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Grief counseling: A Review of the Literature

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Grief counseling has grown over the past two decades to become a well respected specialty within the field of counseling. This article examines books, articles, and literature developed by leading agencies in the field. Grief counseling is an interdisciplinary field focusing on the clinical aspects of working with individuals involved in dying and bereavement.. This review of the literature points out that grief counseling is highly specialized and differentiated from other aspects of thanatology. It is rapidly becoming an area of expertise and has a rich depth of literature to support this differentiation Training programs and certification efforts need to be sensitive to the needs of individuals providing clinical services in thanatology to provide educational experiences and training to increase competence in this area.

Grief counseling: A Review of the Literature

The purpose of this article is to focus on the literature defining one aspect of thanatology, grief counseling or clinical thanatology, as differentiated from educational thanatology, medical thanatology, or ethical thanatology. Educational thanatology focuses on the death education aspects of education and increasing public awareness of issues surrounding death and bereavement (DeSpelder, & Strickland, 2002). Medical thanatology may look at the issues surrounding decision of end of life treatment in hospital settings, medical definitions of life and death, as well as improving care for individuals choosing to

die in hospital settings (i. e. Lipton, & Coleman, 2000; Fauri, Ettner & Kovacs, 1999).

Ethical thanatology focuses on the difficult issues of assisted euthanasia, living wills, and the ethical issues confronted by individuals working in thanatology (Beauchamp, & Veatch, 1996, Werth, 1999).

The focus of this literature review is on the clinical application of thanatology. Thanatology has grown since *Death and Dying* (Kubler-Ross, 1969) and will continue to grow. The literature on the clinical work conducted with terminally ill individuals, their family and the bereaved has increased dramatically in the last decade.

Grief Counseling

The work of grief counselors can be conceptualized in two broad categories, terminal care of the dying individual and the needs of close family and friends. The distinction between these two categories is artificial since the effects of the dying process on terminally ill individuals and people around them are interactive. For the sake of clarity, however, these categories of service will be considered separately in this article. Services in grief counseling are delivered by a variety of helping professionals including counselors, nurses, social workers, chaplains and other religious leaders, and psychologists. The multi-disciplinary interaction of professionals is indicative of the complex needs of the client and her or his family.

Needs of the Terminally Ill

The care of the dying individual is managed by several types of professionals working under the broad heading of hospice care. The term hospice originated in medieval times when it was used to describe a place of shelter and rest for weary or sick travelers on long journeys (Hospice Foundation of America, 1998).

In more modern times, hospice emerged to provide care to individuals who had a life expectancy of six months or less if their disease progressed as expected (Hospice Foundation of America, 1998). Hospice care is provided by a multidisciplinary team with the goal of controlling the client's pain and helping the client deal with the emotional, social, and spiritual impact of the disease (Hospice Foundation of America, 1998). The first hospice in the United States was organized in 1974 in New Haven, Connecticut (Kitch, 1998). Some organizations include the term hospice in their title to indicate that they provide hospice type services, but hospice is a philosophy of care, not a business (National Hospice and Palliative Care Organization, 2001). There are three main types of hospice care: the home care unit, (generally used by groups who are just beginning to provide hospice care), the hospital-based programs, (usually integrating palliative care units in the hospital and hospice workers at home), and the freestanding unit or full-service hospice in which the hospice staff oversee all aspects of terminal care (Kitch). Regardless of the type of hospice, all operate under the same four guidelines: (a) the client and the family are the primary unit of care, (b) care is provided by an interdisciplinary team, (c) pain and symptom control are paramount, and (d) bereavement follow-up is provided (Rhymes, 1990). The goal of hospice care is to make it possible for individuals to die at home, provide comfort and care when cure is no longer possible, and help dying persons and their families meet their spiritual, emotional, social, physical, and practical needs (National Hospice and Palliative Care Organization).

