al., 2021, p. 2)

Suicide Loss

- Common themes and reactions with suicide loss grief include:

1. Shock and disbelief
2. Horror
3. Need to make sense of death. Meaning making is more difficult
4. Answer “Why?”
5. Guilt
6. Blame
7. Rejection
8. Abandonment
9. Stigmatization
10. Social isolation
11. Anger
12. Regret
13. Feeling misunderstood or blamed of death
14. Desire to conceal cause of death

Individual differences based on subgroups (loved ones attempted suicide before vs. those who died with no SI history)

Features of Suicide Grief Supported by Research Evidence

- Abandonment and rejection:
  "He chose to leave me", "She abandoned me"
- Shame and Stigma:
  Higher for suicide survivors, but maybe other traumatic losses as well
- Concealment of Cause:
  Related to shame and stigma, wish to protect memory of deceased
- Blaming:
  Related to anger, projected onto others or self
- Increased self-destructiveness and suicidality:
  Nature vs. nurture, stressors, role-modeling

(Jordan & McIntosh, 2014)

Features Supported By Clinical and Anecdotal Evidence

- Guilt: Includes “What ifs” and “If onlys”
- Anger: To deceased, self, others.
- Desire to Understand Why: Finding meaning
- Relief: Over reduce turmoil or even reduced suffering
- Shock and Disbelief: But not just suicide loss
- Social Issues: Family systems effects, social isolation
- Activism and Involvement in Prevention Efforts: May become obsessional, but usually is positive. Benefit finding

(Jordan & McIntosh, 2014) <<< EXCELLENT RESOURCE!

Homicide Loss

Common themes and reactions:

1. **Trauma** – violent, mutilation, violation, reprocessing imagined replay of the dying, helpless witness, ruminative, intrusive imagery/reenactment (disorganizing)
2. **Victimization** – secondary victimization via disenfranchisement, insensitivity
3. **Personal deterioration** – health complications, terror, fear, avoidance, panic attacks, helplessness, hyperarousal, nihilistic despair
4. **Regrets** – "if onlys"
5. **Anger/rage** – assailant, society, legal system, higher power
6. **Shattered assumptions** – of a safe world
7. **Sensationalism** – media, retelling "belongs" to community
8. **Self-remorse** – failure to keep person alive (attachment obligation)
9. **PGD** – Increased risk
10. **Post-traumatic growth** – changed outlook on life, legacy, social justice involvement

(Buckholz, 2002; Rynearson, 2012)

Death By Drug Overdose

Common Reactions:

- Painful feelings - not having the chance to say “goodbye”
- Helplessness - protecting deceased
- Fear of judgement regarding you, your family or deceased
- Disappointment for not picking up on clues
- Struggling with unanswered questions and the need to understand how this happened
- Mood changes of sadness, anxiety, irritability or crying spells
- Impatience while waiting for toxicology or police reports
- Anger at deceased, or others who may have played a part in their addiction

(Pathways Center for Grief & Loss, 2022)

Death By Drug Overdose

- Needing to place blame
- Difficulty concentrating, forgetfulness, fear of “going crazy”
- Frustration - lack of support and understanding from others about addiction
- Need to have deceased remembered for the good in him/her and not the way he/she died
- Difficulty sleeping, having intense dreams, intrusive thoughts or flashbacks about the deceased or circumstances of death
- Feeling isolated from supports and possibly lacking places to talk about grief
- Fear of this happening to others he/she cares about

(Pathways Center for Grief & Loss, 2022)

Death By Drug Overdose

What Can Help?

- Acknowledge reality of circumstances of death
- Don’t define individual by his/her addiction
- Consider ways to continue legacy of love by finding positive ways to remember deceased
- Find healthy ways of to acknowledge and express feelings
- Understand addiction
- Understand struggle deceased may have had - decrease feelings of guilt
- Help others understand and know what is NOT helpful in regard to comments and actions
- Educate others
- Focus on healthy and positive supports
- Research specific resources availability in area of addiction loss
- Seek mental health services for reactions that persist and interferes with functioning

(Pathways Center for Grief & Loss, 2022)


CULTURE

Cross-Cultural Bereavement

- Cultures have prescribed norms of what is considered appropriate emotional expression to loss, expectations of behavior during/after loss
- Mourning rituals, traditions, and taboos culturally prescribed
- Expectations contingent upon gender roles, religious beliefs, nature of the relationship, nature of the death
- Behavior exhibited varies considerably from culture to culture…and even sub-cultures within a predominant culture.

Cross-Cultural Bereavement

- Influences what is considered appropriate support and interventions
- Affects how deceased is thought of (e.g., to be beneficial to the bereaved or not to be spoken of)

Grief Within Cultural Framework

- Expression and continue bonds regulated (policing)
- Subtly or overtly
- Tied to gender roles
- Differences in loss-orientation and restoration-oriented coping (e.g., Chinese lean towards restoration)
- Expression norms on a continuum, influenced by if death is a community event (e.g., India) vs. those that are more private (e.g., Britain)

(Klass & Chow, 2011; Laungani & Young, 1997)

Grief Within Cultural Framework

- Handling of body, laying out body, transportation to cemetery/crematorium, arrangement for funeral services, if body can/cannot be cremated, who performs which rituals - all related to norms and practices
- How openly death, dying, and grief is discussed is culturally bound
- Prescribes what constitutes death. Dichotomous event? Gradations?
- How long death is “spread out.” How long person remains earthbound. where they can be “found” (e.g., nowhere, shrine, cemetery, etc.)
- Secondary rituals helps mark steps in responsibilities in grief (e.g., end of obligation to mourn and move forward)

(Laungani & Young, 1997; Parkes, 1997)

Cultural Competence

Awareness

"Mindful or conscious of similarities and differences between people from different groups." Aware of privilege, power, and oppression

Humility

Not viewing self as expert in other people's cultures. Therapist is evolving learner

Competence

"Recognizes, affirms, and values the worth of individuals, families, communities, and protects and preserves the dignity of each"

Sensitivity

Requires consciousness, but requires deeper understanding and applies to one's practice

(Barsky, 2021)

Responsiveness

Aware of cultural factors and responding appropriately. Culture included in assessment.

Cultural Competence In Grief Therapy

Should have and develop ongoing knowledge of history, values, social class, traditions, family systems, gender identity and expression, social class, religion/spirituality, mental and physical abilities, immigration and refugee status, race, ethnicity, artistic expression, ritual practices, continued bond expectations, gender socialization, communication expectations (Barsky, 2021)

Ensures adherence to ethical principles of beneficence and nonmaleficence:

Beneficence = "accomplishing something helpful for the client by knowing how to effectively address the problem"

Nonmaleficence = "Avoiding harm to the client through incompetent, ineffective, or deleterious actions" (Gamino & Ritter, 2012, p. 24)

Cultural Awareness In Grief Therapy

Be aware of how one's own values, worldviews, traditions, belief systems, language, norms, gender identification, disenfranchisements, religious/spiritual beliefs, sexual orientation, SES and social status, and experiences with disenfranchisement interacts with the client's worldview

(e.g., beliefs about continued bonds)

Requires awareness of interplay between his/her/their culture and death, loss, and grief.
What does it mean to grieve in his/her/their culture?
(e.g., first generation Chinese in American culture)

Interventions and support should be culturally appropriate
(e.g., expectations around length of mourning)

(Barsky, 2021)

Cultural Sensitivity In Grief Therapy

Respectful and accepting of differences, make no judgement about if differences are good or bad

(e.g., gender expectations in responsibilities after loss)

Understand differences from the client's and culture's perspective

(e.g., expression of emotions after loss)

(Barsky, 2021)

Cultural Humility In Grief Therapy

Acknowledges client's culture cannot be understood in same way as one's own culture

(e.g., meaning of lived traditions applied to rituals)

Requires self-reflection and awareness

How does client's culture affect one's own worldview?

(Barksy, 2021)

Cultural Responsiveness In Grief Therapy

Demonstrate respect, build on cultural strengths, and attend to client contexts of social environment

(e.g., immigration differences within families as it relates to role expectations in end-of-life decision making)

(Barsky, 2021)

Diversity…is not casual liberal tolerance of anything not yourself. It is not polite accommodation. Instead, diversity is, in action, the sometimes painful awareness that other people, other races, other voices, other habits of mind have as much integrity of being, as much claim on the world as you do… And I urge you, amid all the differences present to the eye and mind, to reach out to create the bond that…will protect us all. We are all meant to be here together.

~ William M. Chase, "The Language of Action"

Clinical Considerations

- No absolute guidelines for specific cultures.
- Westerners often apply their norms, customs, etc. as being “normal.” Give as much acceptance to other cultures as we do ours
- Length, rules, and expectations of mourning varies by culture.
- Theories, resolution of grief, and techniques culturally bound
- Events and loss have universal components, but responses and what are considered symptoms are expressed within the specific culture context that may or may not fit clinician’s expected symptoms
- What is considered “help” is different cross-culturally
- Client may defer to clinician’s definition of abnormal grief and acquiesce (clinician as police)
- Attend to judgments about grief responses in one’s own family and communities. Cultural self-awareness necessary
- Attend to restoration or loss orientation differences

(Klass & Chow, in Neimeyer et al., 2011; Parkes, 1997; Stamm, et al., 2004)

Religion and Spirituality

Religion and Spirituality: Definitions

Religion

- "An institutionalized pattern of beliefs, behaviors, and experiences, oriented toward spiritual concerns and shared by a community and transmitted over time in traditions" (Canda & Furman, 1999, p. 73)

Spirituality

- "An innate human need to find meaning and purpose in life and to have a relationship with something outside of, and larger than, oneself" (Moremen, 2005, p. 310)
- Search for meaning and purpose in life, through experience, in relation to self, others, the natural word and the transcendent
- To seek an answer to the question, "How can you make sense out of a world which does not seem to be intrinsically reasonable?"
- How one's soul experiences connection with that which is greater than oneself

(Burke & Neimeyer, 2014; Canda & Furman, 1999; Chapple, et al., 2011; Currier, et al., 2013; Kelley & Chan, 2012; Krieglstein, 2006; Moremen, 2005; Wortman & Park, 2008)

Death and Spirituality

- Dying is a human, social, and spiritual event
- Bereavement is a life crisis
- Grief challenges meaning of human existence
- Spiritual aspects of the bereaved are often overlooked/minimized
- Affects mental, emotional, and physiological responses to dying and bereavement

Spirituality of Grieving

- Bereavement can be catalyst for spiritual growth - creates imbalances that must be addressed

- Forced to engage in efforts to create meaning to reintegrate and find balance. Leads to personal transformation

- Spiritual needs can fluctuate throughout the mourning process

- Affected by one's individual development and cultural modes of expression

- Can give hope, comfort, strength, inner resources, and support

Religion and Spirituality

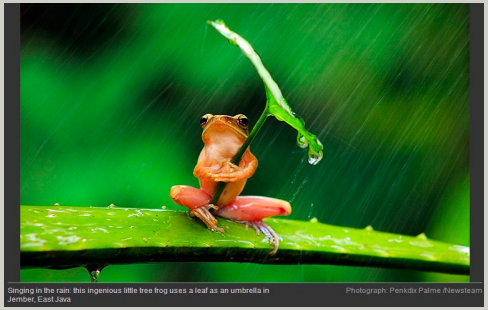
- ”Global conceptualizations of religion do not adequately capture the complete nature of religion in people’s lives” (Wortman & Park, 2008, p. 703)
- Provides perspectives on death
- Loss may lead to fundamental shifts in belief systems – with changed, increased, or deceased faith
- Provides framework and coping resources (e.g., clergy, community, rites and rituals, prayers, behaviors, ceremonies, structure)
- Resource for understanding/coping with loss
- May support meaning making
- Religious coping, private religious practices, and organizational religious activity is factored into post-traumatic growth (PTG)
- Grief can deepen spiritual beliefs and enhance PTG, most especially with violent loss survivors
- Can help reframe loss; be a form of solace; help interpret events differently
- Engaging with beliefs and spiritual leaders can support this process
- May provide comfort and guidance regarding existence beyond physical existence
- Secure attachment to one’s Higher Power (one who is consistently available and responsive) predicts positive religious coping, meaning making, stress-related growth, and reduces depression and anxiety (belief in benevolent Higher Power)

(Burke & Neimeyer, 2014; Chapple, et al., 2011; Currier, et al., 2013; Kelley & Chan, 2012; Wortman & Park, 2008)

Clinical Considerations

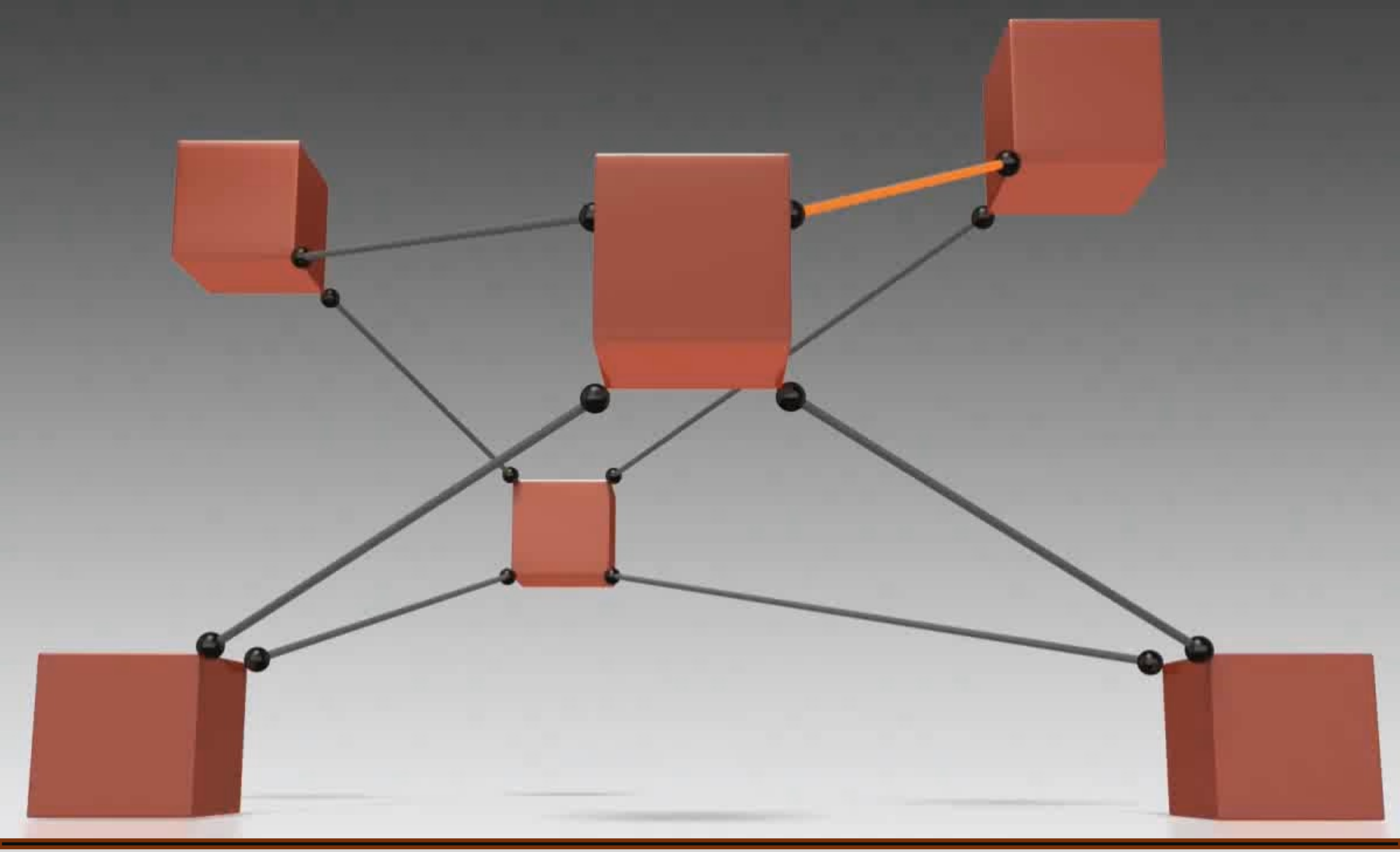
- Explore how clients draw on beliefs and spiritual convictions to navigate grieving process. Be a companion in exploration, not offer definitive answers
- Deal with difficult topics courageously and honestly. Do not shy away
- Explore and reinforce those beliefs, remembering they are a source of strength
- Be aware and attend to the spiritual crisis that may occur as a result of the loss
- Be open to exploring the various ways that religious beliefs encourage guidance in finding meaning in suffering; support hope and compassion
- Welcome client to share post-death encounters (i.e., extraordinary experiences)
- Be willing to hear experiences and beliefs foreign to you
- Become more familiar with religious and spiritual traditions
- "Develop the necessary comfort and skill to deal with client's spiritual concerns in ways most helpful to the client" (Tedeschi & Calhoun, 2006, p. 111)
- Remember religious beliefs may not always be helpful, and may lead to self-blame and other painful feelings and experiences

(Burke & Neimeyer, 2014; Chapple, et al., 2011; Currier, et al., 2013; Tedeschi & Calhoun, 2006)



Singing in the rain: this ingenious little tree frog uses a leaf as an umbrella in Jember, East Java

