# Grief Counseling, its History and Practice

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**Abstract**

The first to conceptualize grief as an internal intrapsychic conflict was Sigmund Freud. He understood grief as a painful experience that needed resurgence to a better ego state. Psychoanalysts following Freud developed grief studies to include children and attachment. While others discovered the specific underlying emotions and grief work that must be resolved to find new meaning in a life without their loved one. This paper reveals that stage models are being rejected for their implication of universality and linear function. Present conceptualizations of grief celebrate individuality, oscillation, reconstruction, and retaining a non-physical attachment to the deceased. These concepts have evolved into practical applications in group grief therapy. This paper focuses on children's grief. Children are often forgotten mourners. Children, despite their inexperience and language barrier experience grief identically to their adult counterparts. But a child's development inhibits their ability to understand and express grief. To aid emotional expression in children counselors apply play, art, talk therapy in their practice. Group therapy provides members a safe space to talk about their pain and a community in which relates to their loss. Grief and grieving have been avoided in conversation and academia alike. There are few programs that offer death and dying courses, even to licensed clinical professionals in training. Lack of education has led to a misrepresentation and misunderstanding of grief. The goal of therapy is not to overcome and get over the loss, but to help people find peace and comfort in their new reality without their loved one.

*Keywords*: grief, ego, attachment, grief work, individuality, oscillation, reconstruction, non-physical attachment, (child) development, mourner, play therapy, art therapy, talk therapy, death and dying courses.

## Chapter 1: Grief and Loss: The Evolution of Conceptualizing Grief and the Grieving Process

To what degree have grief studies been influenced by early historic perspectives on "grief"? There are many models that have attempted to capture the voluminous scope of the grieving process. Before delving into its history, it is important to define the differences between grief, bereavement, and mourning. Grief is the reaction to the perception of loss which comes in a variety of emotional, cognitive, physiological, and physical symptoms (Nolen-Hoeksema & Larson, 1999; Rando, 1993). Bereavement is "an objective state, a change in the network of social relationships, which has been brought about by the departure of some person" (Lindemann, 1976, p.204). In *Mourning and Melancholia*, Freud (1915/17) described mourning as a conscious "reaction to the loss of a loved person" or something they love. Mourning is also defined as the conscious and unconscious "processes related to the deceased, the self, and external world" (Rando, 1993, p.24). It is imperative to those aiding mourners to understand that grief follows loss (Bowlby,1980), and that grieving is a natural reaction (Lindemann, 1976). Death is universal, no one can escape it. It is essential for caregivers, friends, and family to understand the purpose of grief work to ultimately accept their beloved is not returning and aid them in finding peace in this reality (Rando, 1993). There are several factors that affect the expression of grief such as type of loss, relationship lost, and secondary losses (Nolen-Hoeksema & Larson, 1999; Rando, 1993). And loss is unique to everyone (Doughty et al., 2011; Freud, 1915/17); therefore, coping strategies and models were created to combat and support those who are grieving in pain from their loss. This chapter will compare historic literature on views of grief, and stress and coping models to current views and see the influence the past has had on transforming grief and grieving strategies today.

Freud was the first to conceptualize grief as an internal and integrated process in the psyche (Freud. 1915/17; Gana, 2006). Originally topics of death and dying were exclusive to philosophy, religion, and medicine (Klimczuk, 2017). Freud's contribution to the psychoanalysis of death and dying led psychologists, psychiatrists, and philosophers to continue exploring the idea that grief as an internal process that would benefit from discovering methods to help resolve the physical, emotional, and mental pain that accompany loss. Following Freud came psychoanalysts, Melanie Klein, Edward John Bowlby, and Mary Ainsworth who analyzed grief in children. They founded the object-relations theory (Klein, 1921) and attachment theory (Bowlby, 1958) that determined attachment influences the intensity of reaction towards loss (Ainsworth et al., 1978). After the psychoanalysts, came psychiatrists like Elisabeth Kübler-Ross who applied observations in grieving clients and developed stage models that described a linear path of emotion that clients tend to process in grief. Phase models, like Kübler-Ross' 5 stage model, were popular for further identifying the various emotions that coincide with grief but were harshly criticized for alluding to universality of the grieving process (Metzger, 1979-80; Servaty-Seib, 2004). This paper will reveal that present grief strategies are refocusing on early historical concepts developed by psychoanalysts like Freud and Bowlby, rather than historical grief models like Kübler-Ross' stage model. More accepted grief strategies focus on the broad concepts of personal connection and attachment that display the individuality of grief.