Grief Counselors in Hospice Settings

Shneidman (1978) noted several differences between counseling the dying individual and counseling non-terminal clients. He stated that the main goal of providing psychological comfort for a dying person is to make a "chilling and ugly scene go as well as

possible, to give psychological succor in suffering; to permit the tying-up of loose ends; and to lend as much stability to the person as possible” (p. 210). According to Shneidman, there is no movement toward goals in counseling the dying; rather, there is a process that goes on until it is interrupted by death.

A grief counselor working in a hospice setting works on a multidisciplinary team (Hospice Foundation of America, 1998; Kitch, 1998; National Hospice and Palliative Care Organization, 2001; Parkes, Relf, & Couldrick, 1996; Rando, 1984; Rhymes, 1990; Stroebe, Hansson, Stroebe, & Schut, 2001). Tasks of grief counselors include helping the dying individual prepare for the reality of death. This is done through education and supportive therapeutic interventions about the dying process that address the physical, emotional, social, spiritual, and practical needs (Davies, Reimer, Brown, & Martens, 1995; Doka, 1997; Parkes et al.; Rando, 1984; Rando, 2000).

Physical needs. Pain management is one of the most important concerns of hospice care (National Hospice Foundation, 2001). In addition to pain medication, the use of traditional psychological interventions such as biofeedback, hypnosis, relaxation and imagery techniques are used to provide skills that increase the client’s awareness and control of pain. (Arnette, 1996; Cook & Oltjenbruns, 1998; Rando, 1984).

Sensitive education about the physical changes and common processes prior to one’s death can help alleviate anxiety and diminish erroneous preconceptions about dying (Parkes et al., 1996; Rando, 1984; Rando, 2000). Dying individuals who have preconceived notions from the media may be disillusioned when their notions do not match reality. Grief counselors can provide information on how the body changes, what changes to expect in the future, and when to contact a physician (Cook & Oltjenbruns 1998; Rando, 2000). As the

illness progresses, the body often undergoes changes that are either a normal part of the dying process or a reaction to treatment; these changes can affect body integrity, the ability of the body to function normally (Viney, 1984). In her study of 484 seriously-ill patients, Viney found that the loss or threat of loss to body integrity affected the individuals' emotional state, producing feelings of sadness, anger, helplessness, and hopelessness. Reconciling the loss of body parts or changes from treatment (e.g., hair loss) with the individual's identity is important for emotional health (Cook & Oltjenbruns).

Emotional needs. Dying individuals cope with intense emotions such as anger, fear, guilt, and grief (Doka, 1997; Rando, 1984). Dying individuals benefit from counseling as much as anyone and these emotions are both a normal part of the process of dying and can be alleviated by sensitive intervention (Doka; Rando; Shneidman, 1978). Addressing the anticipatory grief of the individual is critical for grief counselors (Parkes et al., 1996; Rando, 2000; Shneidman). Issues of anticipatory grief include helping clients redefine life as it currently is, facilitating communication about feelings of being a burden, supporting clients as they struggle with change, encouraging the search for meaning, and allowing the client to live day-by-day (Davies et al, 1995). Open communication within the family must be developed or supported during this stressful time (Rando; Shneidman).

Social needs. The dying individual needs social involvement as much as he or she did before the illness (Davies et al., 1995; Parkes et al., 1996). Interventions by a grief counselor can facilitate the ability of friends and family to enable the dying individual to maintain a social life in the face of physical limitations (Davies et. al.; Kubler-Ross, 1969; Rando, 1984; Shneidman, 1978). The process of finishing business is an important part of this social realm. Tasks such as interacting with important others to resolve old

disagreements, connecting with long-term friends, and asking forgiveness are all important to the dying individuals' peace of mind (Davies et al.; Rando; Shneidman). Grief counselors working with dying children need to be aware of the unique social needs of children to provide developmentally appropriate care (Stevens & Dunsmore, 1996). Play therapy, art therapy, peer support and support groups are common forms of intervention that allow children with serious illness to live as normally as possible (Cook & Oltjenbruns, 1998).