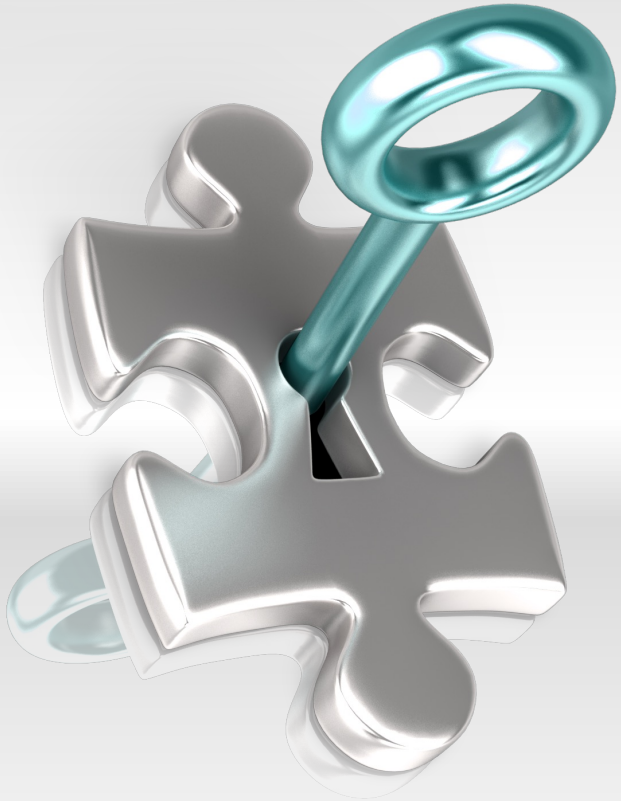
Photograph: Penkdix Palme /Newsteam



Assessment

Gathering information

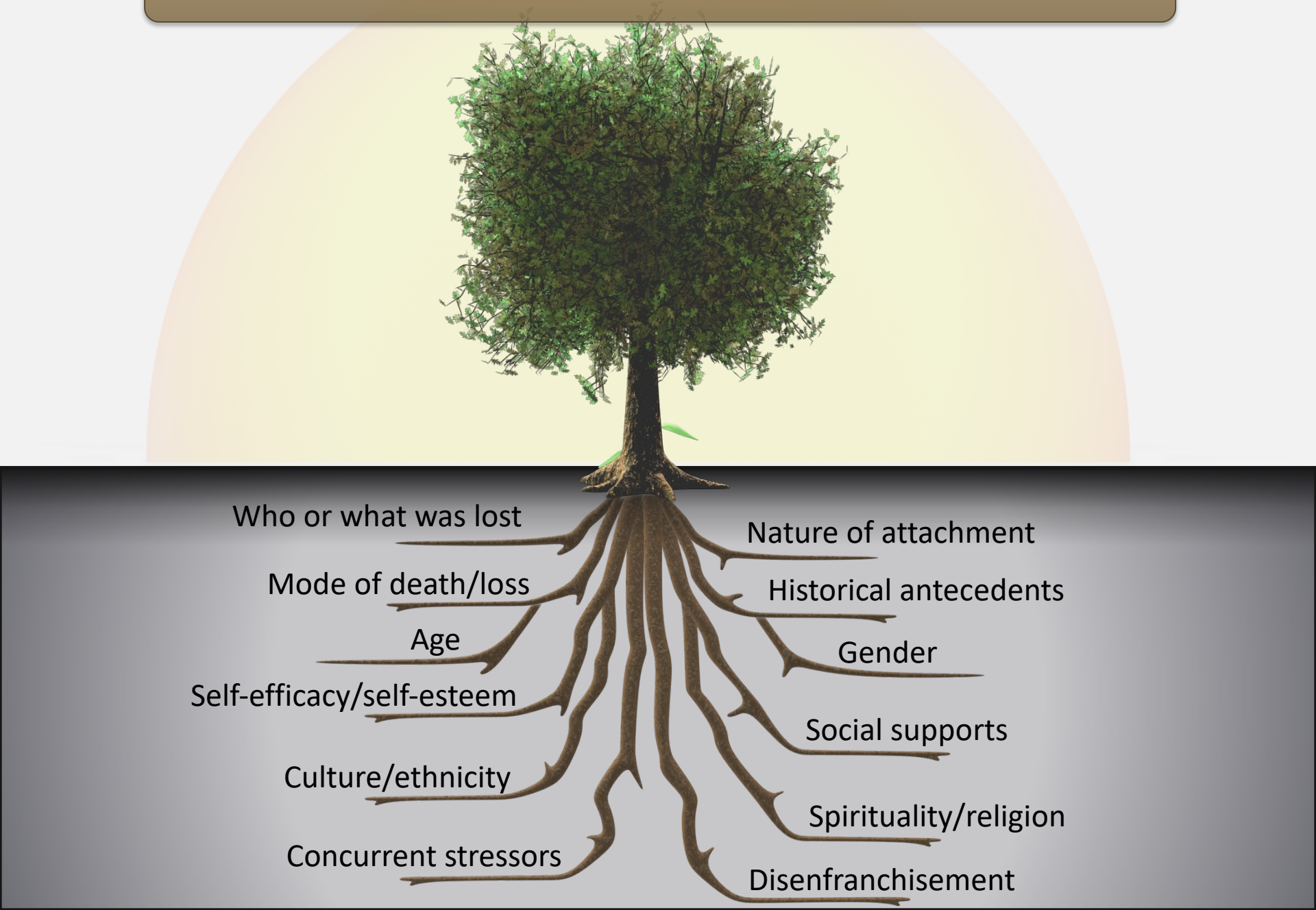
Topics For Assessment



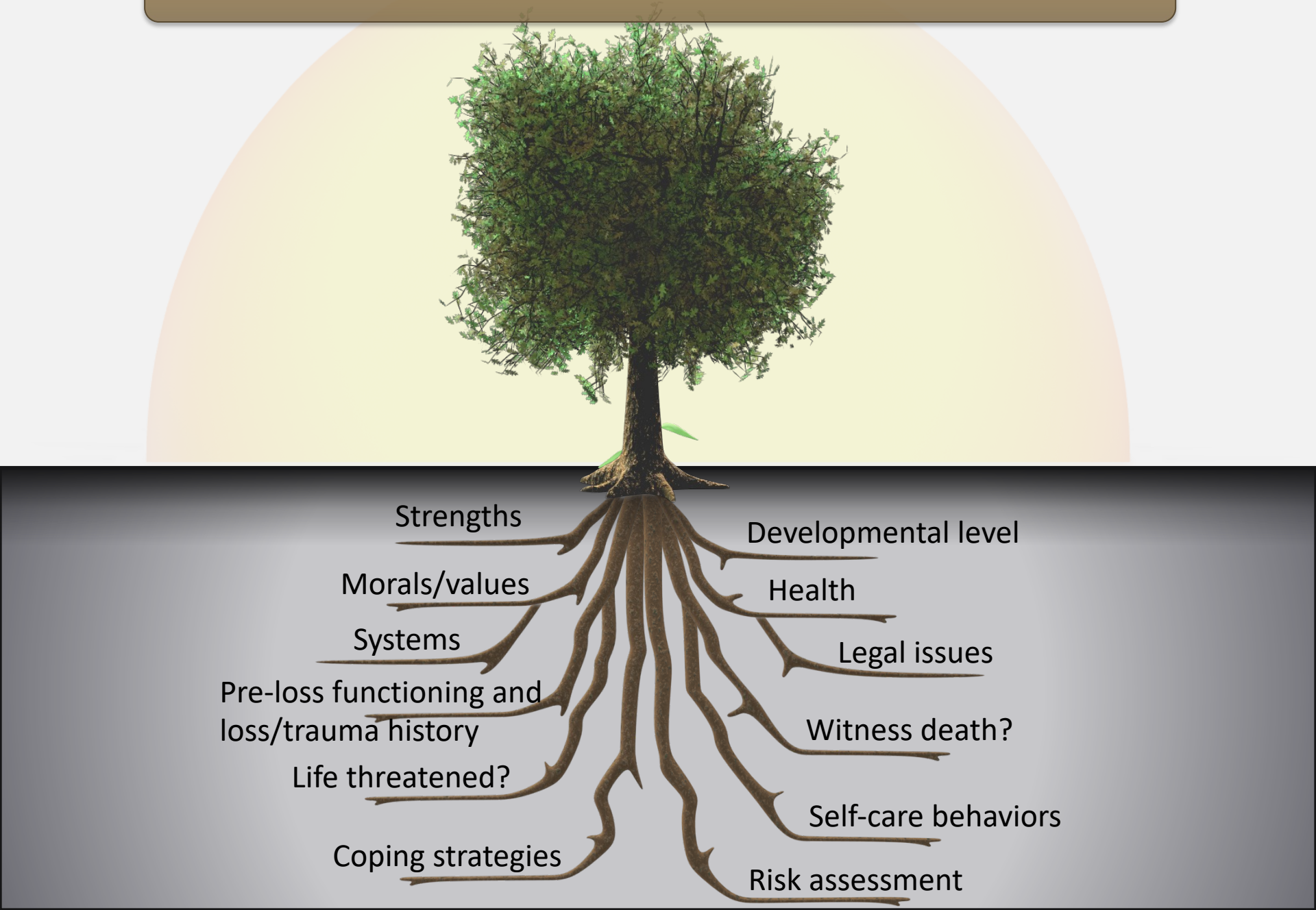
- Circumstances surrounding death/loss
- Nature and meaning of what has been lost
- Reactions to death/loss
- Changes since loss
- History of relationship to deceased
- Self-assessment of coping
- Comprehension of grieving process
- Expectations

(Meichenbaum, ND)

Assessment of Mediators



Assessment of Mediators



Attachment Styles

Secure

2

3

4

Comfortable with intimacy and autonomy

High self-esteem

Coherent and cohesive

Flexible

Relocates bond

Oscillates

Back to main

1

Preoccupied/ Anxious

3

4

Preoccupied with relationship

Low self-esteem

Unable to cope constructively

Stuck in emotional response

High risk of PGD

Back to main

1

2

Dismissive/ Avoidant

4

Dismissing of relationships and intimacy

High self-esteem

Lack of trust

Independent

Avoids emotions

Restoration focused

Back to main

1

2

3

Disorganized

Fearful of intimacy and socially avoidant

Low self-esteem

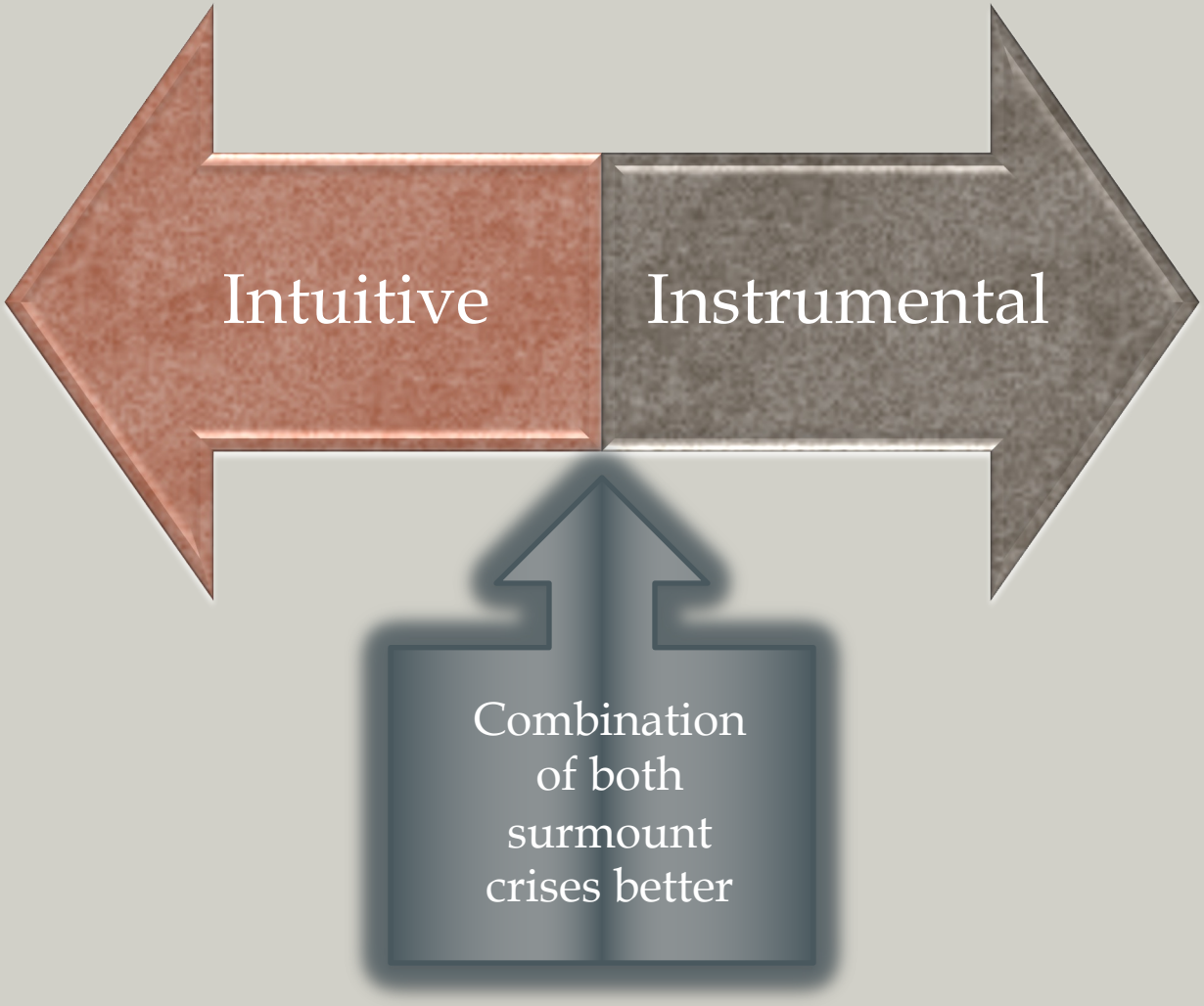
Fear rejection, but wants closeness

Poor adaptation

Remains non-integrated and non-reconstructed

Back to main

Martin & Doka's Adaptive Grieving Styles



(Doka, 2011)

Strengths: Positive Psychology

Positive Psychology Theory by Martin Seligman

Inventory of Strengths Link (10+):

https://www.viacharacter.org/survey/account/register

Wisdom

CREATIVITY
- Clever
- Original & Adaptive
- Problem Solver

CURIOSITY
- Interested
- Explores new things
- Open to new ideas

JUDGMENT
- Critical thinker
- Thinks things thorough
- Open-minded

LOVE OF LEARNING
- Masters new skills & topics
- Systematically adds to knowledge

PERSPECTIVE
- Wise
- Provides wise counsel
- Takes the big picture view

Courage

BRAVERY
- Shows valor
- Doesn't shrink from fear
- Speaks up for what's right

PERSEVERANCE
- Persistent
- Industrious
- Finishes what one starts

HONESTY
- Authentic
- Trustworthy
- Sincere

ZEST
- Enthusiastic
- Energetic
- Doesn't do things half-heartedly.

Humanity

LOVE
- Warm and genuine
- Values close relationships

KINDNESS
- Generous
- Nurturing
- Caring
- Compassionate
- Altruistic

SOCIAL INTELLIGENCE
- Aware of the motives and feelings of self/others
- Knows what makes others tick

Justice

TEAMWORK
- Team player
- Socially responsible
- Loyal

FAIRNESS
- Just
- Doesn't let feelings bias decisions about others

LEADERSHIP
- Organizes group activites
- Encourages a group to get things done

Temperance

FORGIVENESS
- Merciful
- Accepts others' shortcomings
- Gives people a second chance

HUMILITY
- Modest
- Lets one's accomplishments speak for themselves

PRUDENCE
- Careful
- Cautious
- Doesn't take undue risks

SELF-REGULATION
- Self-controled
- Disciplined
- Manages impulses and emotions

Transcendence

APPRECIATION OF BEAUTY & EXCELLENCE
- Feels awe and wonder in beauty
- Inspired by goodness of others

GRATITUDE
- Thankful for the good
- Expresses thanks
- Feels blessed

HOPE
- Optimistic
- Future-minded
- Future Orientated

HUMOR
- Playful
- Brings smiles to others
- Lighthearted

SPIRITUALITY
- Searches for meaning
- Feels a sense of purpose
- Senses a relationship with the sacred

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Formal Assessment Measures

- Do not just use scale or questionnaire. Study research, focus, and appropriateness
- Choices should be tailored
- May be used throughout the course of treatment.
- Many in public domain, but some require purchase and training

Intake Questionnaires

1. **Grief and Mourning Status Interview and Inventory (GAMSII) (Rando)**

Offers:

a. Part I: Basic demographic information

b. Part II: Main parts of history, MSE, and premorbid characteristics

c. Part III: Structured interview with loss-related topic areas based on Rando's 6 R's mourning processes

GAMSII and accompanying chapter provided in handout for this certification

(Permission granted by Therese Rando)

(Rando, 1993)

Intake Questionnaires

1. **Two-Track Bereavement Questionnaire on Life Following Loss (Rubin, Nadav, & Malkinson)**

Self-report assesses response to loss over time. Constructed in accordance with the Two-Track Model of Bereavement.