In his paper *Mourning and Melancholia* (1915/17) Freud psychoanalyzed the process of death and dying. Freud believed that mourning was a painful internal process, and that melancholia was the natural emotional reaction to mourning. He described mourning as a "painful dejection, cessation of interest in the outside world, loss of the capacity to love, and inhibition of all activity" (p.244). Freud conceptualized mourning as a libido attachment to a

loved one, and after they die, the libido must be removed; therefore, admits that mourning is painful and reduces one's self-reproach. In other words, one must move on. Follower of Freud, Heikkinen (1979) described melancholia as an obstacle in processing grief, and therefore an inhibitor of resolving grief. Freud (1915/17) said that once the memories, emotions, and experiences tied to the loved one are severed, the process of mourning is done, and the person continues life uninhibited. Freud further believed that with time, one would simply overcome the loss. Heikkinen (1979) postulated the resolution of grief occurs when the intensity of grief has declined. Like Freud, Heikkinen believed grief requires acceptance and letting go of the deceased so that the survivor can build and sustain a new life without their dead loved one. Heikkinen offered that "these experiences [melancholia and mourning] are not continuous but may recur suddenly until the very end of the process" (p.46). Once they resolve their melancholic state, the grief work such as, irritableness, helplessness, survivor guilt, grieving, etc. will go away. The psychoanalysis of mourning provided by Freud (1915/17) opened avenues to further explore the internal processes of death and dying.

Critics of Freud's philosophy on mourning dispute that Freud's claim is too simplistic and lacks recognition of holding onto the memories of a loved one in a healthy way (Stroebe & Schut, 1999). The deceased has a specific relationship and role in the life of a mourner. It is important to find a way to detach from the identity of the lost; place them in a different role, a deceased role, consequently enabling the mourner to continue the bond but in a realistic, healthy manner (Stroebe & Schut, 1999). Today, techniques counselors suggest reveal that complete detachment from the loved one, or libido, is unrealistic. They believe survivors should have a continuous bond with their loved one (Bowlby, 1980; Kübler-Ross & Kessler, 1969/2005; Servatey-Seib, 2004; Stroebe & Schut, 1999). Grief is not something someone overcomes; it is

something to learn to live with. Mourners must learn to accept, and live with, the physical absence of their loved one. They will never forget the connection and attachment they had with them. Later techniques and theories latch onto the idea of maintaining connections to the deceased (Bowlby, 1980) and also believe that working through the emotions included in grief is imperative to recovery (Stroebe & Schut, 1999). Recovery meaning the mourner has successfully relocated the deceased from a living role in their life to a deceased one, the connection is still there, but relocated.

**Developments of Freud's Theory**

Grief work is "relocating the specific patterns which belonged to the shared life" (Lindemann, 1976). When a person has died, the survivor must look to the past, compare the sequence of life as it was when living together with their loved one and recondition those sequences to fit a life without them (Lindemann, 1976). The survivor must take on the roles of the deceased or share the roles with other people in their life. This is challenging, so one should not grieve alone. Working through grief is best achieved through the help of others (Lindemann, 1976; Stroebe & Schut, 1999). Lindemann offered that having a social network of people to redistribute the functions of the deceased, helps to make grief work more manageable and reach acceptance. Grief work is the cognitive process addressing the emotional baggage relating to loss; it is reminiscing events and memories of the deceased with the end goal of detachment (Stroebe & Schut, 1999). Grief work addresses that there is individuality of emotions between mourners and also offers a hopeful outcome when one accomplishes grief work. Lindemann coins another term, resurrection, which is the "unconscious fusion, of some part of his [the deceased's] image with the self of the survivor" (Lindemann, 1976, p.200). This includes roles that the deceased held in the household/income/work, that are additional work the survivors need

to undertake to resume life. Grief work includes resurrection, coming to terms with the loss, and dealing with secondary losses. Secondary losses are environmental, physical, and emotional loses caused due to the death of a loved one (Nolan-Hoeksema, 1999). Some examples for children and adults are school grades dropping, going to a single income, moving to a new home; downsizing, filling out paperwork for the death certificate and funeral arrangements, having to take on the role of both parents in the household, etc. (Nolan-Hoeksema, 1999). Grief work is originated by Freud in his paper *Mourning and Melancholia*. He thought that grief work was something that needed to be accomplished in order to fully recover and regain enlightenment and restore the ego (Freud, 1915/17). Grief work in Freud's theory, is where the survivor is expected to go through these hard tasks and emotions to avoid dwelling in their grief. Stroebe & Schut (1999) criticize Freud's concept of grief work, proposing the model is narrow minded because it assumes that mourners should be able to quickly resurge a positive state of mind after their loved one dies. In Stroebe and Schut's dual process model they expand on Freud's idea of grief work to be more inclusive.