Spiritual needs. Spirituality has been defined by the Spiritual Care Work Group of the International Work Group on Death, Dying and Bereavement as "...concerned with the transcendental, inspirational, and existential way to live one's life as well as, in a fundamental and profound sense, with the person as a human being.spirituality may be heightened as one confronts death" (Doka & Morgan, 1993, p. 11). The Spiritual Care Work Group continues by providing a 31-item statement of general assumptions and principles that describe the spiritual needs of the dying individual and appropriate responses by caregivers. They state that these assumptions and principles must be implemented within the individual's spiritual life and society (Corless et al. 1990).

Doka (1993) outlined three main spiritual components for grief counselors to provide for dying individuals. First, it is important to help clients find meaning in their lives. This search for the integration of events, experiences, and meaning in life can be precipitated by old age or severe illness. The failure to find meaning in life can create a deep spiritual pain as individuals may feel their life has become empty or meaningless. Grief counselors can facilitate the integration of life events and experience to create meaning by providing time for this reflection and encouraging exploration of events that have been

witnessed or things the individual has done. These reminiscences can be supported by using the creation of picture albums of life events, journals of history, or tape recordings left for the future. Secondly, Doka discusses helping clients create a personal definition of an appropriate death. Individuals desire to die in a way that is consistent with their self-identity. Individuals who have lived an independent life may feel great distress if all control over their own death is taken from them. Grief counselors can alleviate some of this distress by listening to what plans the dying individual has for her or his manner of death, care of the body after death, and the disposition of possessions after death. Lastly, Doka describes the need to help clients transcend death, either through religion and an afterlife, or through future generations or work left behind. Doka states that an important spiritual need is transcendental in that we seek assurance that our life has had meaning and we have contributed something of value.

To support the comfort of transcendental continuation, grief counselors can identify lasting contributions, from modest contributions such as participating in group activities like a Parent Teacher Association to more noticeable contributions such as building a railroad. Opportunities for intergenerational visitation provide subtle reminders of biological legacy. Many religious and spiritual belief systems provide a theoretical framework for immortality, although even in religious or spiritual belief systems that include God, the grief counselor needs to be aware of emotions of anger at God, fear that past sins may have caused the illness, and guilt for not having always lived a righteous life (Parry, 1990). It also is important for grief counselors to recognize that positive psychological growth can occur, such as a new appreciation for others in life, an increased sense of freedom to experience

life, or a new unlocking of emotions (Balk, 1999; Davies et al, 1995; Marrone, 1999; Mead & Willemsen, 1995).

Practical problems. Another area where grief counselors often are involved is helping solve practical problems. Issues such as distribution of possessions, settling financial affairs, arranging wills and trust funds, and pre-funeral planning are all important topics for discussion, but are ones that family members often are hesitant to approach (Rando, 1984). It also is helpful for the grief counselor to be available to discuss changes in social and sexual relations, and difficulties dealing with hospital bureaucracy (Rando; Shneidman, 1978).

Supervision of others. Another potentially important area for grief counselors is that of supervision. Although this area is not often mentioned in the thanatology literature, Vacc (1989) found that the single greatest proportion of time for counselors working with oncology patients was spent in supervising volunteers and counselors in training. Even though not all patients on an oncology unit of a hospital are terminal, this study highlighted the potential importance of supervision issues for grief counselors. Grief counselors who supervise volunteers may be expected to recruit, assess compatibility of the potential volunteer to such work, train, and provide emotional support for volunteers (J. A. Bryers, personal communication, June 18, 2001). Grief counselors also may be involved in training other professionals in the emotional, psychosocial, and spiritual needs of the dying individual and their family (Parkes et al., 1996; Shneidman, 1978).

Summary

Grief counselors working with terminally ill individuals work in a multi-disciplinary team to provide psychological comfort to the dying and their family. They may normalize

emotions during a difficult time, provide spiritual support, educate about normal physical, emotional, and social changes, and assist in managing practical problems. A large part of the grief counselors' time may be spent in supervising and training volunteers or counselors in training. Finally, the grief counselors develop relationships with the survivors to provide services after the death.