Offers:

a. Track I: Biopsychosocial functioning

a. Track II: Ongoing relationship to memories, images, thoughts, and feeling states associated with the deceased.

(Rubin, Nadav, & Malkinson, 2009)

Complicated Grief Measures

1. Brief Grief Questionnaire (Center for Prolonged Grief; Shear et al.)

https://complicatedgrief.columbia.edu/questionnaire-brief-grief/

2. PG-13: Inventory of Prolonged Grief - R (Prigerson et al.)

https://endoflife.weill.cornell.edu/sites/default/files/pg-13.pdf

Complicated Grief Measures

3. Inventory of Complicated Spiritual Grief 2.0 (Burke, et al.)

"a spiritual crisis during bereavement that compromises the griever's sense of relationship to God and/or the faith community, such that he or she struggles to reestablish spiritual equilibrium following the loss" (Burke, et al., 2021)

Measures:

a. Insecurity with God

b. Estrangement from spiritual community

c. Disruption in religious practices

https://www.tandfonline.com/loi/udst20

Suicide and ETOH Assessment Measures

1. Suicide Risk Assessment – C-SSRS (Columbia University Lighthouse Project)

https://cssrs.columbia.edu/

assesses passive and active suicidal ideation, method, plan, intent to act, and suicidal behavior. Clinician administered

FREE Training:
https://cssrs.columbia.edu/training/training-options/

2. TAPS (Tobacco, Alcohol, Prescription Medication, and Other Substance Use) (National Institute On Drug Abuse)

https://www.drugabuse.gov/taps/#/

Consists of combined screening component (TAPS-1) followed by brief assessment (TAPS-2) for those who screen positive. Combines screening and brief assessment for commonly used substances. Self or clinician administered

(Both are in public domain)

Depression Assessment Measure

1. Hamilton Depression Rating Scale

measure assessing number, types, and duration of depressive symptoms across racial, gender, and age categories (in public domain)

https://dcf.psychiatry.ufl.edu/files/2011/05/HAMILTON-DEPRESSION.pdf

2. Beck Depression Inventory-II (13-80 yo)

https://www.pearsonassessments.com/store/usassessments/en/Store/Professional-Assessments/Personality-%26-Biopsychosocial/Beck-Depression-Inventory-II/p/100000159.html

Measures behavioral manifestations and severity of depression. (must be purchased)

PTSD Assessment Measure

2. US Department of Veteran Affairs

PTSD: Clinician-Administered PTSD Scale for DSM-5 (CAPS-5)
https://www.ptsd.va.gov/professional/assessment/adult-int/caps.asp

- 30-item structured interview used to:
- Make current (past month) diagnosis of PTSD
- Make lifetime diagnosis of PTSD
- Assess PTSD symptoms over past week
- Questions target onset and duration of symptoms, subjective distress, impact of symptoms on social and occupational functioning, improvement in symptoms since a previous CAPS administration, overall response validity, overall PTSD severity, and specifications for the dissociative subtype

Violence Assessment Measure

1. Center for Disease Control and Prevention

https://wwwn.cdc.gov/WPVHC/Nurses/Course/Slide/Unit6_8

Assess potential danger to others or to him/herself

2. Short-Term Assessment of Risk and Treatability (START)

http://www.bcmhsus.ca/health-professionals/clinical-professional-resources/risk-assessment-start-manuals

Inform multiple risk domains relevant to everyday psychiatric clinical practice. Violence to others (requires purchase and there is an optional training)

- Suicide
- Self-harm
- Self-neglect
- Unauthorized absence (failure to return from a day pass)
- Substance use
- Risk of being victimized
- General offending

Trauma Assessment Measure

1. Trauma Assessment

https://georgetown.app.box.com/s/tsijlp5br1w87o6ezpzlyeyx3dfxqxn6

2. Life Events Checklist (National Center for PTSD)

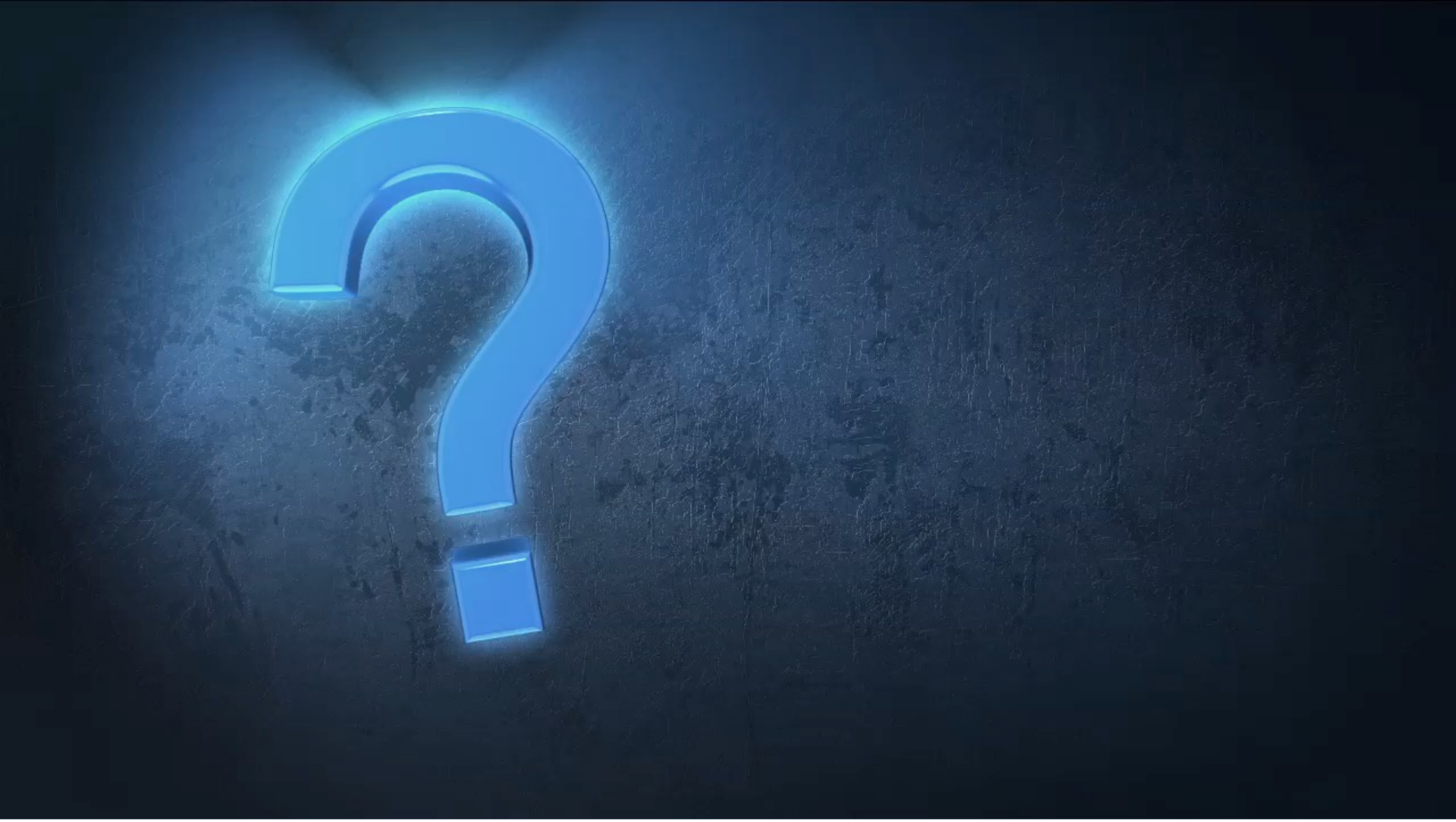
https://www.ptsd.va.gov/professional/assessment/te-measures/brief_trauma_questionnaire_btq.asp

Gathers information about potential traumatic experiences. Respondents indicate varying levels of exposure to potentially traumatic events. (public domain)

Stengths Assessment Measure

Strengths

https://www.viacharacter.org/survey/account/register



Questions?? Comments?

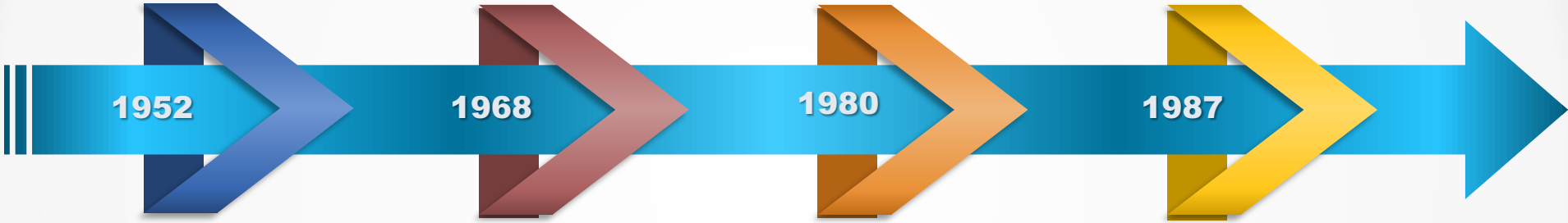
AAAAAAND DONE!

Grief Treatment Certification Course: Clinical Tools for Building Resiliency and Moving Toward Post-Traumatic Growth

Christina Zampitella, Psy.D., FT

DSM/ICD and Differential Diagnoses

Diagnostic and Statistical Manual of Mental Disorders and Grief



DSM-I

Grief was not addressed. All disorders considered reactions of personality

DSM-II

Neurotic/ reactive/ bereavement depression introduced

DSM-III

Multi-axis introduced

Uncomplicated bereavement V-Code

Bereavement exclusion (BE) introduced

DSM-III-R

BE still included

Wording changes

Diagnostic and Statistical Manual of Mental Disorders and Grief

DSM-IV

BE still included

Minor word changes

BE added to adjustment disorder

Controversy starting

V Code is "Bereavement"

DSM-IV-TR

BE Still included

Change of wording

V Code remained

Call for more research

DSM-5

BE removed from MDD but not from AD

V Code > Z Code

Based on significant amount of research

Persistent complex bereavement disorder (PCBD) introduced into Section III

DSM-5-TR

BE still removed

Z Code remains

BE remains in AD

PCBD renamed prolonged grief disorder (PGD)

Placed in Section II in trauma and stressor related disorders

Criteria for Prolonged Grief Disorder

Criterion A

- The death, at least 12 months ago, of a person who was close to the bereaved individual (for children and adolescents, at least 6 months ago).

Criterion B

Since the death, the development of a persistent grief response characterized by one or both of the following symptoms, which have been present most days to a clinically significant degree. In addition, the symptom(s) have occurred nearly every day for at least the last month:

- Intense yearning/longing for the deceased person
- Preoccupation with thoughts or memories of the deceased person (in children and adolescents, preoccupation may focus on circumstances of the death)

Criterion C

Since the death, at least 3 of the following symptoms have been present most days to a clinically significant degree. In addition, the symptoms have occurred nearly every day for at least the last month:

- Identity disruption (e.g., feeling as though part of oneself has died) since the death
- Marked sense of disbelief about the death
- Avoidance of reminders that the person is dead (in children and adolescents, may be characterized by efforts to avoid reminders)

(APA, 2022)

Criteria for Prolonged Grief Disorder

Criterion C (Cont'd)	• Intense emotional pain (e.g., anger, bitterness, sorrow) related to the death • Difficulty reintegrating into one's relationships and activities after the death (e.g., problems engaging with friends, pursing interests, or planning for the future) • Emotional numbness (absence or marked reduction of emotional experience as a result of the death) • Feeling that life is meaningless as a result of the death • Intense loneliness as a result of the death
Criterion D	• The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning
Criterion E	• The duration and severity of the bereavement reaction clearly exceeds expected social, cultural or religious norms for the individual's culture and context

(APA, 2022)

Criteria for Prolonged Grief Disorder

Criterion F

- The symptoms are not better explained by a major depressive disorder, posttraumatic stress disorder, or another mental disorder, or attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition

(APA, 2022)

Prolonged Grief Disorder in ICD-11

Follows death of partner, parent, child, or other person close to the deceased

At least one if the following	• Persistent and pervasive longing for the deceased • Persistent and pervasive preoccupation with the deceased
Accompanied by intense emotional pain	• Examples include sadness, guilt, anger, denial, blame • Difficulty accepting death • Feeling one has lost part of one's self • Inability to experience positive mood • Difficulty engaging with social or other activities
Time and Impairment	• More than 6 months following loss • Clearly exceeding expected cultural, social, or religious norms • Significant impairment in personal, family, occupational, and other important areas of functioning

Adjustment Disorders

Criterion A	• Development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s)
Criterion B	• Causes significant impairments in social, occupational, or other important areas of functioning
Criterion C	• Does not meet criteria for another disorder or exacerbation of current disorder
Criterion D	• Does not represent normal bereavement
Criterion E	• Once stressor or consequences have terminated, symptoms do not persist for more than an additional 6 months

What Does the “Note” Say?

- In distinguishing grief from a major depressive episode (MDE), it is useful to consider that in grief the predominant affect is feelings of emptiness and loss, while in a MDE it is persistent depressed mood and the inability to anticipate happiness or pleasure. The dysphoria in grief is likely to decrease in intensity over days to weeks and occurs in waves, the so-called pangs of grief. These waves tend to be associated with thoughts or reminders of the deceased. The depressed mood of a MDE is more persistent and not tied to specific thoughts or preoccupations. The pain of grief may be accompanied by positive emotions and humor that are uncharacteristic of the pervasive unhappiness and misery characteristic of a MDE. The thought content associated with grief generally features a preoccupation with thoughts and memories of the deceased rather than the self-critical or pessimistic ruminations seen in a MDE. In grief, self-esteem is generally preserved, whereas in a MDE feelings of worthlessness and self-loathing are common. If self-derogatory ideation is present in grief, it typically involved perceived failings via-a-via the deceased (e.g., not visiting frequently enough, not telling the deceased how much he or she was loved). If a bereaved individual thinks about death and dying, such thoughts are generally focused on the deceased and possibly about “joining” the deceased, whereas in a MDE such thoughts are focused on ending one’s own life because of feeling worthless, undeserving of life, or unable to cope with the pain of depression. (APA, 2022, p.142)

Bereavement vs. MDD

Characteristic	*Bereavement*	*Major depressive episode*
Pattern	Waves or pangs of grief associated with thoughts or reminders of the deceased that are likely to spread further apart over time	Negative emotions experienced continually over time
Predominant affect	Emptiness and loss accompanied by occasional pleasant emotions	Pervasive depressed mood and the inability to anticipate happiness or pleasure
Self-esteem	Typically preserved, but if self-derogatory thoughts are present they usually involve perceived failings in relationship to the deceased (e.g., not visiting the deceased more often, failing to communicate their love enough to the deceased)	Critical toward self, feelings of worthlessness, and self-loathing
Sociability	Maintains connections with family and friends who have ability to console	Withdraws from others physically and emotionally and has difficulty being consoled
Thoughts	Preoccupation with thoughts and memories of the deceased; tends to be hopeful	Self-critical or pessimistic thoughts; tends to be hopeless
Thoughts of death or suicide	Thoughts of death and dying focused on the deceased and perhaps reuniting with the deceased	Explicit suicidal thoughts related to feelings of worthlessness, a belief that one is undeserving of life, or a sense that one is no longer able to cope with the pain of depression
Triggers	Depressed mood triggered by thoughts or reminders of the deceased	Depressed mood not tied to specific thoughts or preoccupations

(Kavan, 2014)

Differential Diagnosis of prolonged grief disorder, major depressive disorder, and post-traumatic stress disorder			
Characteristic	**Prolonged Grief Disorder**	**Major Depressive Disorder**	**Post-Traumatic Stress Disorder**
Affective Symptoms			
Depressed mood	Prominent; focused on loss; diagnostic criterion	Prominent; diagnostic criterion	May be present
Disbelief about death	Prominent; focused on loss; diagnostic criterion	Not usually present	May be present
Anhedonia	Not usually present	Prominent and pervasive; diagnostic criterion	Prominent and pervasive; diagnostic criterion
Anxiety	May be present; focused on separation anxiety	May be present	Prominent and pervasive; diagnostic criterion; focused on fear of recurrent danger
Yearning and Longing	Prominent and pervasive; diagnostic criterion	Not usually present	Not usually present
Guilt	Common; diagnostic criterion; related to regrets with deceased	Usually present; related to feelings of being undeserving and worthless	Prominent and pervasive; diagnostic criterion; usually focused on event or aftermath
Cognitive and Behavioral Symptoms			
Difficulty concentrating	Not usually present	Common; diagnostic criterion	Common; diagnostic criterion
Preoccupying thoughts	Common; Focused on thoughts and memories of the deceased; diagnostic criterion	May be present, focused on negative thoughts about self, other, the world	Negative, exaggerated, distorted thoughts related to the event; diagnostic criterion
Recurrent preoccupying images or thoughts	Common; focused on thoughts/memories of deceased; diagnostic criterion	May be present	Common; focused on event; associated with fear; diagnostic criterion
Avoidance of reminders of loss	Common; focused on reminders of the finality if the death; diagnostic criterion	May be present, but usually focused on social withdrawal	Common; focused on loss of safety or reminders of the event; diagnostic criterion
Loss of meaningful life	May feel meaningless without deceased; diagnostic criterion	May be present	May be present
Seeking proximity to the deceased	Common; diagnostic criterion	Not usually present	Not usually present

Treatment Planning

Counseling vs. Therapy

Counseling

~ facilitate uncomplicated, or normal, grief to healthy integration

Therapy

~ uses specialized techniques that help with abnormal or complicated grief reactions

~ helps resolve conflicts of separation, avoidance, and adaptation

~ trauma work (developmental, acute, etc.)