The dual process model, created by Stroebe and Schut (1999) "describes ways that people come to terms with the loss of a close person" (p. 211). They developed Freud's concept of grief work and incorporated it with Bowlby's concept of retaining attachment with their loved one through oscillation. Oscillation is the most integral component in this model. Oscillation, according to Stroebe and Schut (1999) is "the alteration between loss- and restoration-oriented coping, the process of juxtaposition of confrontation and avoidance of different stressors associated with bereavement" (p. 215). In other words, mourners will have periods where they concentrate heavily on the loss, periods where they concentrate on secondary losses, and other periods where they take a break from grieving (Worden, 2009). This model emphasizes that a

mourner goes through periods of grieving each stressor separately while also having a grace period where no grief is experienced. Worden (2009) compares this model to taking doses. Similar to taking pills, mourners can take doses of coping strategies depending on the severity of pain they are experiencing. Stroebe and Schute (1999) call 'taking a break' voluntary suppression or involuntary repression of expression. The dual process model addresses not one, but two adaptive types of grief work. Stroebe and Schut's (1999) introduces the interconnection between loss-oriented stressors and restoration-oriented stressors. Where loss-oriented stressors are associated with grief, feelings, and ruminations of the death. Restoration-oriented stressors refer to secondary losses (Stroebe & Schut, 1999). Restoration- oriented stressors include changing the identity of the world they previously lived in with their loved one to one where they are physically independent from them (Worden, 2009). And oscillation between the stressors acknowledges the individuality of mourning and consider environmental and personal factors that affect the grief process. This model is useful for addressing differences in environmental and personal factors such as culture, socioeconomic status, personal experience with death, etc. (Sevaty-Seib, 2004). Additionally, it provides a layered effect of grieving, those grieving go back and forth between stressors and periods of mourning when the emotions resurge. It is not a linear process, but one dictated uniquely by the one grieving (Worden, 2009).

Another model branching off the idea of individualism is the constructivism method. Constructivism focuses on the interpretations of an individual's grief and the re-construction of the individual's experience after the death (Doughty et al., 2011), which is similar to Stroebe and Schut's (1999) restoration-orientation stressor. Neimeyer (1999) suggests that clients write poetry, journals, letters, and other narrative strategies to express their personal grief to have a physical and visual reference to express their emotions. Neimeyer (1999) saw counseling as a

way to reach into the mind of a client and find what they are struggling with in their grief. Reconstruction is the key element in this grief method. “The reconstruction of a world of meaning is the central process in grieving” (Neimeyer, 1999, p.65). A mourner must learn to cope with the reality of their loved one being gone. Re-construction or adaptation to the reality of death is critical to Niemeyer’s constructivist approach. Constructivism includes interpersonal processes eliciting intimate and vulnerable meanings to the death of a loved one (Doughty et al., 2011; Neimeyer, 1999). Re-construction allow mourners to create new traditions and reality that memorialize their loved one, including them in a non-physical, healthy way.

**Object-Relations Theory**

Melanie Klein, a Freudian psychoanalyst, developed the object-relations theory which focused on the development of the unconscious phantasy to the paranoid-schizoid position and depressive position in children. Her theory focuses on the relationship between an infant and its primary caregiver (Klein, 1935). It starts with the unconscious phantasy attached to their mother’s breast, in which the infant’s primary focus is feeding and their anxiety or pleasure that comes it (Klein, 1935). Klein suggested that the infant could distinguish between a “good breast”, when they felt satisfied through feeding and the “bad breast”, when they were anxious or dissatisfied. This distinction is the paranoid-schizoid period in a child’s development when the infant mentally splits the “good” and “bad” breast apart (Klein, 1935). An infant’s anxiety arises from hunger and frustration. Children compartmentalize their frustration onto the “bad breast” whereas when they are content and well-fed, they relate this to the “good breast”. This splitting occurs within the baby’s ego. Klein called this projective identification, where the infant projects his/her negative feelings of anger and anxiety onto the “bad breast” (Klein, 1935). The final position involved in Klein’s object-relations theory was the depressive position which occurs

when the baby is weaned. Instead of seeing the mother as two separate entities, good breast and bad breast, the infant begins to see her as a whole and separated from himself/herself. This causes a real grief and a sense of loss as he/she is no longer one with the mother but separated from her.

In response to Freud's "*Mourning and Melancholia"* Klein proposed the depressive position was directly related to the mourning process later in life (Klein, 1940). She theorized that the loss of a loved one reactivated the depressive position that infants go through (Klein, 1940). Just as an infant experiences separation and loss, the grieving person has lost a loved object that they must reconcile with. Klein concluded that the focus should be on reinstating the "good object" and "by rebuilding his inner world, which was disintegrated and in danger, that he overcomes his grief, regains security and achieves true harmony and peace" (Klein, 1940, p.120).