Grief Counselors Working with Survivors

The term survivor has traditionally been used to designate individuals who had a close relationship with the deceased (Rando, 1994). In this manuscript however, survivor is meant to indicate a broad group of individuals who have been affected by the death of an individual. Survivors have unique needs that differ from the needs of a dying individual. As Parkes et al. (1996) noted, the hardest work and greatest pain is reserved for the survivors. Often, these needs are interwoven with the needs of the dying individual in the reality that human lives are intertwined with others. For clarity, however, the unique needs of the survivors are considered separately here. Also, a distinction is made here between services provided to survivors prior to the death (referred to as anticipatory grief) and services provided after the death of a loved one.

Anticipatory Grief

Anticipatory grief can be conceptualized as:

...a phenomenon encompassing seven generic operations (grief and mourning, coping, interactions, psycho-social reorganization, planning, balancing conflicting demands, and facilitating an appropriate death) that, within a context of adaptational demands caused by experiences of loss and trauma, is stimulated in response to the

awareness of life-threatening or terminal illness in oneself ...and the recognition of associated losses in the past, present, and future. (Rando, 2000, p. 4)

This grief in anticipation of loss is connected to and interactive with the grief and needs of the dying individual. Grief counselors can be helpful in facilitating the discussion of the impending death, normalizing emotions, and providing a safe environment in which to express emotions (Davies et al., 1995; Parkes et al.; Rando). Issues involved in the anticipatory grief process include emotional, social, and spiritual needs of survivors, as well as dealing with the practical issues and the ethical dilemmas inherent in right-to-die issues.

Emotional needs. Families and others close to dying individuals often feel guilty about experiencing anger toward the terminally ill, disgust at the appearance of the dying individual's body, exhaustion with care giving duties, and the uncomfortable wish that the loved one would die (Doka, 1997; Parkes et al., 1996; Rando, 1984). These and other difficult emotions need to be normalized, and encouraged as expected reactions to a stressful situation (Cook & Oltjenbruns, 1998; Rando, Worden, 1991).

Physical needs. The physical changes that occur during the dying process can be difficult to watch. These physical changes may evoke fear, feelings of helplessness, and anger in the survivors due to the inability to provide physical comfort (Davies et al., 1995; Rando, 2000). Providing acceptance and support for the survivors' difficulty in coping with the physical symptoms of the dying individual helps the survivor be present with the dying individual and may reduce complications in the mourning process (Parkes et al; Rando, 1993; Rando, 2000; Shneidman, 1978).

Social needs. In the hospice model of care, the main caretaking duties for a terminally ill person fall on a close family member or friend (Capossela & Warnock, 1995;

Parkes et al). For family or friends of the dying individual who are performing these caretaking duties, it is important for caretakers to engage actively in meeting their own social needs (Capossela & Warnock; Davies et al., 1995; Rando, 1984; Rando, 2000). Caretaking is exhausting and trying to do too much without taking time out from duties can cause depression and burn-out in the most dedicated of caregivers (Rando, 1984). Many institutions provide grief counselors for respite services or volunteers who will come in and sit with the terminally ill person so the caretaker can get away and interact socially with other people (Hospice Foundation of America, 1998).

Further, the grief counselor can educate family members about how to discuss what is happening with children and others in the normal grief processes, differences in how individuals grieve, and how the family role and structure will change during the illness and after the death of the loved one (Cook & Oltjenbruns, 1998; Davies et al., 1995; Parkes et al., 1996; Rando, 1984; Shneidman, 1978).

Similarly, the risks and need for self-care are evident for grief counselors as well (Rando, 1984; Rando, 2000). The serial loss of people with whom the grief counselor has become attached can create bereavement overload (Kastenbaum, 1969). In working with dying individuals, the grief counselor is as vulnerable to grief reactions as anyone and, left unresolved, these grief reactions can lead to unresolved grief or complicated grief (Rando, 2000; Raphael, 1998). In consideration of this risk, it is important for the grief counselor to engage in the same rituals, mourning rites, and care that they advocate for their clients (Rando, 2000).