Treatment Plan: Uncomplicated Grief

- Walk along side, do not lead
- Fingerprint analogy - flexible
- Must consider attachment style
- Natural, adaptive, non-pathological
- Maintain process
- Grief facilitation

Treatment Plan: Uncomplicated Grief

1. Accept reality and permanence of death
2. Experience painful emotions of the death
3. Recognize and resolve ambivalent feelings
4. Adjust to changes in everyday life
5. Identify and preserve positive memories of deceased
6. Redefine relationship with deceased as one of memory
7. Develop new relationships and deepen existing ones
8. Make meaning from the loss
9. Foster enhanced problem-solving and conflict resolution

(Cohen, et al., 2001: Worden , 2018)

Shear's HEALING Milestones

Honor your loved one and yourself; discover own interests and values

Embrace emotions, both painful and pleasant; learn to ease emotional pain

Accept grief and let it find a place in life

Live with reminders of loss, allowing them to be bittersweet

Integrate memories into life; let them help you learn and grow

Narrate stories of the death for self and to share with others

Gather around others; let them into your life; let them support you

Can be achieved in no particular order as the healing process often naturally unfolds. Grief finds a place in life and recedes into background (Shear, 2020)

Treatment Plan: Meaning Reconstruction

- Process event story, it's implications, and make sense of it (interventions go here)
- Access the back story of relationship to restore a sense of grounding and security (interventions go here too!)
- Resolve unfinished business (and MORE interventions!)
- Re-attach in a new way
- Integrate deceased's absence in a way the preserves the attachment

(Neimeyer, 2018)

Treatment Planning (Neimeyer)

- The Three "R's"
    1. **Reduce distress** – education, relaxation autonomy, safety
    2. **Revise the narrative** – Retelling, transitional
    3. **Re-engage** – meaningful activities and relationships
- The Three "P's"
    1. **Presence** – non-anxious
    2. **Process** :
        a. Purpose (where is process leading to client needs)
        b. Pacing – Gauging client readiness
    3. **Procedures** – Techniques while tracking client's emotional struggles

Goal – shift the acute death story to a more adaptive and integrated story through story telling and bringing the deceased to a living memory

(Neimeyer, 2018)

Treatment Planning: Prolonged Grief Therapy (Shear)

- Prolonged Grief Therapy from Columbia University by Katherine Shear (Center for Prolonged Grief)
  * 16 modules/sessions
  * Thorough evaluation measures
  * Weekly assignments, including grief monitoring, interval plans, imaginal revisiting, situational revisiting, imaginal conversation, memories and pictures, attention to self-care, core values, and meaningful future plans, and bringing in one person for one session
- Requires training with a trainer with audiotaped sessions, 2 cases
- Goals: Relieve preoccupying thoughts about or yearning for the deceased, improve emotional regulation, assist bereaved to reimagine life without deceased, and engage again in other relationships and activities
- Two foci: 1. Restoration (of functioning) and 2. loss (thinking about deceased without invoking intense anger, guilt, or anxiety) (Perng & Renz, 2018; Shear, 2020)

Treatment Planning: Prolonged Grief Therapy (Shear)

Three Phases:

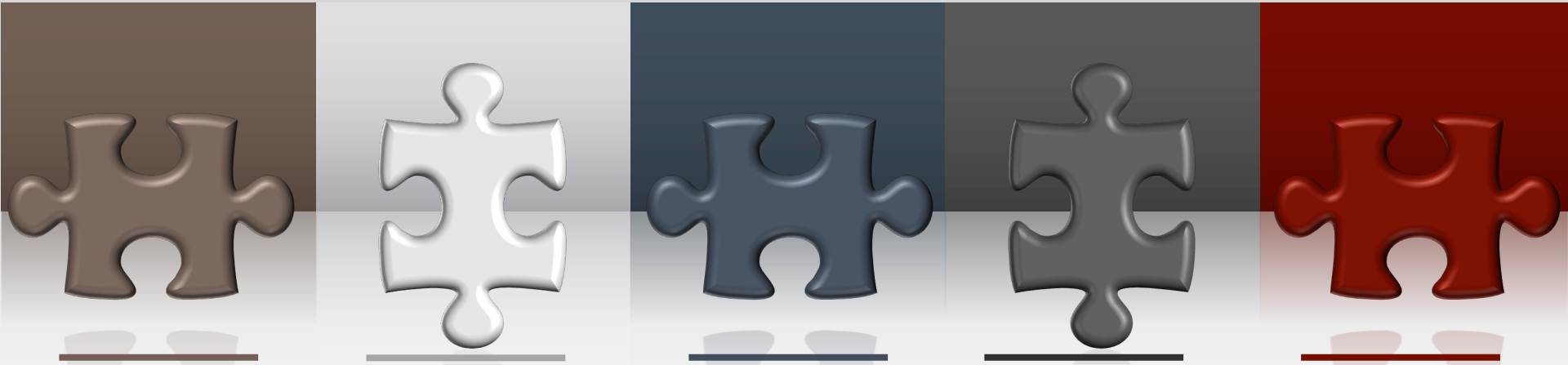
1. Introductory Phase (Sessions 1-3) Laying the Foundation – Establish a sense of companionship – Explain complicated grief and the complicated grief treatment – Begin grief monitoring and discussion of personal aspirations – Include support person Middle Phase

2. (Sessions 4-10) The Heart of Treatment – Loss Focus – imaginal revisiting of the death, situational revisiting, memories and pictures, imaginal conversation – Restoration focus – aspirations and plans, self-care, re-engaging with others Termination Phase

3. (Sessions 11-16) Transition to Ongoing Life – Summarize gains and plans for the future – Process termination

(Doka, Neimeyer, & Rando, 2017)

Integrative Cognitive Behavioral Treatment for PGD



Relaxation techniques

Gestalt Therapy

Solution Focused Brief Therapy

Multi-generational Family Therapy

Imagery Work

(Rosner, Pfoh, & Kotoučová, 2011)

Integrative Cognitive Behavioral Treatment for PGD

Phase 1

Stabilization, exploration, and motivation

Phase 2

Confrontation, exposure, and reinterpretation

Phase 3

Integration and transformation

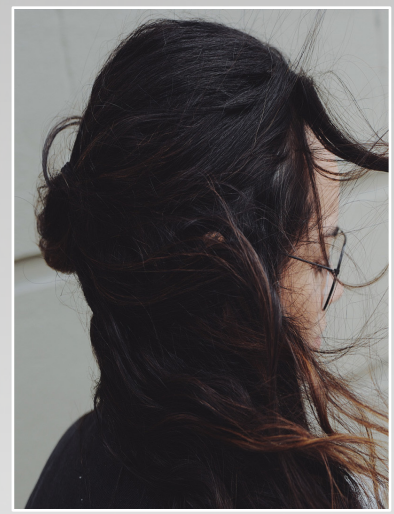
(Rosner, Pfoh, & Kotoučová, 2011)

Integrative Cognitive Behavioral Treatment for PGD

Session number	Session content	Treatment strategies
A1	Admin. contracting, psychoeducation about treatment	Work sheet on social roles and tasks and symptoms, safety planning
A2	Nodal events: My loss in a bigger perspective, stabilization	Genogram, life line, grounding exercises if necessary
A3	Psychoeducation on normal and complicated grief and introduction of CG-model	Worksheets to prepare psychoeducation and CG model to enable the patient to recognize dysfunctional behavior and personal triggers
A4	—	—
A5	Primary and secondary losses in my life	Introduction of the deceased with pictures, music, etc; worksheet on life changes due to bereavement
A6	Review of information and treatment goals	Four blocker method similar to motivational interviewing: Advantages and disadvantages of change, worksheet on treatment motivation, and treatment goals
A7	—	—
B8 oder	Relaxation	Introduction to relaxation, progressive muscle relaxation
B8	Relaxation and demarcation	Imagery work addressing distressing cognitive stimuli followed by relaxation techniques
B9	Identification of dysfunctional thoughts	Cognitive restructuring, metaphors, psychoeducation regarding thought processes, helpful, and non-helpful thoughts
B10	Rumination and guilt	Socratic dialoge, reframing, metaphors, worksheet
B11	Emotions and perceptions	Worksheet, dialoguing (Gestalt)
B12 & 13	Worst moments: confrontation *in sensu*	Confrontation of thoughts, emotion, and/ or situations that are avoided
B14	Worst moments and identification of “hot spots”	Identification of “hot spots” and dysfunctional cognitions, cognitive restructuring, reinterpretation; Preparation of “Walk to the Grave”
B15 & 16	Confrontation, cognitive restructuring, and acceptance	Dialogical work “Walk to the Grave”
C17	Heritage and continuing bonds	Presentation/letter/essay, worksheet, home activities
C18	Memento and future	Dialoguing or letter, description of new life, dedication
C19	New life	Describing new status quo and life plan
C20	Termination	Review, relapse prevention, feedback, questions
Optional	Family session—preparation	Identification of topics and tasks (for example, different ways of grieving in the family)
Optional	Family session—implementation	Dealing with different grieving styles; collateral narratives, circular questioning
Optional	Special event planning:	
	Birthday, anniversary, holidays	Preparing plan, modify rituals, include social network
	Court appointments	Identify course of events, elicit information from lawyer, contact social support, carry out plan *in sensu*

(Rosner, Pfoh, & Kotoučová, 2011)

Narrative Reconstruction Therapy for PGD



- Assumes loss is not cohesive and is disorganized, therefore is not integrated
- Lack of integration and intrusive memories maintain acute grief and no adaptation
- Painful memories inconsistent with current goals, remain in working memory as repeated intrusions rather than being integrated into larger autobiographical memories
- Difficulties building a coherent narrative and personal meaning of loss - can lead to yearning

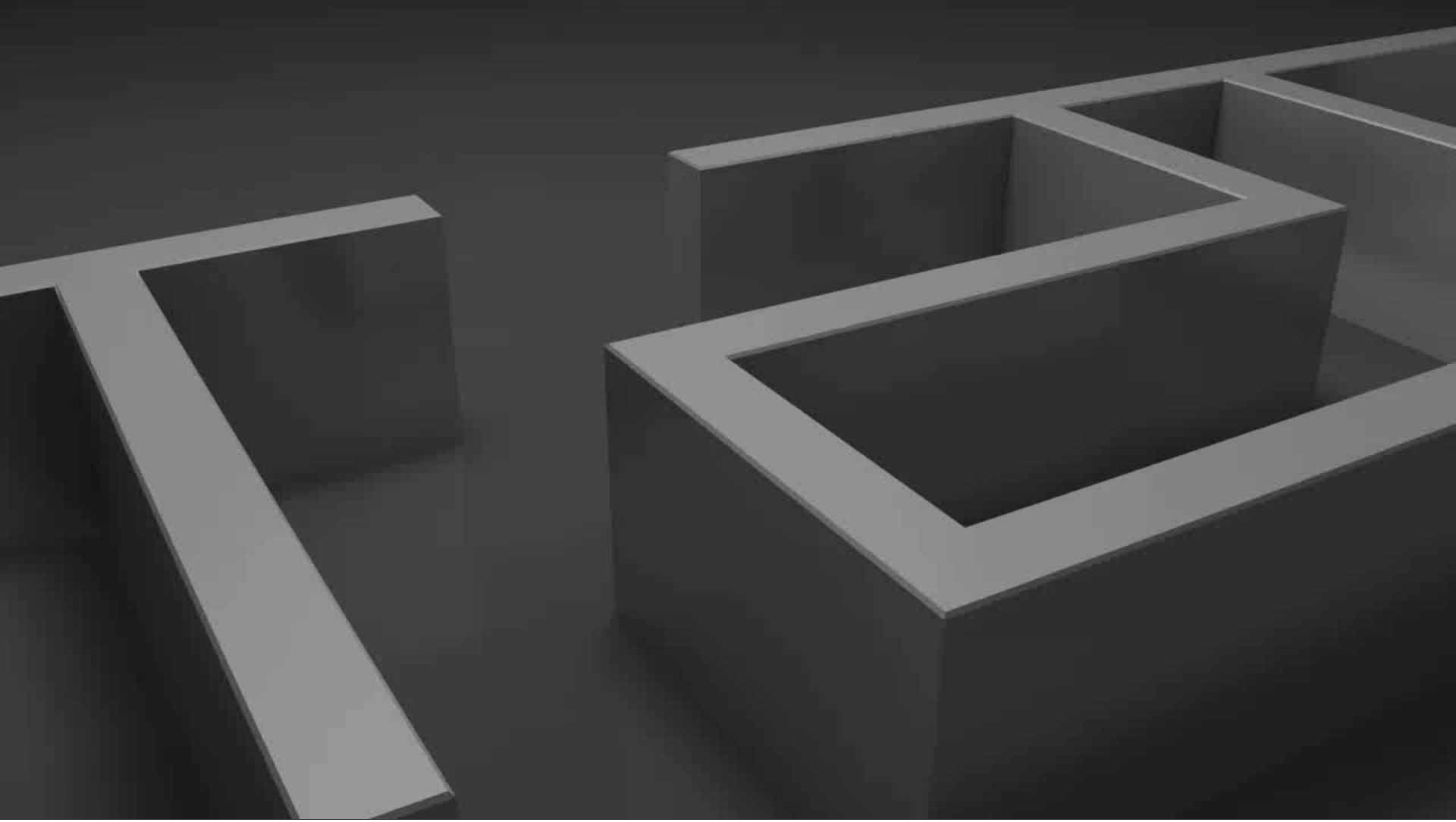
(Peri, Hasson-Ohayon, Garber, Tuval-Mashiach, & Boelen, 2016)

Narrative Reconstruction Therapy for PGD

Involves the following goals:

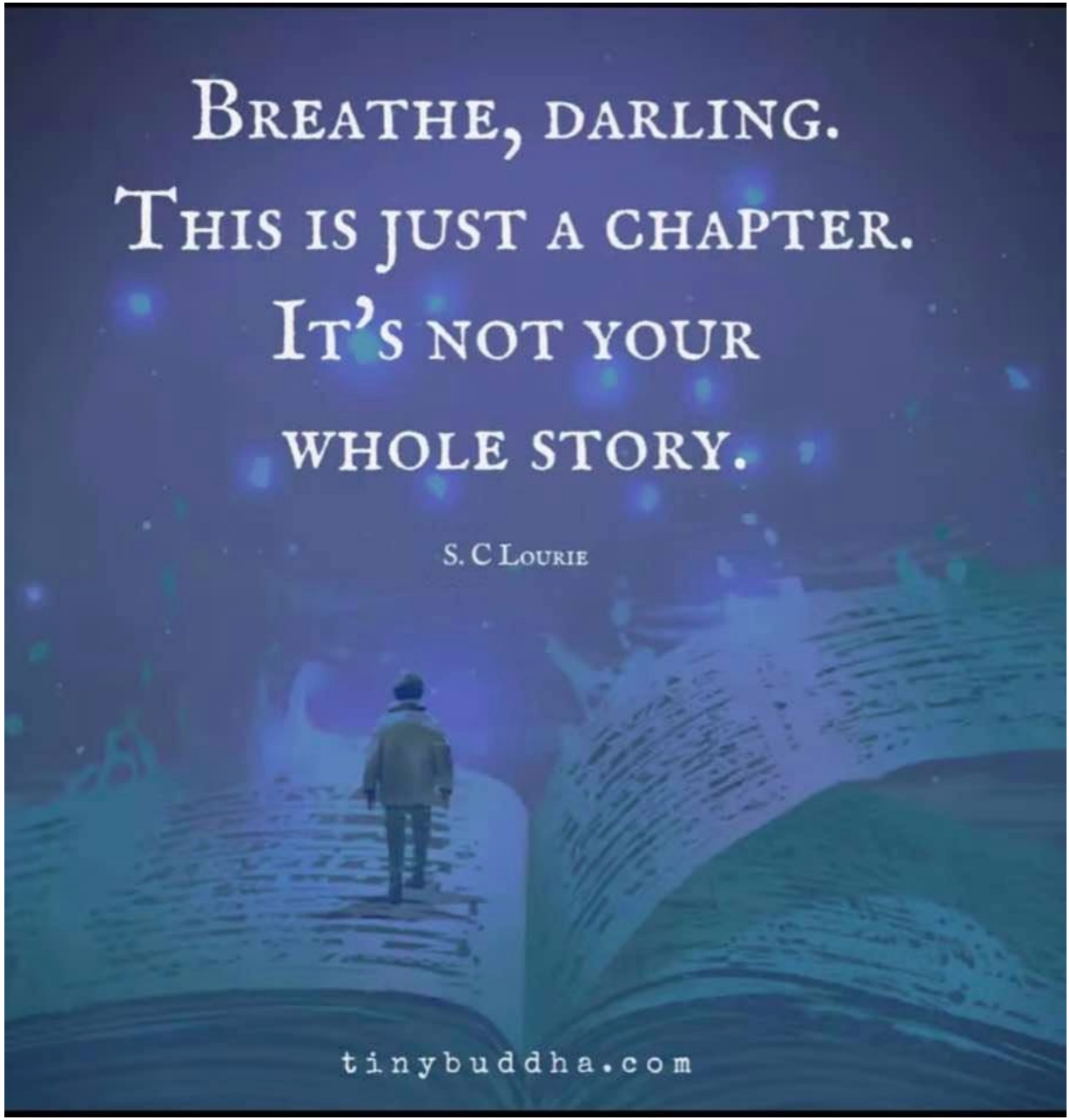
1. Exposure through retelling of the event
2. Systematic reconstruction and reorganization of memory into coherent written narrative
3. Integration with other autobiographical memories
4. Development of personal meaning associated with his/her past experiences