**Attachment Theory**

Influenced by Klein and Kleinian theory, was psychoanalyst Edward John Bowlby. He gleaned from Klein's "good breast" and "bad breast" concept in her object relations theory from *The Psychoanalysis of Children* (1932). Bowlby further developed the theory between the child and its mother. He ignored Klein's conflict between libidinal drives and focused on the external word drives in children. The attachment theory designed by John Bowlby described the emotional attachment between infants and small animals with their mothers (1958). In *The Nature of The Child's Tie to its Mother* written in 1958, Bowlby coined the term primary object clinging in which a child clings to its mother in order to receive feelings of safety and comfort. The need to feel safe is a strong drive towards attachment (Worden, 2009). Bowlby (1958), views human attachment as a strong natural connection between a child and their mother. In

1969 Bowlby published the first volume: *Attachment*, in the trilogy *Attachment and Loss* where he describes attachment behavior as "seeking and maintaining proximity to another individual" (Bowlby, 1969, p.166). Children tend to cling to their maternal figure when they feel, alarmed, scared, threatened (Bowlby, 1969), and the intensity of the attachment is dependent on factors such as "pain, illness, and unhappiness" (p.172). The need for attachment is driven by the desire of proximity with their primary caregiver (Bowlby, 1980; Doughty et al., 2011) and children show this need through non-verbal physical external actions such as crying (Bowlby, 1969). In 1980 Bowlby published the third volume of this trilogy: *Loss Sadness and Depression.* This volume focuses on child-mother separation and reactions thereafter. For a child whose parent dies they completely lose their attachment figure physically. Grief and mourning sprout from missing attachment (Bowlby, 1980; Bretherton, 1992). When experiencing loss, Bowlby (1980) emphasizes the importance for children to find, explore, and retain a non-physical attachment to their loved one. The concept of maintaining connection with their loved one beyond the years of their death is central to the conceptualization of death and dying strategies (Bowlby, 1980; Doughty et al., 2011; Stroebe & Schut, 1999, 2010)

Mary Ainsworth joined Bowlby's team studying attachment in children. In her studies Ainsworth and colleagues (1978, 2015) discovered three different styles of attachment: secure, anxious-ambivalent insecure, and anxious-avoidant insecure. The attachment theory and type of attachment with the deceased can more accurately assess a child's grief reaction (Doughty et al., 2011; Parkes, 2002; Servaty-Seib, 2004). Children who have anxious-ambivalent insecure attachment are more likely to express symptoms aligning with chronic grief (Doughty et al., 2011). In regard to grief counseling methods, the attachment theory's main goal is to maintain a non-physical attachment to the deceased (Bowlby, 1980; Sevaty-Seib, 2004). The grieving

process should result in reestablishing their relationship with their loved one (Bowlby, 1980). Bowlby and Ainsworth provided insight for interpersonal counseling strategies (Servaty-Seib, 2004) and behaviors expressed during grief (Worden, 2009). “It provides a way for us to conceptualize the tendency in human beings to create strong affectional bonds with others and a way to understand the strong emotional reaction that occurs when those bonds are threatened or broken” (Worden, 2009).

**Stage Model**

The Kübler-Ross’ stage model is the most remembered model for grief (Breen, 2010). In her book *On Grief and Grieving*, Kübler-Ross compartmentalizes grief into five broad stages, 1) denial 2) anger 3) bargaining 4) depression 5) acceptance. These stages provide a framework in which the bereaved experience grief. Kübler-Ross’ model suggests that individuals go through these stages in progression throughout their grief journey, starting with denial, in which a mourner expresses disbelief, numbness and shock. They do not deny that their loved one is dead, but they cannot fathom the reality they are in, so their natural bodily reaction is denial/numbness to the overarching idea of their loved one being physically gone (Kübler-Ross & Kessler, 1969, 2005). The next step, anger, “affirms that you *can* feel, that you *did* love, and that you *have* lost” (Kübler-Ross & Kessler, 1969, 2005). According to Kübler-Ross this is a vital step that is not to be rushed because if a friend, counselor, etc. tries to rush this stage it is invalidating the person’s emotions and does not allow them to grieve at their own speed (Kübler-Ross & Kessler, 1969, 2005). In the bargaining stage the survivor begins to blame themselves or others for the death of their loved on, asking themselves, “what if and if only” questions (Kübler-Ross & Kessler, 1969, 2005). Following bargaining is depression, a stage in which life and daily tasks feel pointless. Kübler-Ross offers that “depression is a way for nature to keep us protected by shutting down the

nervous system so that we can adapt to something we feel we cannot handle" (p.21). Kübler-Ross states that all of these steps are necessary to work towards the process of healing with the ultimate goal of recovery. Recovery is the stage in which the mourner accepts the reality of the loss and is able to live in their new reality, one without their loved one. Unlike Freud (1915/17) and Heikkinen (1979) but similar to Bowlby, the final stage of acceptance which "is a process that we experience, not a final stage with an end point" (p.27).