Spiritual needs. The impending death of a loved one often raises questions of the survivor's spiritual or religious faith, their own mortality, the meaning in life, and other

significant spiritual issues (Doka, 1993; Doka, 2000; Neimeyer, 1998; Rando, 1984; Rando, 2000). When working with survivors, grief counselors need to be aware of spiritual issues such as a difference in spiritual beliefs between them and the client, a resistance among survivors to having their spiritual beliefs challenged by the patient, and in cases where the patient's effort to find meaning is intense and unsuccessful, the subsequent grief of survivors may be complicated (Doka, 2000).

Practical problems. Survivors face many practical problems that the terminally ill person may not. They must learn to use unfamiliar medical equipment, monitor physical conditions, administer medications, learn new vocabulary, learn the intricate and sometimes difficult process of dealing with the medical system, and manage personality changes in the terminally ill person (Davies et al, 1995; Parkes et al. 1996; Rando, 2000 Schneidman, 1978). Grief counselors can be useful in interpreting medical vernacular, explaining personality changes, and educating the survivors about physical changes and medication use (Davies et al.; Parkes et al.; Schneidman).

Ethics. The debate over right-to-die has brought new ethical concerns for grief counselors who may be called upon to discuss physician assisted suicide with family members of a terminally ill patient (Werth, 1999). Survivors who have already assisted in the death of a loved one and now are suffering guilt and painful memories of the death, which may not have gone as planned, may experience exacerbated grief processes. Werth stated that grief counselors can be particularly helpful in deciding if there is significant psychopathology interfering with the decision for assisted death, assessing if there is subtle or overt influence on the terminally ill person to commit assisted death, and working with the survivors. The largest ethical issue for grief counselors is in determining if assisted

suicide is self-harm as defined by codes of ethics. This is a complex issue and is still under considerable debate (Werth). In addition, grief counselors can be helpful in discussions about organ donation and whether to stop life support (Beauchamp & Veatch, 1996).

Bereavement Care

Survivors of the recent death of a loved one experience higher rates of death and physical illness than those in the general population, with the greatest risk occurring to surviving spouses, especially widowed men (Bowling, 1987, Bowling, 1994; Parkes, 1964; Rees & Lutkins, 1967; Stroebe, Stroebe, Gergen, & Gergen, 1981; Stroebe & Stroebe, 1983; Stroebe, 1994; Young, Benjamin & Wallis, 1963). Further, there is now sufficient evidence that the death of a loved one is deleterious to both the mental and physical health of survivors (Stroebe, 1994; Stroebe, Hansson, Stroebe, & Schut, 2001). The recently bereaved also experience greater risk of depression, substance abuse, and suicide (Allumbaugh & Hoyt, 1999; Parkes; Yalom & Vinogradov, 1988). Counseling following the death of a loved one has been shown to be effective in alleviating survivors' distress and preventing negative outcomes (Allumbaugh & Hoyt; Raphael, 1998).

The 1982 Tax Equity and Fiscal Responsibility Act established Medicare benefits for hospice care with all certified hospice providers being required to offer bereavement services for up to one year after the death (Bulkin & Lukashok, 1988; Foliart, Clausen, & Siljestrom, 2001). Although bereavement support services are required for Medicare certified agencies, such services are not reimbursed, and the type of services offered are left to the discretion of the provider (Foliart et al., 2001; J. A. Bryers, personal communication, June 18, 2001). Thus, grief counselors in hospice care centers, funeral homes, and community settings offer varied programs and services.