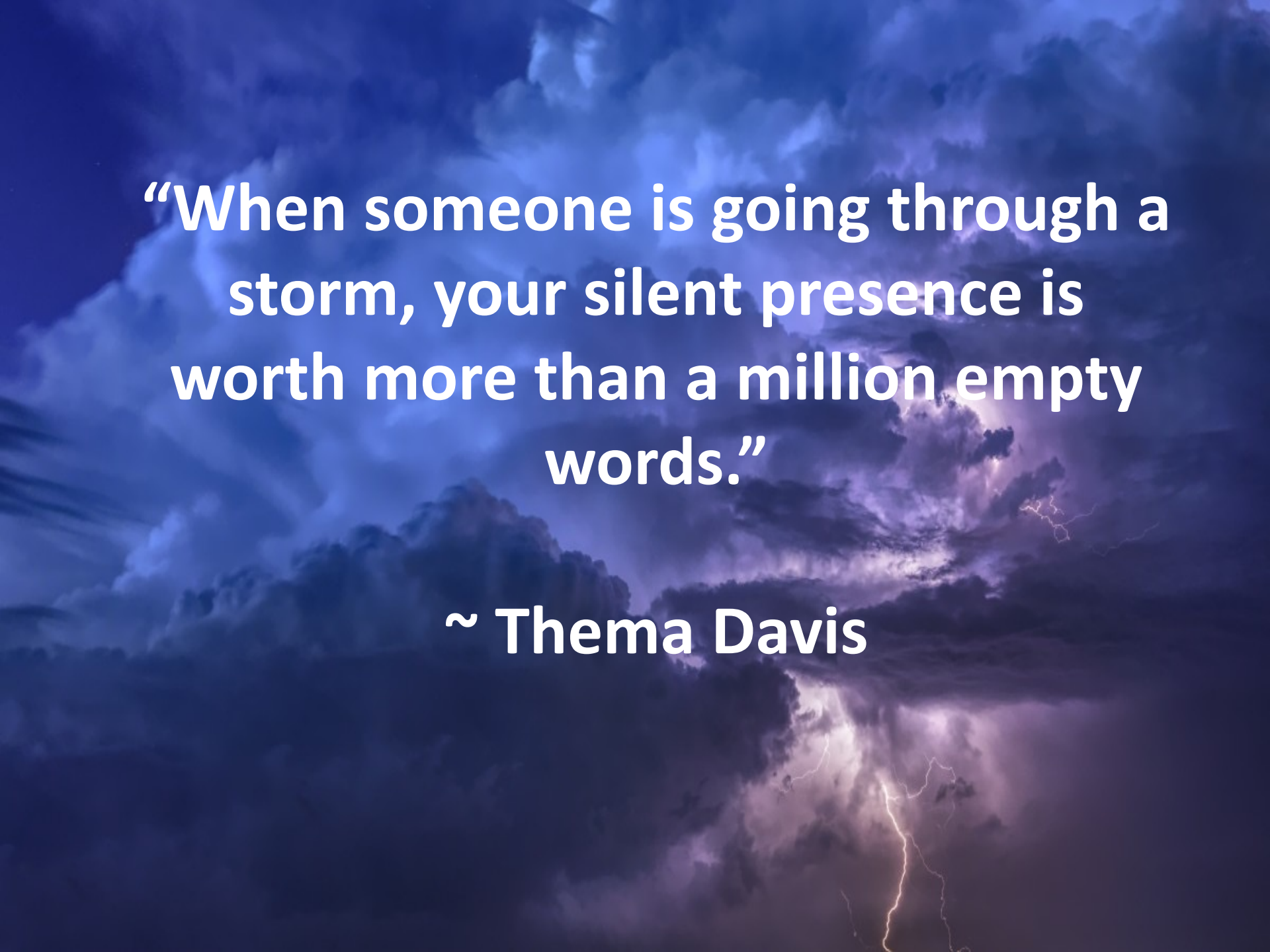
Peri, Hasson-Ohayon, Garber, Tuval-Mashiach, & Boelen, 2016)



Interventions


Solution


BREATHE, DARLING.
THIS IS JUST A CHAPTER.
IT'S NOT YOUR
WHOLE STORY.
S. C LOURIE
tinybuddha.com


“When someone is going through a storm, your silent presence is worth more than a million empty words.”
~ Thema Davis

1 Develop Collaborative Attitude	2 Respect Resistance	3 Respect Privacy	4 Integrate Homework in Session	5 Value in "being and "doing"
Be a therapeutic team. Be flexible based on client feedback. Co-create work	Respectfully understand reason, not disrespectfully overridden	Let client share what they wish. May lead to disclosure later	Acknowledge work and invite discussion about how it went.	Work is not always "doing" something. Sometimes no assignments are indicated

Narrative Approach

These five considerations are applicable to whatever approach you take in assessment and treatment

(Neimeyer, Narrative Strategies in Grief Therapy, 2018)

Medications

To Use or Not Use? THAT is a GOOD Question!

Key symptoms (i.e., profound separation distress, preoccupation with the death, meaninglessness in the absence of the loved one) are not analogous to depression, but have more in common with anxiety

PGD has different neural profiles when compared to MDD or PTSD. (e.g., nucleus accumbens activated in PGD, but not depression or PTSD)

Neurobiology of PGD involves same circuitry as reward pathway ("reward dysfunction disorder")

Current research focusing on addiction approach; drugs that work on dopamine receptors and competes against opioid receptors

Does not touch core symptomology, may provide more energy to engage in self-help

May ameliorate symptoms of depression and anxiety, but NOT grief

Tricyclic antidepressants and benzodiazepines not been proven effective for PGD

Naltrexone, which is currently used to treat alcohol and opioid dependence, being studied

Could prevent professionals, social support, and clients to pursue others forms of support and coping that are as effective as medications

Bui, et al., 2012; Gang, et al., 2021; Neimeyer, 2021)

Restorative Retelling

- Narrative Process
- Three narratives

1. External narrative – “What happened?”
2. Internal narrative – “What’s happening in you?”
3. Reflexive narrative – “What are you making of what is going on here?”

Goal is to weave all together to create a stronger “through line”

(Neimeyer, 2016)

Restorative Retelling

- Three steps
  1. Bracing – modulation and support
  2. Pacing – GO SLOW, dose
  3. Facing – Victim > navigator, witnessing

Retell for 15 minutes starting when death was imminent or announced

Reconstructing and relearning as the person is now with more resources that can be used to bear the pain

"The only thing we can do is change the past by assigning different meanings."
Restoration happens in this reconstruction

(Neimeyer, 2016)

Systematic Desensitization

Steps to reduce situational avoidance:

1. Teach deep muscle relaxation/breathing exercises
2. Create fear hierarchy starting at stimuli that creates least anxiety (fear) and build up in stages to most fear-provoking images (provides a structure for therapy)
3. Work his/her way up fear hierarchy, starting at least unpleasant stimuli and practicing relaxation techniques as he/she/they go.

Once client is comfortable with a step, he/she/they moves to next step

Can return to previous behavior and use relaxation skills

Repeated while working through all the situations in anxiety hierarchy until most anxiety-provoking is no longer triggering.

In-vivo (actuality) or in-vitro (imagination)

(McLeod, 2021; Shear, 2011)

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THE CITY MAPS OF EUROPE
Kenneth Nebenzahl
Maps of the Bible Lands
THE TIMES Atlas of
The Bester FLORILEGIUM
Plants of the Four Seasons

Free Online Memorial Websites

- GatheringUs.com
- ForeverMissed.com
- Remembered.com

Linking Objects

Symbolic Objects and Actions

- Validate relationship
- Complex vs. Simple objects
- Facilitates remembrance
- Encourages expression of feelings
- Represents bereaved and the relationship
- Represents emotion invested in relationship
- Manages separation anxiety

(Castle & Phillips, 2003; Sas & Coman, 2016; Romanoff, 1998)


MEMORY
BOX
www.kcpaperlady.blogspot.com
Image copyright 1990-2010 Stampin' Up!

Journaling

Journaling - Guidelines

- Focus on loss that is most upsetting/traumatic
- Write about aspects of experience discussed least adequately with others
- Write from standpoint of deepest thoughts and feelings, then shift to event
- Do not worry about grammar, spelling, penmanship
- 20 minutes, 4 days
- Schedule transitional activity

(Neimeyer, 2016)

Journaling - Precautions

- Secure privacy
- Postpone journaling until stable instead of directly after loss if needed
- Share (with consent) after relationship is secure with therapist

(Neimeyer, 2016)

Guilt

"Remorseful awareness stemming from a perception of having *done* something wrong or failing to have done something" (Baugher, 2009, p. 2)

Regret

Unfulfilled desire or action that could or should have done or not done (e.g., "I should have…")

Shame

Event brings disgraces, dishonor, or condemnation. Impacted by how others think of us. Can lead to feelings of negative self-image (e.g., "I am a failure"). *Focuses on "self" and moral character*

Embarrassment

Feeling self-conscious, sometimes due to the way someone died (e.g., suicide). More public than shame and level of public humiliation

(Felix, 2019)

Interventions for Guilt and Regret

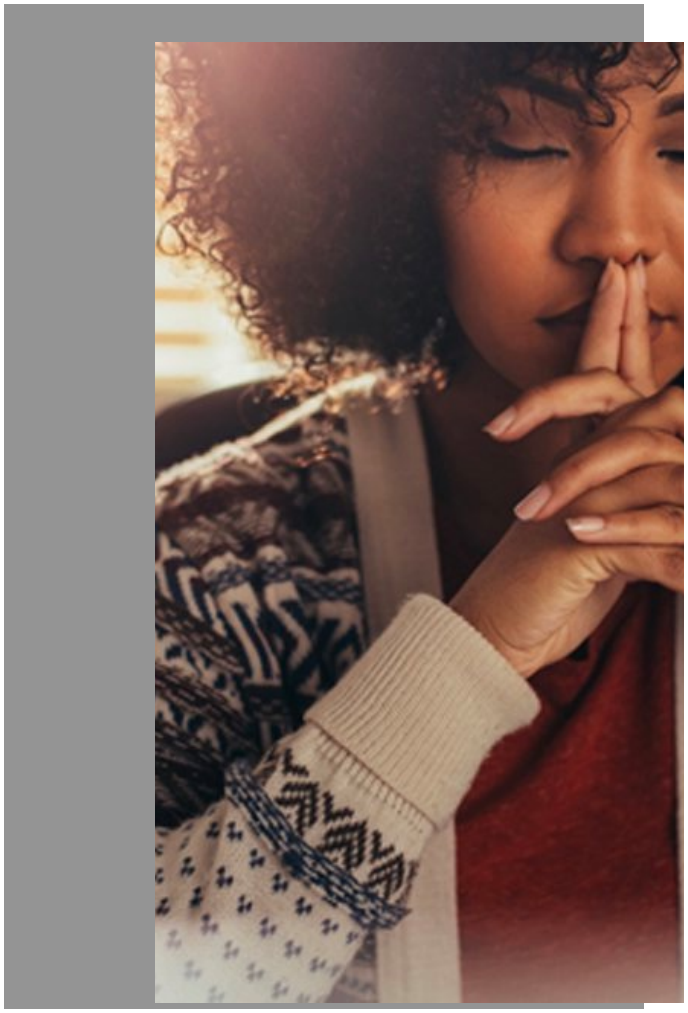
- Self-talk is important element in guilt and regret

1. Write story of the guilt
2. Address “Shoulds” and “If-Onlys” by remembering nothing can be done about them now. Thought stop by omitting phrases and replace with “What can I do now?”
3. Practice responding to others
4. Ritual
5. Compile memories
6. Identify and reduce self-punishment

“Guilt is putting today’s knowledge on yesterday’s problems” (Golden, 1996, p. 68)

(Baugher, 2009)

Interventions for Shame



Source: Adobe Stock

1. Be Aware and Identify

- Become aware of cause, whether internal (thought patterns) or external (specific circumstances)

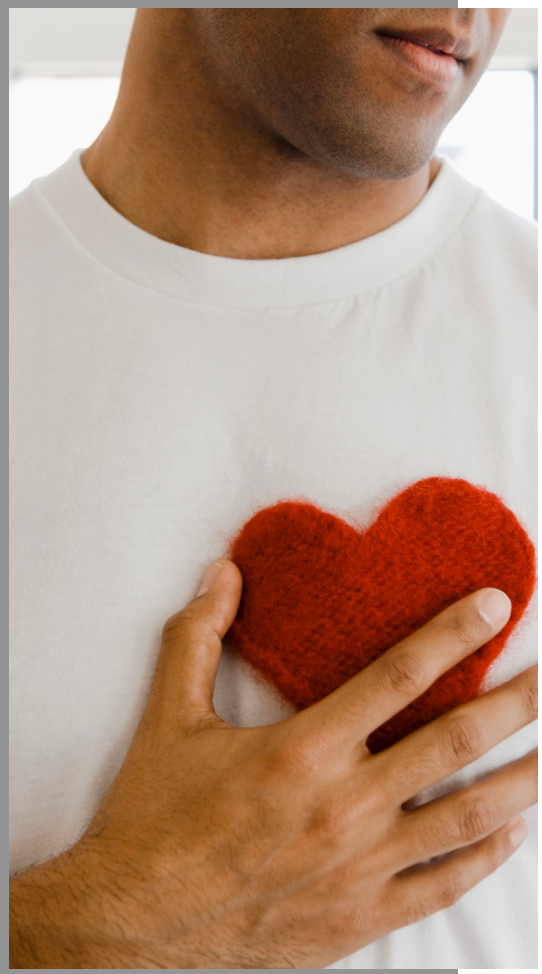
- Ask:
  a. What messages replayed often?
  b. How do they affect well-being and others?
  c. How does shame make you feel?
  d. Can something be done now?

- Reduce perfectionism and "shoulds"

- HOW?
  a. Journaling: about the "asks" above
  b. Mindfulness: increases self- awareness. Allows you to catch and change negative thoughts
  c. Ask growth-minded questions (how can I change my attitude towards the situation? etc.)

(Felix, 2019)

Interventions for Shame



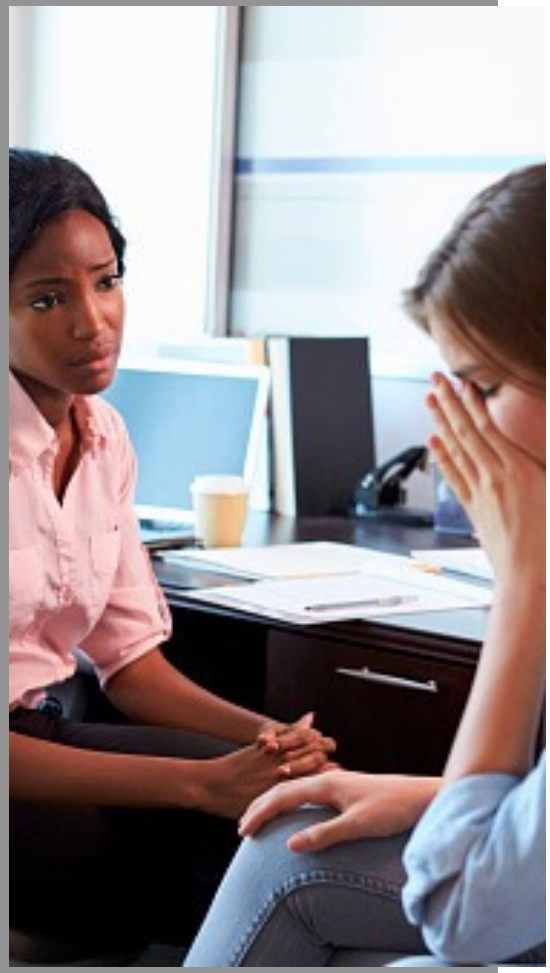
https://ggsc.berkeley.edu/what_we_do/event/mindful_self_compassion_core_skills_training1

2. Practice Self-Compassion

- Reduce rumination
- Mindfulness to observe self-talk, behaviors, and actions and relate to how you are treating yourself
- Visualizations
- Affirmations
- Mantras
- Gratitude journal
- Practice non-judgement
- Treat yourself as you would others you care for

(Felix, 2019)

Interventions for Shame



https://www.adaptivebehavioralservices.com/individual-therapy

3. Develop Shame Resilience

- Question the shame
- Talk about shame to trusted others
- Increase empathy for self
- Adopt a growth mindset
- Become purposeful with motivations and intentions

(Brown, 2010; Felix, 2019)

Interventions for Shame

https://leadershipfreak.blog/2011/10/28/control-your-feelings-%E2%80%93-don%E2%80%99t-express-them/

4. Experience and Express

- Acknowledge shame (do not hide it)
- Express in healthy ways (e.g., seek forgiveness, therapy, journaling)
- Own emotions
- Apologize if needed
- Make distinctions between guilt, shame, fear, anxiety, embarrassment, and regret
- Be aware of defenses (e.g., displacement, projection, etc.)