**Reflections on Kübler-Ross**

In *Pathological mourning and childhood mourning* (1972) Bowlby proposed that clinical conditions such as intense and persistent anger, changing roles and caring for others, and denial are phases bereaved go through. These conditions are strikingly similar to the five stages of grief in Elizabeth Kübler-Ross' *On Grief and Grieving* (1969, 2005). Bowlby (1972) elaborates, similarly to Kübler-Ross, that each variant, or phase/stage does not represent one's whole mourning process. The phases are often intertwined, or as Bowlby states, not mutually exclusive (1972). Each stage of phasal models varies between clients and depends on their environmental factors such as, brevity of loss, type of loss, experience with loss, etc. (Heikkinen, 1979; Kübler-Ross & Kessler, 1969, 2005). Bowlby (1972) and Kübler-Ross (1969, 2005) also recognize the difficulty of taking on the deceased's role while mourning. When a loved one dies the people surrounding them must fill the roles that they played. They not only have to mourn the relationship but also take over their responsibilities. For example, when a father dies the oldest sibling, or the mother must take on the "father" role for the family. The role can also be split between family members or even friends, but either way role transitions is an immense responsibility the survivors must undertake in addition to their grief. Bowlby and Kübler-Ross also share similar perspectives of the phase/stage of denial in their mourning/grief models.

Bowlby (1972) addressed denial as a fantasy and split reality that could lead to clinical syndromes. And Kübler-Ross identifies denial as refusing to believe that their loved one is dead.

Dwelling in grief can lead to psychopathological consequences (Stroebe & Schut, 1999). Both Bowlby (1972) and Freud (1915/17) associated, in their own way, severe feelings of melancholia and denial to mania or other conditions such as anxiety and depression. The reactions to loss of a loved one differ from person to person due to the individuality of the relationship they lost (Kübler-Ross & Kessler, 1969, 2005). Initial reactions to death is a hyper-attachment which leads to the denial of reality (Altschul & Pollock [Forman], 1988). Forman (1988) defines what Kübler-Ross says are stages, as defenses. Denial and fantasy being the first defense, followed by introjection of part of the lost object, resistances to withdraw attachment, and transference of neurosis. Denial is a coping mechanism for both adults and children to start the process of freeing the ego and letting go of the attachment (Freud 1915/17; Altschul & Pollock [Forman], 1988). Denial is viewed as a defense to preserve the attachment. This is where historic psychoanalytic theories and psychiatric applied models differ. Kübler-Ross sees denial as a normal reaction to grief, therefore grief is the cause for denial, rather than denial being a precursor to mania.

Freud (1915/17) says that melancholia, the response to mourning, is an inhibiting emotional response. Melancholy directly inhibits the ego. Freud's views of melancholia align with symptoms of depression: worthlessness, incapable of achievement, despicable, vilifies themselves, deserving of punishment… heightened self-criticism (p.246) which can override the ego and lead to suicide or mania. Stroebe and Schut (1999) believe that there are coping strategies that prevent psychopathology. Kübler-Ross accepts that grief causes symptoms of depression and anxiety, but unlike Stroebe and Schut, believes that her phase model could

mitigate diagnosing a client with depression. Kübler-Ross would first view the symptoms as reactions to grief and use her model to help with grief and resolve their depression and grief. Obviously, if the symptoms worsen or develop, Kübler-Ross would then see a need for further action. One key element in phase/stage models is the belief that counseling is used to identify the losses of their client (Heikkinen, 1979). Opposed to these models, are conservatism (Neimeyer, 1999), attachment theory (Bowlby, 1969), and the dual process model (Stroebe & Schut, 1999) which acknowledge the individuality of the client, and offer more open ended, less restrictive counseling strategies and coping models.

Although highly regarded for identifying the emotional progression expressed in clients, stage models, such as Kübler-Ross', were criticized for denying individuality of grief (Neimeyer, 1999; Stroebe & Schut, 1999). Stage models impose a rigid path for everyone to follow through to reach acceptance. There is yet to be an all-encompassing theory utilized for grief. Existing theories are criticized for their lack of capturing the complexity of an individual's grief experience. Today, counselors have a collective conceptualization of grief. They take ideas and concepts from different models and use them in practice (Servaty-Seib, 2004). Although, counselors do not accept the linear progression of stage models, they acknowledge the underlying emotions observed in the model. This research has shown that strategies today are reverting to traditional approaches to grief treatment (Servaty-Seib, 2004). They are focusing on the individual, looking at their attachment (Ainsworth et al., 1978, 2015), past interpersonal experience with death (Bowlby, 1969, 1980), stressors (Stroebe & Schut, 1999), and other personal aspects that make everyone's grief process unique to them. Grief therapy strategies strive to help their clients find meaning in the reconstruction of their lives without their loved one (Neimeyer, 1999,2001; Servaty-Seib, 2004).