Grief Counselors Working in Hospice Bereavement Services

Because Medicare and other insurances do not reimburse for bereavement care, many of the services offered by hospice centers are provided by volunteers (Foliant et al., 2001; Hospice Foundation of America, 1998; Nassar & Borders, 1999; Parkes et al., 1996). Grief counselors working in hospice bereavement support are likely to operate support groups for adults and children, provide telephone follow-up to survivors, and assess for the need of more intensive support, such as individual counseling (Foliant et al.; Gray, Zide, & Wilker, 2000; Parkes et al., 1996; Walsh-Burke, 2000). Grief counselors also may be involved in providing supervision and training for volunteers and counselors in training (cf. Vacc, 1989). If an individual is determined to require more intensive support than offered by the center, they are referred to a local grief counselor working in private practice or community settings (J. A. Bryers, personal communication, June 18, 2001; Parkes et al., 1996).

Grief Counselors in Community Settings

Grief counselors working in community settings with the bereaved often receive referrals from local hospice centers to provide services to individuals who need more intensive intervention (Parkes et al., 1996; Walsh-Burke, 2000). Bereavement needs vary according to cultural backgrounds (Klass, Silverman, & Nickman, 1996), social support networks, age (Parkes, 1964; Parkes, 1988), gender (Campbell & Silverman, 1996; Doka, 1997; Silverman, 1981), family dynamics (Walsh & McGoldrick, 1991; Wortman & Silver, 1989), psychological health (Sanders, 1989), physical health, and illness or death-related factors (Rando, 1993; Raphael, 1998). Counseling services generally are considered

different for normal grief and for complicated grief (Allumbaugh & Hoyt, 1999; Parkes et al.; Rando; Raphael; Worden, 1991).

Normal Grief Counseling

Counseling for normal grief reactions is generally brief (under eight sessions) with a focus on working through a normal developmental process and restoring previous functioning (Allumbaugh & Hoyt, 1999; Worden, 1991). A frequent task for the grief counselor is to give the bereaved permission to grieve (Miller, 1982). Also, the grief counselor may encourage emotional expression, normalize grief reactions, provide education on tasks previously performed by the loved one, and support the establishment of a new identity and social life (Allumbaugh & Hoyt; Miller; Neimeyer, 1998; Parkes et al., 1996; Raphael, 1998; Rando, 1984, 1993). Though a variety of theories and techniques are used to provide these services, all share an emphasis in helping the survivor recognize the reality of the loss, experience the emotions, adapt to life without the loved one, and become comfortable with the deceased existing in memory (Klass, Silverman, & Nickman, 1996; Parkes et al.; Raphael; Rando, 1993; Worden, 1991). Interventions that are more intensive usually are reserved for individuals who are determined to be suffering from complications in their grief process (Parkes, 1980; Rando; Worden, 1991).

Complicated Grief Counseling

The definition or determination of when the normal processes of grief have become complicated, or in some way not progressing as the observer expects, is difficult. Any attempt to operationally define complications in the grief process would require the consideration of what the particular death meant to the particular individual at the particular time and place that the particular death occurred, and the individuals cultural norms in the

grief process (Rando, 1993). This difficulty in an operational definition of complications in the grieving process creates difficulties in delineating the differences between normal grief and cases where the normal processes have been compromised. Complicated grief will be considered to be responses to the death of a loved one that interfere with the survivors ability to develop a new identity, a new social role, and a new psychological, emotional, and spiritual perspective of self.

The incidence of complicated grief has been estimated to be one out of three bereavements (Raphael, 1998). The rate of complicated grief is expected to increase in coming years (Rando, 1993). This increase is due to the rise in factors that increase the risk of complications. One type of factor is those associated with the specific death, such as sudden or unexpected death, and antecedent/subsequent variables such as an ambivalent relationship with the deceased, concurrent stressors, and previous unresolved losses (Rando, 1993). Grief counselors need to be aware of the types of complicated grief and become familiar with differing treatment protocols for each type.

Complicated grief is displayed in three different ways: absence of grief (Deutsch, 1937; Worden, 1991; Rando), inhibited grief (Rando, Worden), and chronic grief (Parkes et al., 1996; Rando; Volkan, 1994; Worden). Certain circumstances surrounding the death, such as murder, suicide, or traumatic loss, also may complicate the grief process for survivors (Doka, 1996; Parkes et al; Rando; Redmond, 1990; Spungen, 1998).