(Felix, 2019)

Interventions for Shame

https://www.havoca.org/survivors/grief/acceptanceforgiveness/

5. Practice Acceptance

- Invite guilt and shame – for brief amounts of time
- Treat guilt and shame as fleeting emotions
- Understand positive aspects of guilt and shame (e.g., increase self-awareness, increase humility, righting wrongs, etc.)
- Use to catalyze change and growth
- Remember past cannot be changed
- Focus on what can be done for you and others, not the shameful act
- Work towards “letting go”

(Felix, 2019)

Interventions for Forgiving Others

Enright Model - A structured intervention that consists of 20 units and four phases.

- Phase 1: Uncovering

Help to understand the psychological defenses at work within, recognize and acknowledge anger felt, and evaluate psychological harm caused by the offense.

- Phase 2: Decision Making

Possibility of forgiveness as a response is explored, followed by a commitment to forgive.

- Phase 3: Cognitive Reframing of the Offense

Help to develop empathy for the offender and accept the pain experienced.

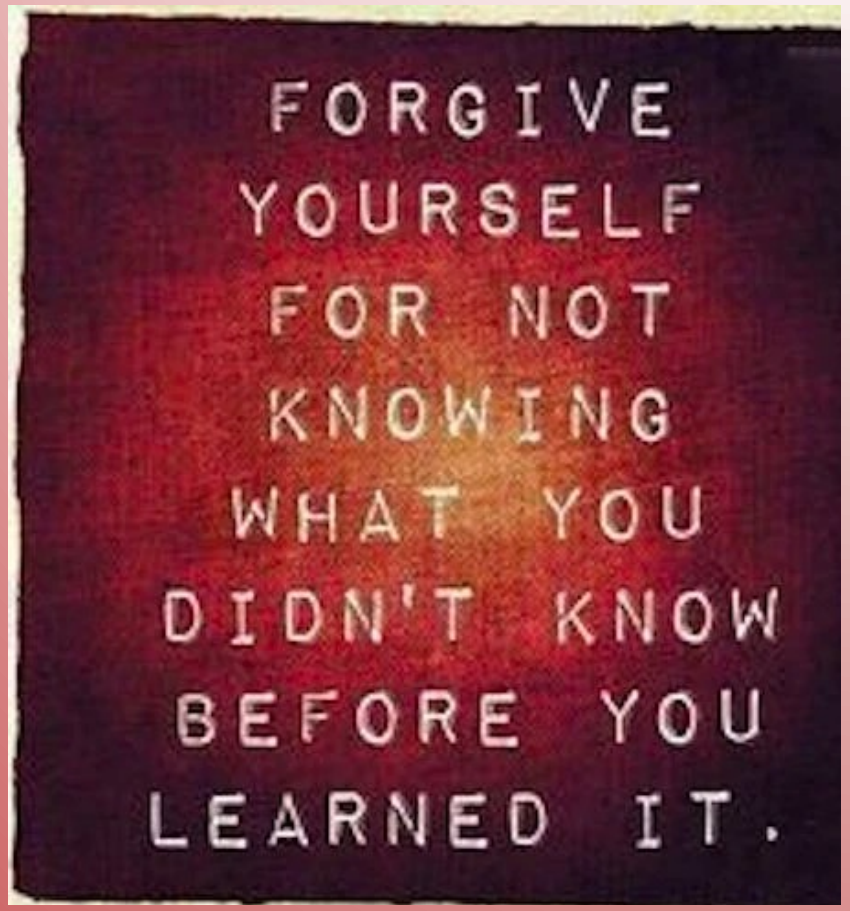
- Phase 4: Deepening

Help to find meaning in their suffering.
(Enright & Fitzgibbons, 2000)

https://inspiration.org/christian-articles/forgiveness-let-it-go/

"Forgiveness is the practice of letting go of the suffering caused by someone else's wrongdoing (or even our own). It does not mean excusing, overlooking, forgetting, condoning, or trivializing the harm or jumping to a premature or superficial reconciliation; it doesn't necessarily require reconciliation at all. Instead, it involves changing our relationship to an offense through understanding, compassion, and release" (Graham, 2014)

Interventions for Self-Forgiveness



https://orlandorecoveryfamily.com/2016/01/01/the-pitfalls-and-profits-of-self-forgiveness/

1. Identify and reduce self-punishment
   a. How do I punish myself?
   b. How do I permit others to punish me?
   c. What am I thinking when I punish myself or allow others to punish me?
   d. For what reasons do I punish myself?
   e. Do I hurt others when I punish myself?
   f. Am I willing to let go of self punishing (what can I commit to today? On what day? What would it be like if I never did it again?
2. Write out the commitment

(Baugher, 2009)

Self-Compassion

- Kindness, compassion, and support towards self when suffering.
- Three components:

    1. Self-kindness vs. self-judgment (treating self with kindness and compassion)

    2. Common humanity vs. isolation (seeing one's failures as part of being human)

    3. Mindfulness vs. Over-identification (balanced view of one's failures, suffering, and experiences and not suppressing or exaggerating them)
- Compassionate letter to self
- Best friend approach

(Baugher, 2009; Sedighimornani, Rimes, & Verplanken, 2019)

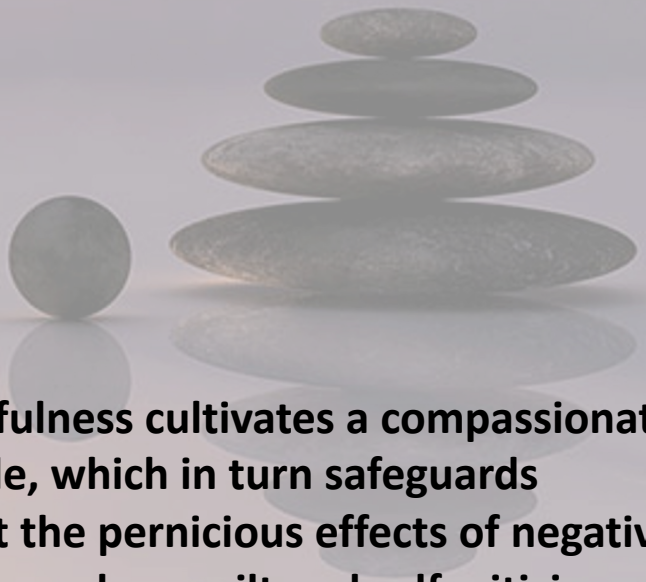
If-Onlys and Shoulds

- Examine or experiment with ruminative thoughts – do not dismiss
- Empty chair (self)
- Reconstruction by focusing on deceased (deceased) e.g., "What do you feel that person would think and feel?"
- "What would be there if the ___ was not?" (others)
- Legacy work (event)

(Neimeyer, Pitcho-Prelorentzos, & Mahat-Shamir, 2021)

Mindfulness and Meditation

- Non-judgmental attention to emotions, thoughts, and inner experiences in the present moment
- Acceptance and openness to moment-by-moment experience
- Observing without overwhelming reactions
- Avoid making assumptions
- Through multiple modalities:
    1. Sitting meditation
    2. Body scan
    3. Visualization
    4. Progressive relaxation
    5. Guided imagery
    6. Walking meditation



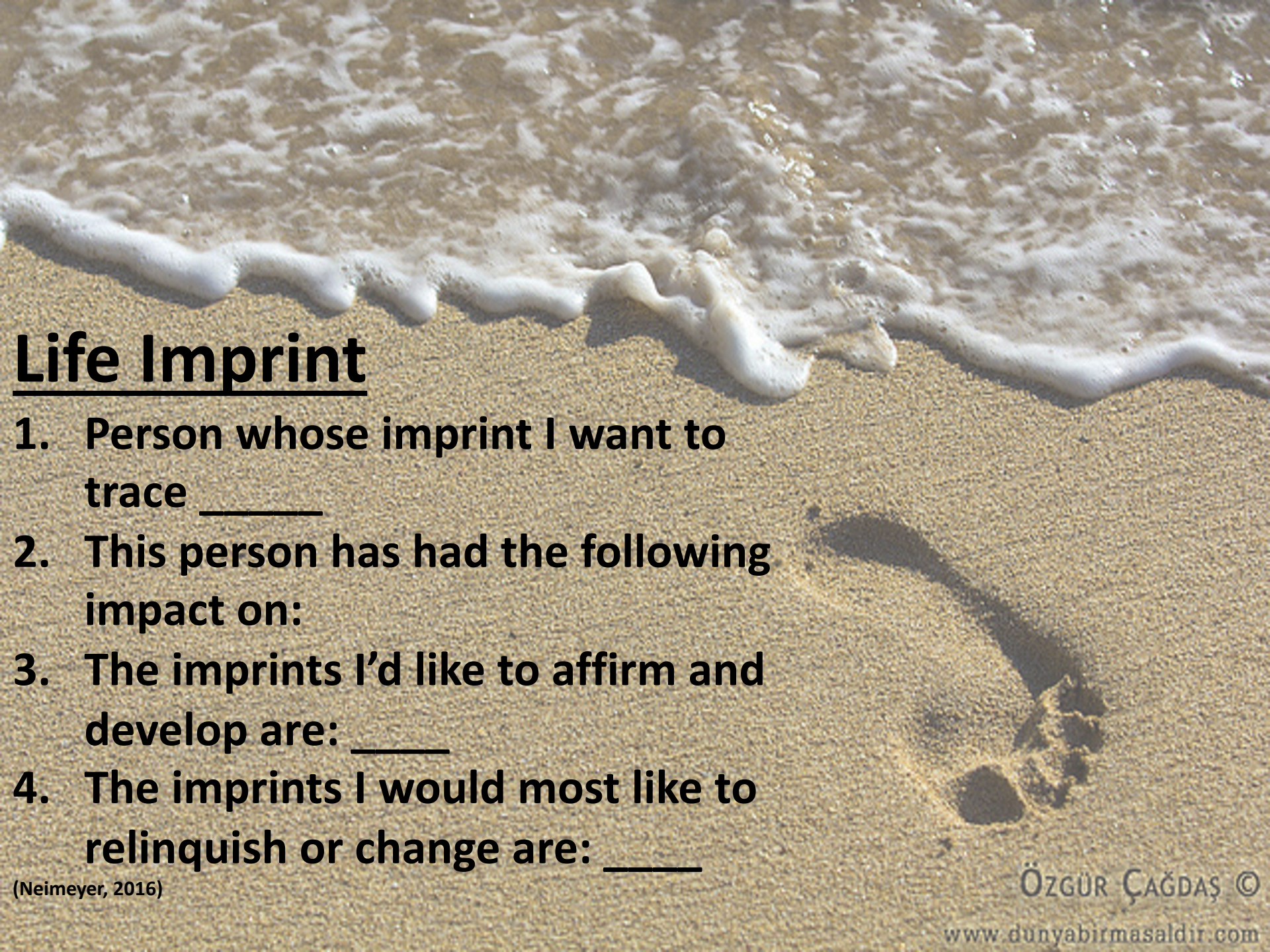
"Mindfulness cultivates a compassionate attitude, which in turn safeguards against the pernicious effects of negative feelings such as guilt and self criticism, and facilitates well-being" **(Hollis-Walker & Colosimo, 2011, p. 226)**

(Sedighimornani, Rimes, & Verplanken, 2019)


Correspondence with deceased

Photonarratives

Photographs/Family Albums

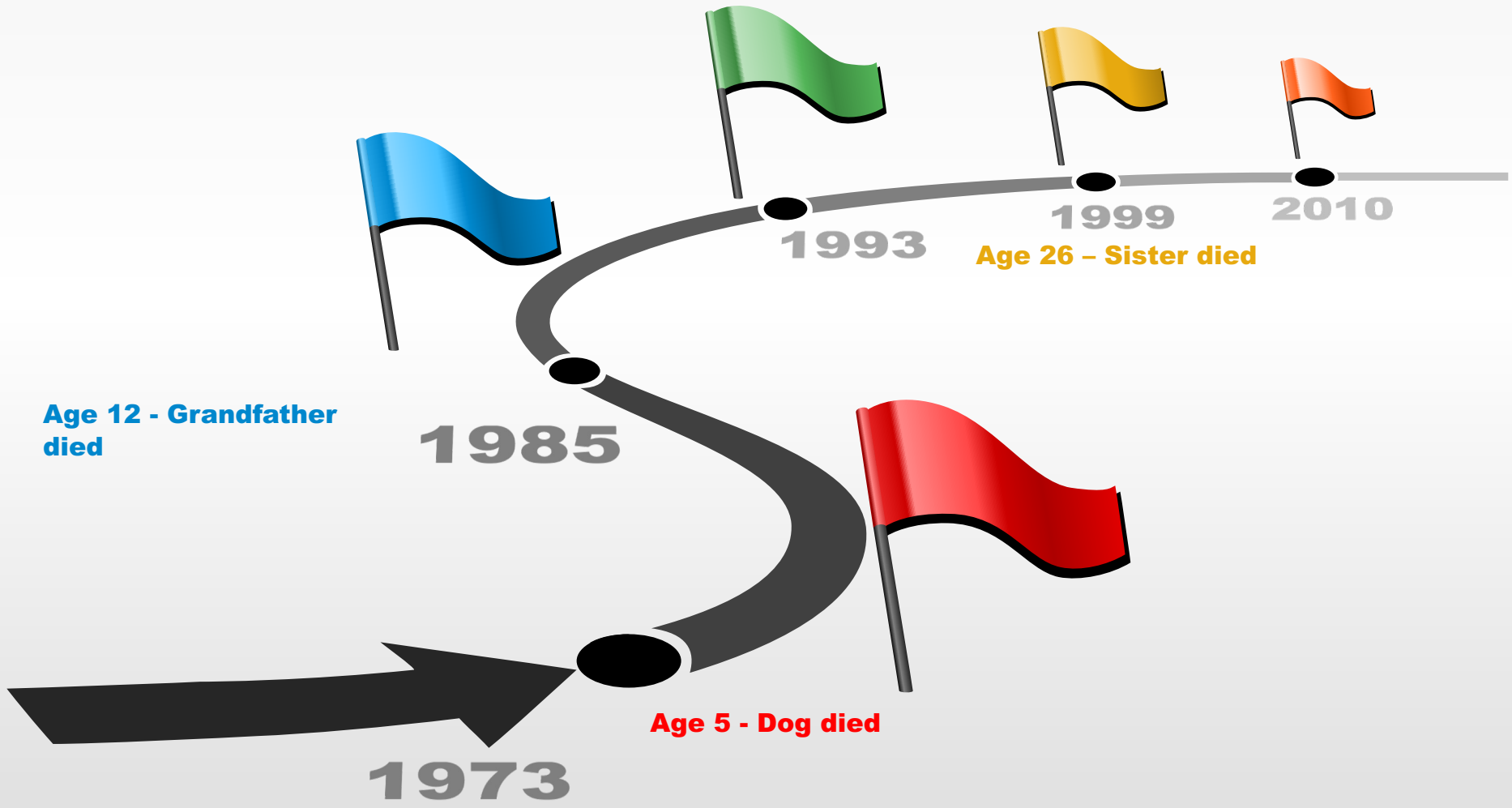


Life Imprint

1. Person whose imprint I want to trace _____
2. This person has had the following impact on:
3. The imprints I'd like to affirm and develop are: ____
4. The imprints I would most like to relinquish or change are: ____

(Neimeyer, 2016)

Loss Line


Age 20 - Moved
Age 37 - Divorce
1993
1999
2010
Age 26 – Sister died
Age 12 - Grandfather died
1985
Age 5 - Dog died
1973

Music Interventions

- Linked to improved executive functioning (Zuk, et al., 2015)
- "Expression of deep feelings of sorrow by singing can…lead to an emotional shift" (Smeijsters & van den Hurk, 1999, p. 249).
- Raises dopamine levels (Salimpoor, 2011)
- Playing with playlists, singing (Austin 2008; Iliya, 2015)

Sleep Hygiene

1. Adult: 7-9 hours. Children (6-12yo): 9-12. Adolescents (13-18): 8-10
2. Wake up same time every day (1/2 hr leeway)
3. Cool, dark, quiet room
4. No electronics 30-60 minutes prior (blue light interferes with melatonin production)
5. Cannot get back to sleep for 20 minutes? Get up, do something relaxing in low light, then try again
6. Cut down afternoon and evening caffeine
7. Exercise
8. Get sunlight exposure
9. Reduce stress
10. Do not eat late

(Suni, 2020)

- **Physical health often declines after loss. However, there are barriers that include guilt, lack of time, fatigue, and no motivation**

- **Research supports higher likelihood of hospital visits, longer hospital stays, cardiovascular problems, increase cortisol levels, reduces productivity and functioning at work**

- **Based on meta-analysis by Williams, et al., (2021), exercise benefits health outcomes and positively impacts the bereavement process:**
    1. **Alleviates depression**
    2. **Reduces anxiety**
    3. **Reduces PTSD symptoms**
    4. **Creates a sense of freedom**
    5. **Enables emotional expression**
    6. **Provides distractions**
    7. **Escape from grief**
    8. **Increases social engagement, cohesion, and reduced loneliness**
    9. **Improves quality of life and life satisfaction**
    10. **”Let’s off stream”**
    11. **Decreases stress**
    12. **Decrease fatigue (emotional and physical)**
    13. **Increases motivation**
    14. **Improved adaptation to adverse life events**
    15. **Improves sleep quality and decreases insomnia**
    16. **Reduces aggression**
    17. **Increases self-efficacy**

Me: omg I'm so tired from all that crossfit this morning

Friend: it's pronounced croissant... and I'm not sure how you managed to eat 12

Yoga

Reduces hyperactivity, impulsivity, mild mood swings

Reduces fatigue, blood glucose levels, blood lipids, stress, and sleep difficulties

Reduces depression and anxiety while increasing acceptance

Increases mindfulness, breathing skills, and grounding


What I feel like when doing a plank...
What I'm pretty sure I look like doing a plank.