## Chapter 2: Grief Counseling: An Exploration of Individualized Experience in Group Therapy

There is no universal definition of grief, therefore measuring grief is inconsistent among counselors (Altmaier, 2011). Also, it is statistically shown certain individuals do not benefit from grief therapy at all and hurt rather than help their grieving process (Doughty et al., 2011). Additionally, feelings of grief are individualized to each person (Doughty et al., 2011). If this is so, and each client expresses different emotions and attitudes towards the deceased and loved one. Counselors are challenged to create an atmosphere where each client's emotions are adequately addressed without having someone feel singled out, isolated or excluded from the conversation. That is, the complexity of grief complicates the ability to supply efficient and effective conversations in group therapy. This exists even more significantly when the clients are children (Crenshaw, 2005; Webb, 2011). Given that children seldom have long attention spans (Goldman, 2004) and have difficulty expressing their feelings with words (Crenshaw, 2005) counselors must employ a variety of grief processes, which, simultaneously voice truth into each child's life. Every child has a different relationship with their deceased loved one. One child may feel relief that the person is dead and could feel guilty for feeling relieved; another may not have enough memory to fully grieve the loss; still another could have been extremely attached to their loved one. The possibilities of combinations of relationship, attachment, and emotion towards the deceased are limitless. Currently, there is no single, universal model to address the variety of grief exhibited by children. There are several models attempting to assure all varieties of grief can be addressed. This paper will provide several strategies, activities, and coping mechanisms that help make grief group therapy effective and efficient for pre-adolescent children.

### Grief Counseling

Grief and loss encompass human experiences that everyone will endure throughout their lifetime (Doughty et al., 2011). Yet, as Elizabeth Kübler-Ross and Kessler (2005) state, "our grief is as individual as our lives" (p. 7). No two people identically experience grief. Like snowflakes, each mourner has an intricate design of how they continue living without their loved one. As such, there is no right or wrong way to grieve. Death is all around us, no one person can escape it. Not even children can be protected from this painful experience. The challenge for many adults is that children do not cognitively or emotionally process their grief as easily (Crenshaw, 2005; Webb, 2011). This makes grief counseling a relatively new therapeutic construct. Children, families, and adults attend sessions hoping to find closure and a way to communicate across their different grief experiences. Counselors provide either individual therapy, group therapy or a combination of the two to provide coping mechanisms; "tools" that children and adults can put in their toolboxes as they experience their grief. These "tools" guide clients toward stability in their new life without their loved one. This paper will additionally focus on group therapy and the challenges counselors face with the complexity of grief. If each child's grief is unique, is it possible for group therapy to validate individual emotions while maintain a connection with the group? Further, in addressing those individual emotions, do counselors risk singling out or isolating group clients? This paper will explore the dynamic strategies employed by counselors to create individualized experiences in a group therapeutic setting.

**Group Counseling for Grief**

There is stigma around counseling (Prior, 2011). People fear being perceived as weak by their peers or find their self-perception reduced because they are "unable" to hold the weight of their emotional baggage. Especially in instances of grief, where the loss may not be visible to

society, there is a presumption that the emotions must be handled privately. When children are involved, that presumption extends to their parents, who are perceived as responsible for helping them through their grief (Bowlby, 1972). For this reason, many families do not seek counseling for grief. Yet, counseling supplies a mourner with applications and an outside perspective that allow them to gain access to their inner grief (Crenshaw, 2005). It is critical for mourners to come into counseling with a positive outlook, seeing it as a productive aid to acceptance rather than something that needs to be fixed or resolved (Altmaier, 2011). As quoted in Altmaier (2011), Wampold states sessions are grossly misrepresented. Counseling is more than applying techniques and resources to improve well-being. The belief that counseling will solve the problem, inflates the probability of successful treatments provided in counseling which can lead to impractical assurance of recovery (Altmaier, 2011). Counseling is not something that will abate a situation; it is simply a counselor-client relationship; where the client feels understood, valued, appreciated, and supported (Altmaier, 2011). For grieving children, entering a group can be intimidating. Participants in therapy are expected to share a vulnerable and potentially painful emotion to complete strangers. Some studies have found evidence that grief therapy may induce more symptoms of grief after leaving therapy (Larson & Hoyt, 2007), while other studies find group therapy to be the chosen treatment for people experiencing complicated grief (Grebin & Vogel, 2007).