Absent grief. The complete absence of grief is rare but does occur, often in individuals who have not seen the body or who are experiencing psychotic symptoms (Deutsch, 1937; Worden, 1991). The task of the grief counselors in this case is to help the individual accept the reality of the death of the loved one. This is done by confronting the

survivor with evidence such as the length of the loved ones' absence and other indications of reality (Worden). More common than the complete absence of grief is the inhibition of grief, or the unwillingness of the bereaved to engage in grieving (Rando, 1993; Raphael, 1998; Worden; Volkan, 1994).

Inhibited grief. When working with a client who is experiencing inhibited grief, grief counselors use specific techniques to determine where the grief process stopped, encourage expression of blocked emotions, and facilitate the progress of a normal grief process (Rando, 1993; Raphael, 1998; Volkan, 1994; Worden, 1991). A common technique used is re-grief therapy in which the grief counselor encourages the bereaved to bring in objects, called linking objects, that remind her or him of the deceased (Volkan). These linking objects are used to elicit discussion of the deceased and the expression of emotions connected with the loss (Volkan). It is not enough, however, for the emotions to be expressed. It also is important for the bereaved to be able to express why he or she feels that way, what has been lost, and what impact the loss has on her or his life (Worden, 1991). Gestalt therapy techniques such as an empty chair often are used in complicated mourning to provide the bereaved an opportunity to say a final good-bye or say things unsaid when the deceased was living (Parkes et al. 1996; Raphael; Rando; Worden).

Chronic grief. For bereaved individuals experiencing chronic grief, the pain of grief seems to continue and is usually associated with anxiety and depression (Parkes et al., 1996; Rando, 1993). Interventions by grief counselors include reviewing the relationship with the deceased in detail, examining the details of the death, behavioral interventions, and considering what secondary gains the bereaved may be receiving by remaining in grief (Parkes et al.; Rando; Raphael, 1998; Volkan, 1994; Worden, 1991). Often, individuals

experiencing chronic mourning had a dependent relationship with the deceased. In this case, the grief counselors' main task is to help the bereaved discover her or his own strength and competence in meeting the challenges of life (Parkes et al.).

Traumatic loss. Murder, suicide, and other sudden, unexpected deaths generally occasion complicated grief (Doka, 1996; Rando, 1993; Redmond, 1990). The resolution of these types of deaths is compounded by the need to resolve the trauma first (Redmond). Grief counselors provide a safe place to review the trauma and work through the intrusive images associated with a traumatic loss (Rando). Also, grief counselor needs to be aware that the client may feel a need to protect the clinician from the horror of the story (Redmond). In this case, the grief counselor will need to encourage the retelling of the clients' story. Emotions and thoughts of vengeance or doing harm to the persons responsible for the death of the loved one may be difficult for the bereaved to reconcile with her or his self-image, and normalizing these reactions is helpful (Doka; Rando; Redmond; Spungen, 1998). In cases of murder or suicide, the bereaved may need to be supported by the grief counselor as the legal system and media become involved (Doka; Redmond). When the legal system is involved, it is beneficial to provide the bereaved with information on how the system works and what they can expect to happen (Redmond). Grief counselors working with traumatic loss survivors work both with groups (Redmond; Rando; Yalom & Vinogradov, 1988) and individuals (Doka; Rando; Redmond).