Food is Medicine


I'M NOT SURE
HOW MANY
COOKIES IT TAKES
TO BE HAPPY, BUT
SO FAR IT'S NOT
TWENTY SEVEN.

Natural Settings are Restorative

1. **Leave behind daily tasks and direct attention to a new endeavor, providing a sense of 'getting away.'**

2. **Fascinating objects and processes that are "soft" in quality, which hold attention in a gentle and effortless manner, an opportunity to ponder other concerns.**

3. **Particularly high in compatibility, a special resonance between the natural setting and human inclinations.**

4. **Cycles help get in touch with larger self and universal cycles**

(Arvay, 2016: Kaplan, 1995)

Behavior and Natural Environments

1. **Challenges accustomed patterns of functioning, feeling, and problem-solving.**

2. **Impartial, holding no criticalness or negative feelings and, therefore, it is a safe place to be authentic and non-defensive.**

3. **Relative predictability leads to a sense of control, therefore relaxed and open to learning.**

4. **Openness leads to genuine self-expression.**

5. **Not interacting with another person and the variables associated with the relationship, one has a greater sense of personal control and clarity of feelings.**

(Davis, 1998; Kaplan & Kaplan, 1998; Knopf, 1987)

- Anticipate and prepare ahead of time
- Intentional ritual
- Acknowledgement and connection
- Meaningful event
- Social support
- Something pleasurable
- Honor continued bonds – achievements, love and caring, admired traits and actions
- Care for self and let others care for you as well

Holidays/Anniversaries

(Shear, 2015)

Therapeutic Bereavement Rituals

1. Emotional reactions identified with feelings of person represented by symbol.

2. Symbolic actions comparable to changes in bereaved's life

3. Actions with symbols evoke and shape new experiences

4. Body/mind congruency

(Cas & Coman, 2106; van Unden & Zondag, 2016)

Therapeutic Bereavement Rituals

6. Increases sense of control of uncontrollable event
7. Experiences emotional shift
8. Movement towards integration
9. Enables closure
10. Cuts through intellectualization
11. Enables separation from loss

(Gillian, 1991; Rando, 1993; Sas & Camon, 2016; Wyrostok, 1995; van Der Har 1983)

Types of Rituals in Grief Therapy

Honoring

- Elicit and externalize positive emotions
- Via holding and sharing objects

Disposal

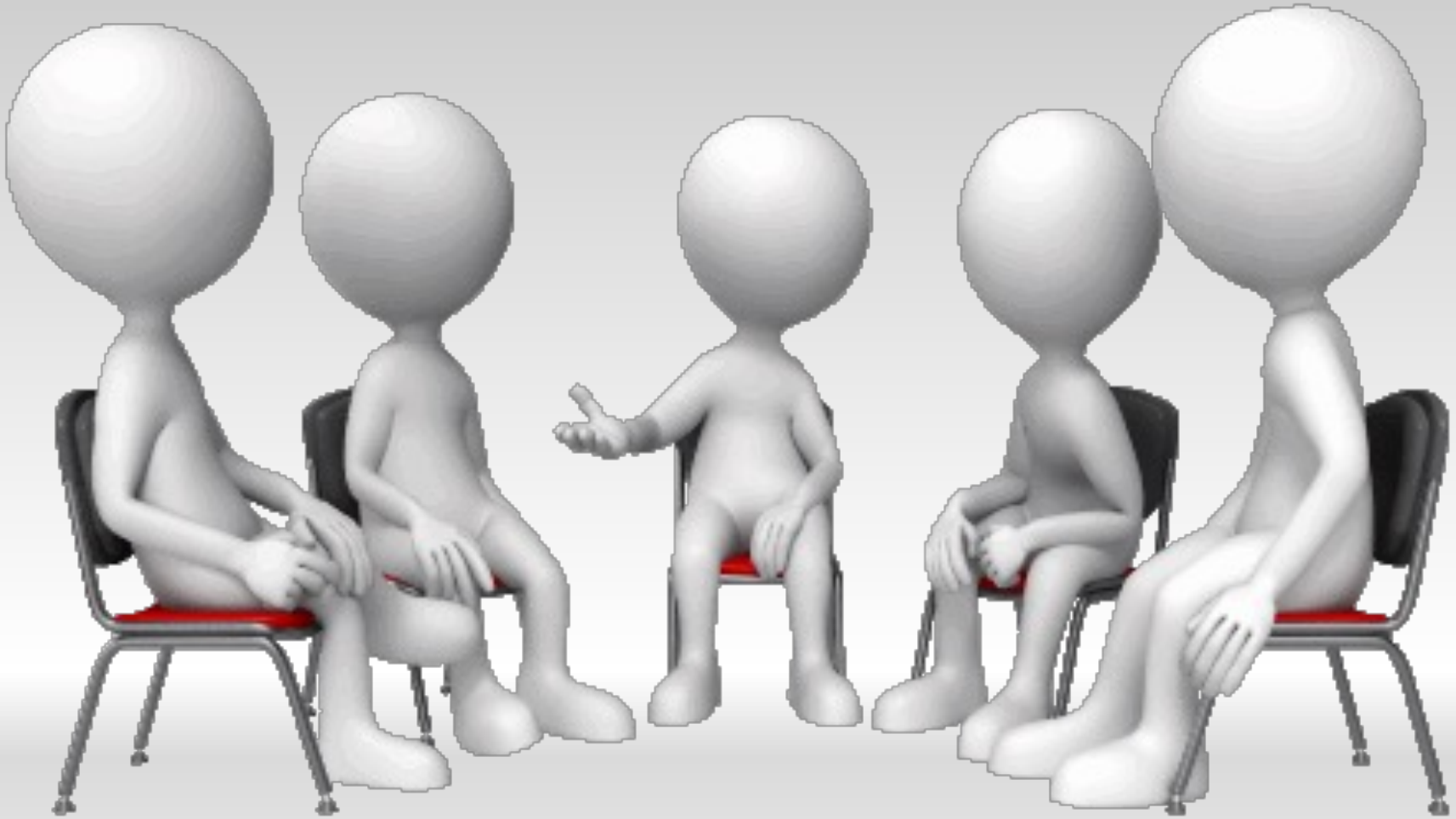
- Letting go
- Processing and releasing painful emotions
- Enacted with transformation of symbolic actions
- Often through use of 4 elements

Transforming

- Self-transformation
- Evaluate life
- Identify negative feelings of process
- Planning for future
- Strong future orientation, dreams, and aspirations
- Often transform objects

(Cas & Coman, 2016)

God is too big to fit into one Religion



Group Therapy

Closed vs. Open Groups

Closed Group

- All members start and end together
- No drop-ins
- Tend to be time-limited
- Smaller group size
- Therapeutic
- Run by trained professionals
- Leads towards homogeneity
- Usually vetted
- Usually has a “syllabus”

Open Group

- Participants can drop in and out, unpredictable attendance
- Not time limited
- Can be small or large
- Supportive
- Run by trained professionals or volunteers
- Can be homogenous or heterogeneous
- Not usually vetted
- Not usually planned out

(DeLeo & Cimitan, 2014)

Positive Experiences of Support Groups

- **Support and feel part of community again**
- **Reciprocity**
- **Environment for safe, free expression**
- **Welcome participants who are disenfranchised**
- **Discuss concerns, fear, and uncertainties**
- **Share hope**
- **New behavioral strategies, advice, and information**
- **Get through difficult times together**

(DeLeo & Cimitan, 2014)

Negative Experience of Support Groups

- Not meeting needs or expectation
- Added personal stress
- Poor organization and structure
- Insufficient leadership
- Less optimal for traumatic losses/PGD

(Dyregrov, et al., 2013-2014)

Ideal Grief Group Recommendations

I. Informational issues

a. Inform how to find groups and their affiliation

b. Communicate aim and structure

II. Organizational Issues

a. Be explicit about possibilities and limits

b. Competent leadership

c. Homogenous group

d. Flexible or restricted groups pragmatically practiced

e. Time for attendance may vary

(Dyregrov, et al., 2013)

Ideal Grief Group Recommendations

III. Issues Concerning Content

a. Semi-standardized content

b. Content to promote hope and reduce rumination

(Dyregrov, et al., 2013-2014)

Example 8-Week Group

(Walijarvi, et al., 2012)

Week #:

1. Telling the story
2. Worries and fears
3. Anger and hurt
4. Releasing the trauma
5. Memories and bonds
6. Rebuilding
7. Creating a memorial
8. Good-byes and transitions

Couple of helpful resources:

Models of Adult Bereavement Support Groups (Sherman, N.)

Bereavement Groups and the Role of Social Support: Integrating Theory, Research, and Practice (Hoy, W.)

Post-Traumatic Growth

- Transformation following trauma
- Positive psychological growth after a loss or trauma
- Adversity challenges core beliefs
- New understandings of self, the world, how to relate to other people, consider a different future, and have a better understanding of how to live life
- Social interest and meaning making are significant predictors of PTG. Strongest is meaning in life

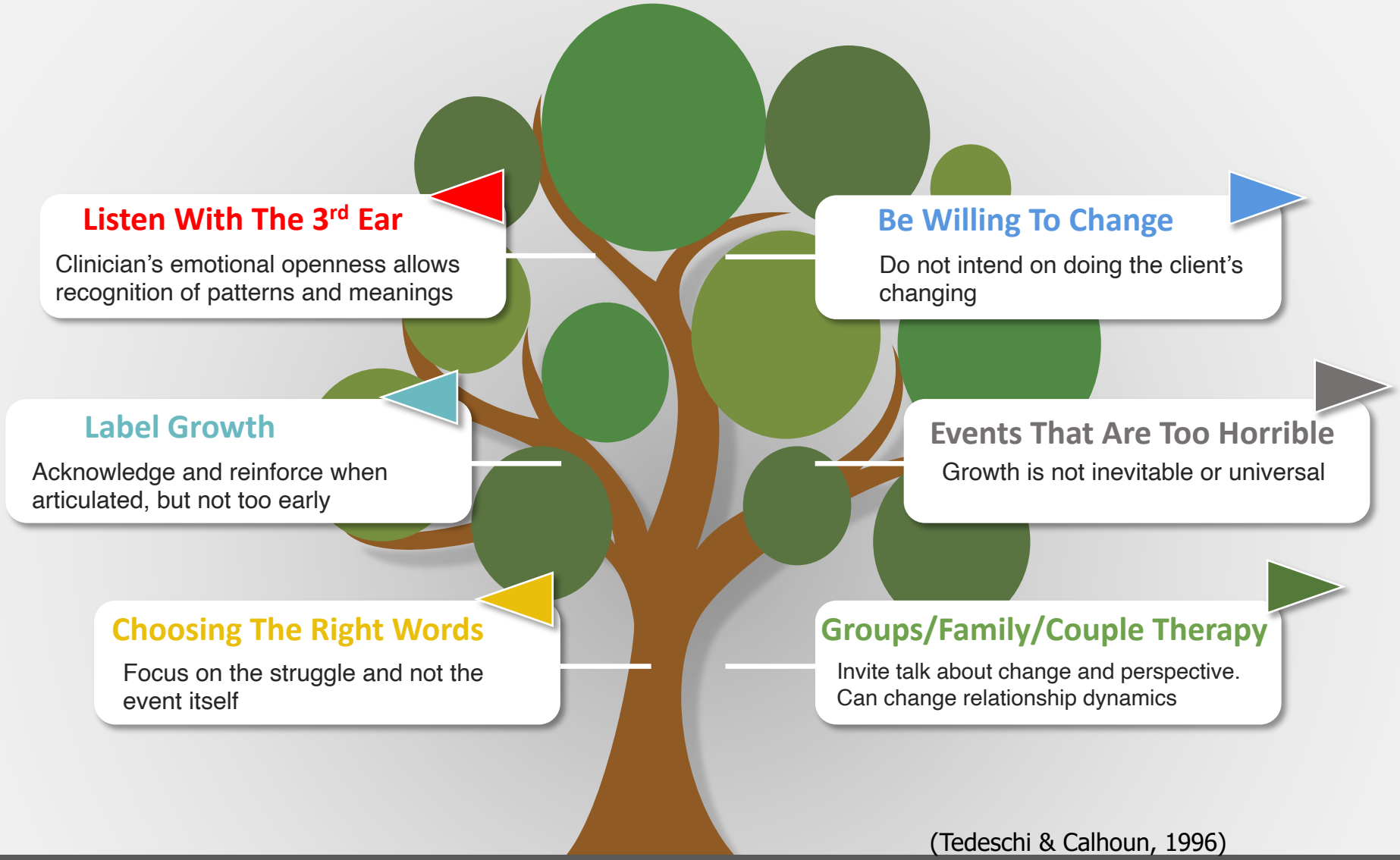
(Grad & Zeligman, 2017; Tedeschi & Calhoun, 1996)

Areas of Post-Traumatic Growth

1. Greater appreciation of life
2. Greater appreciation and strengthening of close relationships (most common)
3. Increased compassion and altruism
4. The identification of new possibilities or a purpose in life
5. Greater awareness and utilization of personal strengths
6. Enhanced spiritual development
7. Creative growth

Must notice and verbalize growth as the client approaches it (get beyond the specific meaning of words to see the larger pattern of struggle towards growth)

The Posttraumatic Growth Inventory developed by Tedeschi & Calhoun (1996) and **World Assumptions Scale** developed by Janoff-Bulman (1989)



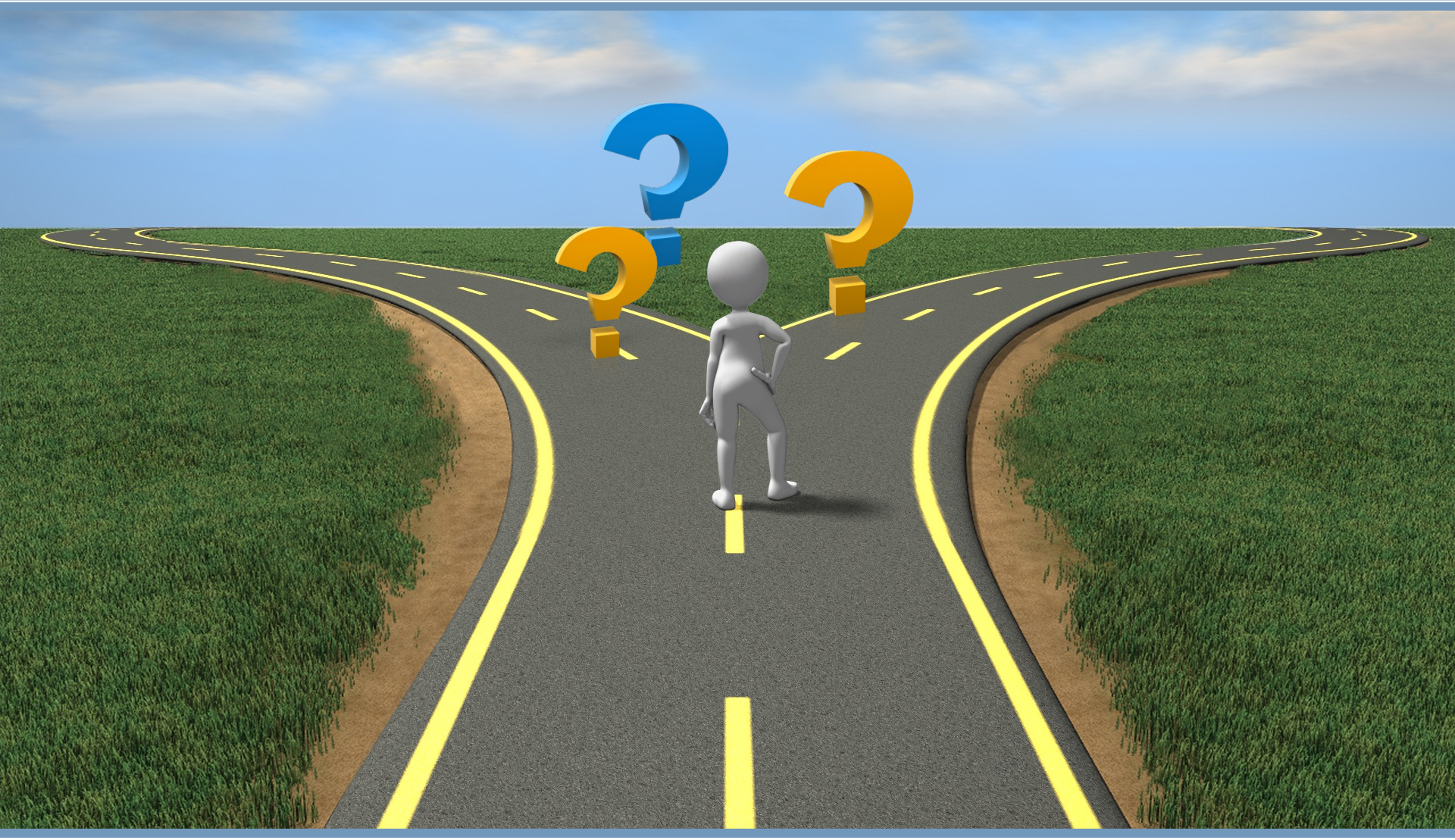
(Tedeschi & Calhoun, 1996)