The first challenge for counselors is composing the group. Individuals may not be ready for or the right fit for a group because of the type of relationship they lost and the type of loss they experienced (Piper et al., 2007). Counselors attempt to put similar losses (i.e., spouses, children, parents) into the same group, while also taking into consideration the type of loss (i.e., disenfranchised, natural causes, unanticipated, …). These are critical steps to ensure that each

group member feels safe, heard, and understood within the group. Meaningful relationships can be created within the group which is a unique aspect of group therapy compared to individual therapy (Grebin & Vogel, 2007). Warden (1991) and Rando (1993) emphasize the importance of establishing new emotional ties with others and starting new relationships in order to help cope with grief. Group therapy allows individuals to openly discuss their loss with others who have experienced similar losses and provides that both socially and emotionally supports the client (Grebin & Vogel, 2007). Group counseling supplies supportive therapy that allows members to relate to one another and help each other improve their adaptation into the world they must endure (Piper et al., 2007). Grebin and Vogel (2007) describe group therapy like this: the group really becomes another support system outside of the home.

Within this client-supported group dynamic, there is a personal client-counselor relationship as well. Productive growth in a client is dependent on a counselor's personal experience and the interpersonal relationship with the client (Altmaier, 2011). Clients must feel supported, engaged, and safe in the environment the counselor creates. This includes, but is not limited to warm, open, astute, and vulnerable conversations with the client facilitated by the counselor (Altmaier, 2011). However, the facilitator's role in the group is not to dictate the events, but, rather, to guide conversation and provide activities to evoke the emotions that are being suppressed (Altmaier, 2011). While many facilitators may have experienced personal losses, they are not the ones experiencing the immediate loss of a loved one. The goal of the facilitator is to relate to each griever's emotions and connect with them while allowing the group to freely discuss their pain.

**Child Therapy for Grief**

There are several ways children experience loss. They mourn the loss of relationships, external objects (toys/baby blankets), skills, pets, etc. Regardless of the nature of the loss, a child will experience grief (Goldman 2013). Grief is an overwhelming process which children find hard to emotionally express and understand (Webb, 2011). When provided with the opportunity, bereaved children express depression, anxiety (Ener & Ray, 2018; Goldman, 2004), feelings of abandonment (Ener & Ray, 2018), less hope for their futures and low self-esteem (Ener & Ray, 2018; Goldman, 2004). However, a child's understanding of the loss may vary with age (Webb, 2011). Hoeksema and Larson (1999) propose five components of loss understanding in children: universality, irreversibility, non-functionality, causality, and noncorporeal continuation. However, as Webb (2011) argues, most children do not fully understand these five concepts; knowing these is a very mature thinking of death. According to the research of Hoeksema and Larson (1999), Universality is the understanding, by children, that everything eventually dies. Younger children, however, often believe they cannot die, nor anyone close to them (Hoeksema & Larson, 1999). Irreversibility is the understanding that once something is dead, that the death is permanent. There is no way to return to living once dead. Non-functionality is the idea that a dead person can no longer complete physical activities. They cannot smell or feel etc. This concept is harder for children to understand. It is recommended that parents and counselors focus on relatable, short, concrete phrases such as: "Grandma cannot eat or taste an ice cream cone; Grandma cannot throw a baseball; Grandma cannot hear you sing" when explaining death to children. Causality represents the knowledge of how a person died. Noncorporeal continuation is the belief that after someone dies there is a life after death to some capacity.

Despite these deep and varied grief experiences, children are not, commonly, seen as mourners. Yet, studies show that children feel safer to express their emotions when they are

initially affirmed as a mourner (Goldman, 2004). This can be done by incorporating children into rituals. Allowing children to attend funerals provides assurance that they are as recognized as a mourner as the adults that are grieving (Goldman, 2004). Much of the difficulty is perceiving children as mourners, centers around their inability to adequately express the emotions they are feeling. Children's lack of understanding loss and their limited emotional vocabulary, cause them to shy away from using words to express their grief (Webb, 2011). This presents a unique set of challenges for counselors working with grieving children. Play, art, and other creative therapies allow children who seek grief therapy to relax and feel safe. During moments where a child is occupied coloring or playing with figurines, their guard is down and they are more likely to unconsciously reveal their inner emotions to a counselor when probed with questions (Crenshaw, 2005; Webb, 2011). Such child-friendly therapies offer outlets of emotional expression and strategies to produce good coping mechanisms (Webb, 2011). These therapies are applied and utilized by counselors to discover how much a child understands death (Webb, 2011). Children grieve and they must feel validated for them to openly share their emotions. They must be recognized and told the concrete truth about death.