Bereaved children. Some experts (Rando, 1993) consider all bereavement by children to be traumatic. The goals of counseling bereaved children are the same as those for adults, but the interventions vary (Corr & Balk, 1996; Fry, 1995; Grollman, 1995; Webb, 1993; Wolfelt, 1996). Grief counselors working with bereaved children must understand the

cognitive and social developmental processes to provide appropriate interventions and communicate effectively (Corr & Balk; Goldman, 2000; O'Toole & Cory, 1998). An understanding of the developmental level of the child facilitates the ability of the grief counselor to help the child understand what has happened, experience grief, commemorate the death, and move on in life (Goldman, 1996, 2000; Silverman, 1999). Depending on the developmental level of the child, various interventions are used with children to accomplish the tasks of grieving including; play therapy (Goldman, 2000; Fry, 1995), art (Webb, 1993; Smith & Pennells, 1995), and allowing the child to ask questions and talk (Corr & Balk; Fry; Smith & Pennells; Goldman, 1996, 2000; Webb; Wolfelt, 1996). Grief counselors working with bereaved children provide services in both group (Beckman, 1990; Keyser, Seelaus, & Hahn, 2000; Schuurman, 2000) and individual settings (Ward-Wimmer & Napoli, 2000; Wolfelt).

Spiritual Needs of Survivors

To understand an individual's response to loss, it is critical to understand their religious and spiritual concerns (Marrone, 1999). The spiritual or religious component of loss "involves a profound, growth oriented spiritual/existential transformation that fundamentally changes our central assumptions, beliefs, and attitudes about life, death, love, compassion, or God." (Marrone, p. 498). Previous views of the world and life are challenged by the crisis of the death of a loved one and these previous views may no longer be useful to conceptualize an individual's role in life. This requires a building of a new conceptualization.

Neimeyer (1998) describes the process of accommodating to the death of a loved one as "the attempt to reconstruct a world of meaning" (p. 83). Important components of this

accommodation process are the rebuilding of an assumptive world, redefining self both psychologically and socially, and finding meaningful ways to symbolize for self and others the transition undertaken in the course of bereavement (Neimeyer). Death requires the survivor to accept a tumult of subjective emotional experiences and objective new demands, which invalidate previously held assumptions about the world in very individualistic ways. It requires the development of new assumptions about the world to provide a semblance of meaning, direction, and predictability to a life that is permanently transformed (Marrone, 1999; Neimeyer). Grief counselors can support client's efforts to reconstruct a worldview by providing time and space to tell the story of loss, support attempts to place the event in the story of the client's life, and encourage the development of a conceptual view of the future (Neimeyer).

The redefinition of identity occurs in negotiation with others. Grief counselors can facilitate this interaction between humans in the development or redefinition of identity by encouraging the client to explore new possibilities of identity. For example, if the client had always been a dutiful wife and homemaker, the death of her husband may allow her to explore, find, and develop new aspects of her personality that had previously been denied. Such redefinition of identity can create friction in family systems, social support systems, and cognitive dissonance within the survivor. Grief counselors can offer support for this change, explain the difficulties others may have in accepting new identity formation and offer family counseling to encourage family members to accept the new growth of the client (Neimeyer, 1998).

The death of an important person and the development of a new identity can benefit from the use of a ritual or other way to observe the transition and changes. Meaningful

observances of such transitions should be developed individually according to what is most meaningful to the client (Neimeyer, 1998). Grief counseling can be useful for clients in helping them identify important rituals, support the completion of these rituals, and in constructing meaning from the observance of these rituals.

Summary

Bereavement services are provided on a continuum, ranging from less intensive (e.g., providing pamphlets and telephone calls) to more intensive (e.g., counseling for complicated mourning). Based on this review of the literature, grief counselors working in bereavement services engage in a wide variety of activities servicing both adults and children, including (a) supervision and training of others, (b) assessing the treatment needs of the bereaved, (c) providing brief support individually and in groups, (d) providing education and information about the grief process, (e) supporting clients in the legal systems, (f) provide help in developing new support systems, and (g) providing longer-term counseling that is more intensive.

Conclusion

Grief counseling is an interdisciplinary field focusing on the clinical aspects of working with individuals involved in dying and bereavement.. This review of the literature points out that grief counseling is highly specialized and differentiated from other aspects of thanatology. It is rapidly becoming an area of expertise and has a rich depth of literature to support this differentiation Training programs and certification efforts need to be sensitive to the needs of individuals providing clinical services in thanatology to provide educational experiences and training to increase competence in this area.

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