Fostering Post-Traumatic Growth

Examples of Posttraumatic Growth

- A changed sense of self
- Taking on new roles
- More resilient
- More independent/interdependent
- More confident
- Awareness of life's fragility
- New meaning
- More sensitive
- Change in values
- More flexible
- Openness to feelings
- More spiritual
- More empathetic

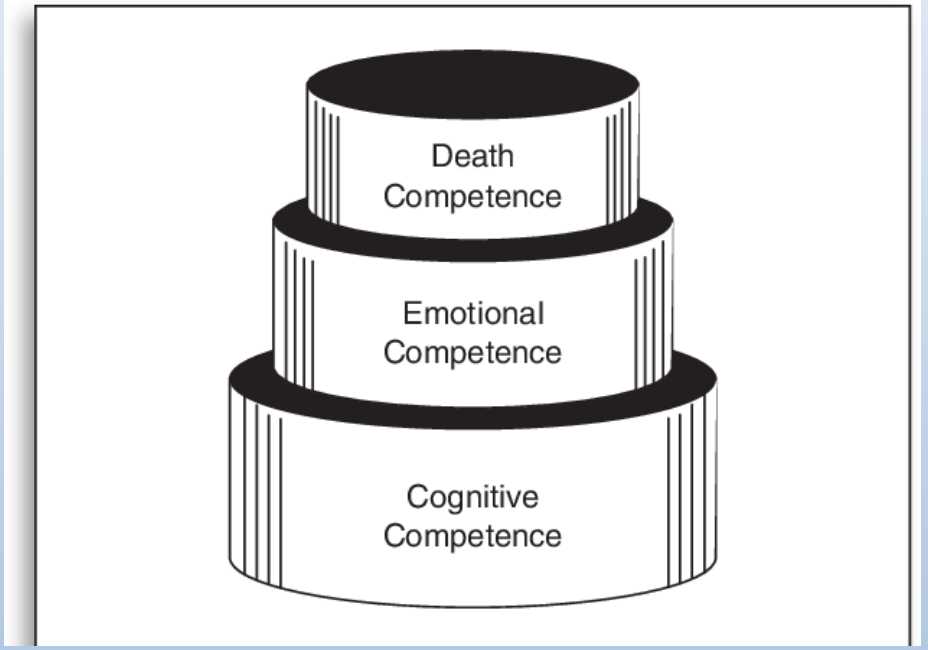
(Gilles & Neimeyer, 2006; Skinner-Cook, 2007)



ETHICS

Ethics: Cognitive Competence

- Knowledge base
- Sound training
- Supervised experience
- Proficiencies
- Discriminating who needs counseling
- Empirically valid treatment methods



(ADEC, 2006; Gamino & Ritter, 2012)

Ethics: Emotional Competence

- Capacity to hold intense emotions
- Psychological resilience
- Ongoing self-care
- Support from others
- Countertransference
- Maintain therapeutic process and objectivity
- Understand and accept own loss integration

(ADEC, 2006; Gamino & Ritter, 2012)

Ethics: Death Competence

- Ethical imperative
- Capacity to tolerate intense emotions of death and loss
- Self-awareness (source of feelings)
- Manage sense of powerlessness over death
- Understand own coping
- Listen empathetically, understand accurately
- Understand motivations in work
- Knowledge of death related data, methodology, and theory
- Work in area of clinical competency
- Intellectual versus emotional competence

(ADEC, 2006; Gamino & Ritter, 2012)

Additional Competencies Needed

(Chan & Tin, 2012)

1. **Self-competence:**

   A. Personal resources – "personal attributes or experiences possessed by the helping professional" (Chan & Tin, 2012, p. 903).

   B. Existential coping – Ability to navigate existential issues

Additional Competencies Needed

1. **Self-competence (con't)**:

   C. Emotional coping – Ability to navigate one's own emotions

2. **Practice competence**: Ability to apply knowledge and skills

3. **Knowledge competence**: Knowledge needed to provide ethical care within professional competency

(Chan & Tin, 2012)

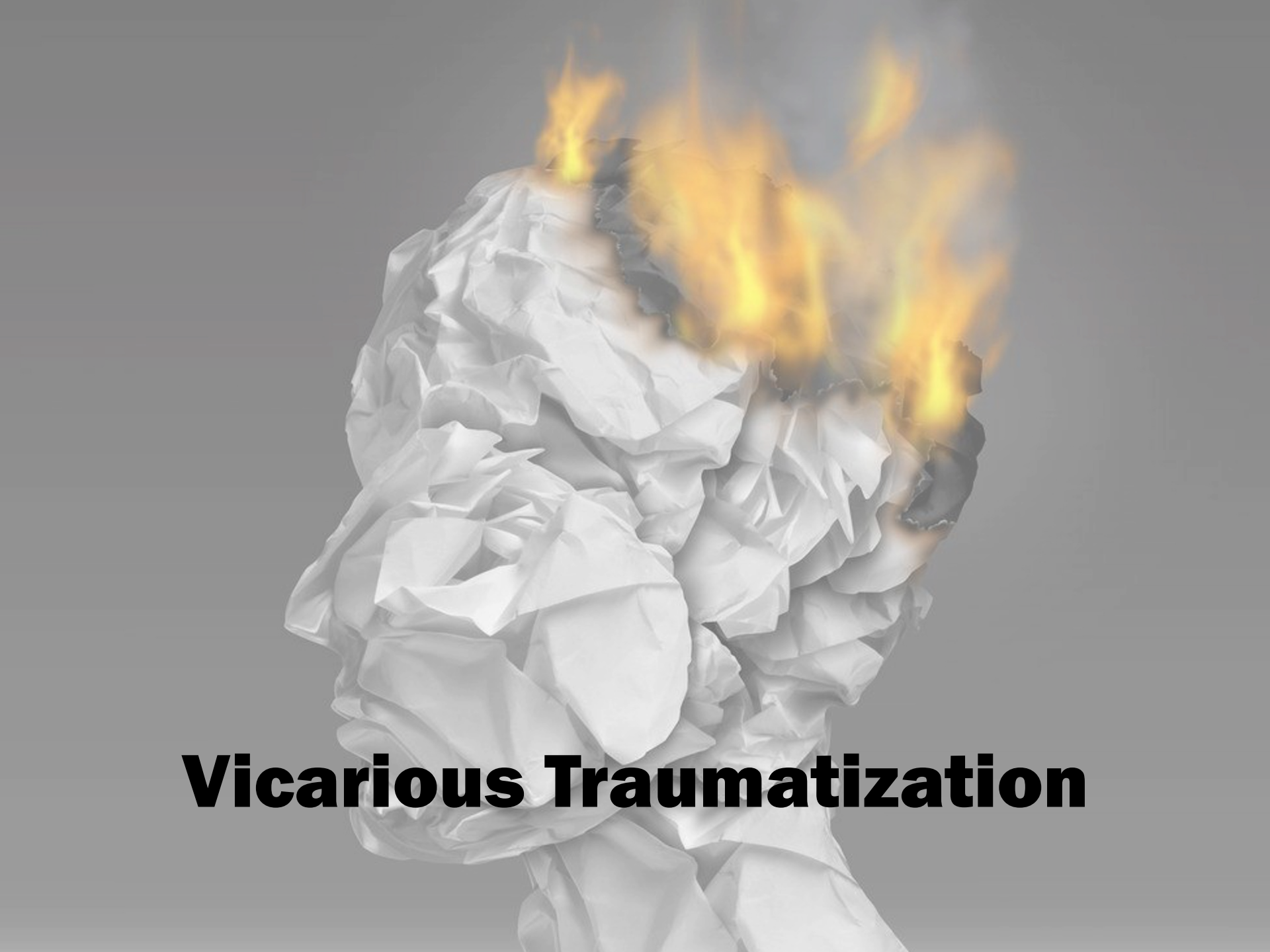
Additional Competencies Needed

4. **Work environment competence**: Healthy and helpful work environment

There is a relationship between coping and personal resources. Awareness of those resources is imperative

Knowledge and skills are not enough

(Chan & Tin, 2012)



Vicarious Traumatization

Vicarious Traumatization

"The cumulative transformative effect upon therapists resulting from empathetic engagement with traumatized clients" (Michalchuk & Martin, 2019, p. 145)

Resulting from "repeated empathetic engagement with trauma survivors and associated cognitive, schematic, and other psychological effects" (Sprang, et al., 2007, p. 260)

Disrupts sense of trust, power, independence, control, safety, esteem, and intimacy

Results in depression, memory problems, disconnection, anxiety, poor social engagement, cynical, becoming judgmental, somatic disruption, and disrupted beliefs.

(Cunningham, 2003; Michalchuk & Martin, 2019; Pearlman & Saakvitne, 1995; Sprang, et al., 2007)

Compassion Fatigue and Burnout

Compassion Fatigue

- Emotional physical exhaustion leading to numbness
- Takes on client's suffering
- Leads to burn out
- Decreased empathy and compassion

(Clay, 2020; Sprang, et al., 2007)

Burnout

- "Emotional exhaustion, depersonalization, and reduced personal accomplishment" (Maslach, 1982, p. 3).
- Diminished self-efficacy
- Cynicism, dissatisfaction, numbing, somatic problems, mental distress, poor interpersonal functioning, poor quality of life
- Reduced level of care, therapeutic effectiveness, increased inappropriate behaviors (e.g., over-involvement)

(Fothergill, et al., 2004; Maslach, 1982; Posluns & Gall, 2020; Sprang et al., 2007)

Signs of Caregiver Burnout

Some of the signs include:

- Increase of absences from work
- Forgetting to attend important meetings /sessions
- Checking out and disengaging in sessions/meetings
- Physical ailments that relate to depressionanxiety (e.g., headaches, heartburn, fatigue, etc.) Especially Sunday nights and Monday mornings
- Excessive weight gain/loss
- Inappropriate responses in meetings/ sessions (cussing, randomness, overly joking, crude remarks)
- Frequent canceling sessions
- Avoiding supervisors/co-workers
- Increase in careless mistakes on paperwork or work that is continuously left undone
- Daydreaming about alternate jobs/careers
- Feeling of emptiness or loss of purpose


SELF
CARE

Self-Care is an Ethical Imperative!

- "Engage in self-care activities that help to avoid conditions (e.g., burnout, addictions) that could lead to impaired judgment and interfere with their ability to benefit and no harm others" (Posluns & Gall, 2020, p. 2)
- Should be prevention, not in reaction (could be too late!)
- Practitioners not always aware of impact of conditions leading to poor self-care (e.g., workload, heavy emotional load)

(Posluns & Gall, 2020)

What Works? Self-Care Practices

- **Awareness**: understanding risks, symptoms, professional impairment, realistic expectations, work stressors, monitoring needs, what is happening in therapy room, drained
- **Balance**: attending to various domains in life where one domain does not negatively affect others.
- **Flexibility**: use of coping strategies, ability to adapt, reduced perfectionism, emotional regulation

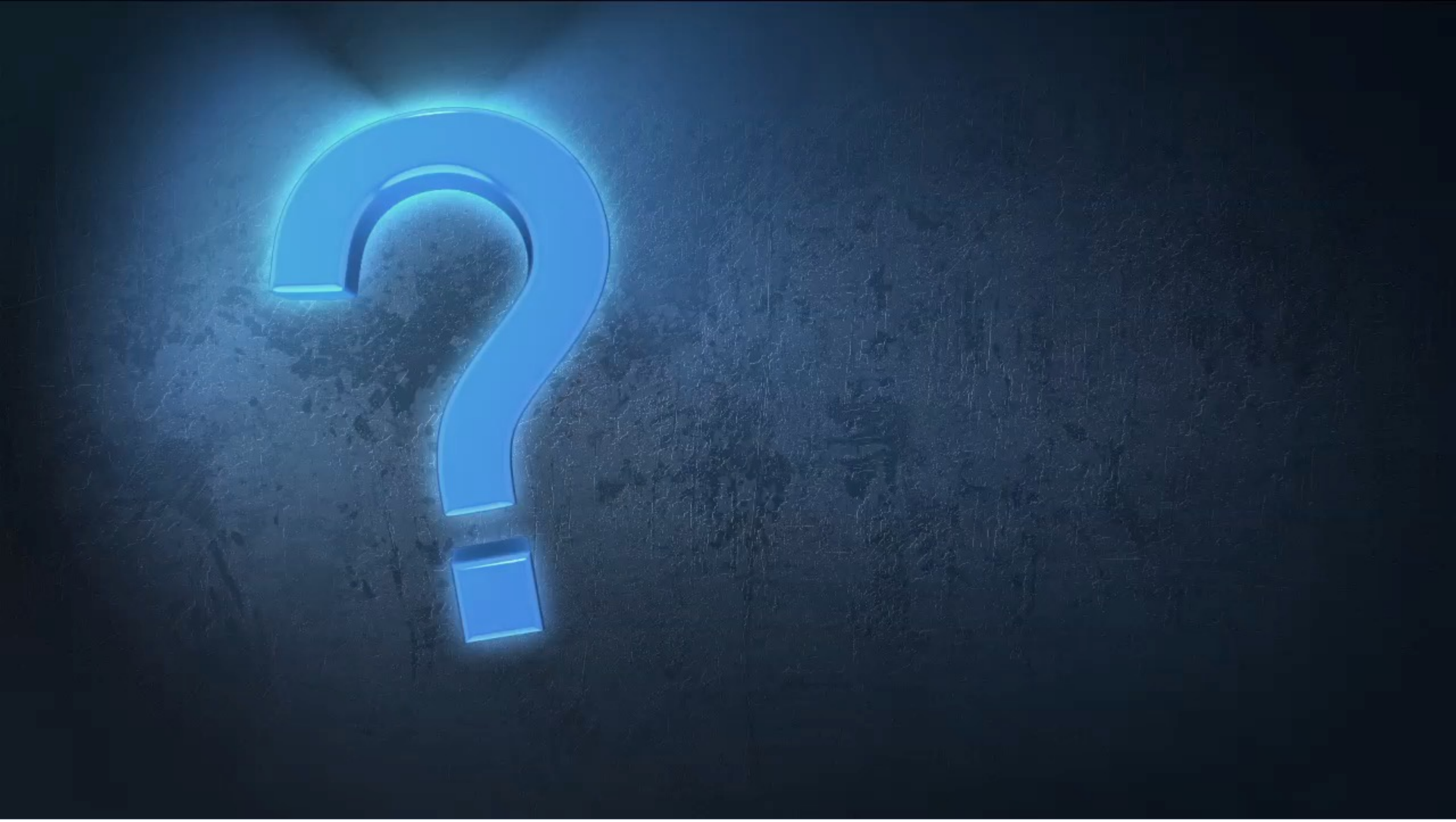
(Butler, et al., 2019; Posluns & Gall, 2020)

What Works? Self-Care Practices

- **Physical health**: sleep, exercise, diet, health maintenance/adherence
- **Social support**: connection to and interactions with supportive others (personal and professional), therapy, supervision and consultation
- **Spirituality**: connection with self, other, and divine, connected to numinous, meaning making, nature, prayer, mindfulness

(Butler et al., 2019; Posluns & Gall, 2020)


Mental Health Self Care Wheel
PHYSICAL
Regular medical care
Eat healthy
Regular sleep
Exercise
Get a massage
Enjoy physical intimacy like hugs & holding hands
PSYCHOLOGICAL
Take time for self reflection
Therapy or counseling
Meditation
Keep a journal
Be creative
Join a support group
EMOTIONAL
Explore a hobby
Cuddle with your pet
Community engagement
Practice self love
Cry
Laugh
SPIRITUAL
Practice forgiveness
Spend time in nature
Connect with a spiritual community
Sing or dance
Yoga
Volunteer for a cause
PERSONAL
Plan & set goals
Spend time with family
Learn a new skill
Read a book
Make time for friends
Reflect on who you are & what makes you special
PROFESSIONAL
Take your full lunch break
Leave work at work
Take mental health holidays
Learn to say NO
Use your vacation time
Set boundaries



Questions?? Comments?


My emotional support dog
after I tell him all my problems


Live like someone left the
gate open!


THANK
YOU

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