**Practical Application**

Practices applied in child grief therapy typically consist of several creative activities. Children's short attention spans and limit death vocabulary to express their emotions, leave counselors with limited information to gather how to help the child (Goldman, 2004). Studies find that art and play therapy are effective strategies employed to have a child share their inner thoughts (Lusenbrink, 2004; Webb, 2011). Because children, especially pre-adolescent children have difficulty communicating their feelings clearly and have a small emotional tolerance of grief, play therapy is a great way to express their emotions in a "language" they are comfortable

speaking. Children are capable of grieving through play, skits, and drawings (Webb, 2011). Play therapy is a practice in which a counselor provides toys, such as blocks, dolls, animals, cars, and other play materials for children to play out the death in their own creative way (Webb, 2011). Therapists can ask the children direct questions about the death to hopefully able the child to express their interpretation and understanding of their loved one's death (Webb, 2011). The dialogue expressed is the child unconsciously projecting their grief verbally and non-verbally (Goldman, 2004).

Another common coping mechanism for a child that can be built through group therapy is helping them nurture and maintain a relationship with their deceased loved one. This requires cognitive awareness and upkeep of memories and action relating to the person they lost (Goldman, 2004). Memory boxes can help children complete unanswered questions. Counselors structure the activity to include questions such as "What is the most important thing they learned from their loved one"; "what was life like before their loved one died"; "what is their funniest memory"; "where they were when their loved one died"; "what was their first thought after they died" (Goldman, 2004, p.181). These prompts help children expand their emotions and further develop their understanding of grief (Goldman, 2004). They also provide a tangible connection to the dead. Each object in the box has a specific memory or connection to their loved one (Goldman, 2004). Art therapy, projective play and dream work are other common techniques employed to target inner unconscious expression of grief (Goldman, 2004; Lusenbrink, 2004). Interventions such as painting, memory work, letters, etc. are beneficial to children in understanding their own grief while also providing a counselor with the progress of the emotional grieving process in that child (Crenshaw, 2005; Goldman, 2004). There have been many studies exploring interpretations of drawings that is outside the scope of this paper, but

these techniques are yet another outlet children can utilize to genuinely express themselves in therapy.

**Strategies of Inclusivity in Group Therapy**

In general, employed strategies of grief counselors today are strikingly different from the ones utilized even 10 years ago. Today, grief counselors are moving away from stage models and towards cognitive and behavioral strategies (Doughty Horn et al., 2013). Stage and phase models are criticized for ignoring the individuality of the mourner (Doughty et al., 2011). They imply clients should go through and resolve each stage before they find resolution to their grief, eluding the universality of grief (Doughty et al., 2011; Niemeyer, 1999). Today, grief strategies address the complexity each client expresses and considers moderating factors of grief such as culture, experience, and personality (Doughty et al., 2011). Recognizing the individuality of grief allows counselors to tap into more behavioral and cognitive routes. These strategies are based on attachment theory (Bowlby, 1969), the dual process model (Stroebe & Schut, 1999), constructivism (Neimeyer, 1999), and adaptive grieving style (Martin and Doka, 2000) that highlight individualism (Doughty et al., 2011). The emotional roller coaster of mourning compromises one's ability of expressing emotional, cognitive, and behavioral functions (Altmaier, 2011). New models of grief also have one very important concept in common: intimate client-counselor relationships.

Currently, counselors emphasize having open, honest, and genuine conversations with the children. These conversations allow children to view their counselor as someone they can trust with their deepest darkest emotions without feeling inferior or unheard and decreases anxiety (Goldman, 2013). In addition to the individuality of every griever, the type of loss provides its

own unique stressors that individuals must overcome. Counselors must listen attentively; considering all moderators that could potentially affect a client's grief, and genuinely acknowledging their emotions. These moderators can include: The structure of the group (open versus closed, the length of group (time-limited versus long-term), the diversity of the people in the group (gender and culture), and the type of loss experienced (traumatic, disenfranchised, expected, unexpected etc.) (Grebin & Vogel, 2007; Nolen-Hoeksema & Larson, 1999). Types of death include disenfranchised, expected, and unexpected (Nolen-Hoeksema & Larson, 1999) and are identified as uncomplicated or complicated, and can vary how one grieves (Grebin & Vogel, 2007). Creating a safe environment, in spite of theses moderators, for a child to express their grief, fears, anger, and any other emotion tied to their loss is imperative for any person involved in a child's griefwork (Goldman, 2013). Counselors need to acknowledge and validate their grief and their feelings, these will be contrary and opposing to an adult's reaction to loss, but it does not make their feelings any less relevant (Goldman, 2013). Without trust between the child and the counselor the techniques will not be successful (Crenshaw, 2005).

## Chapter 3: Greif Education and Counseling

Talk therapy has been around for many years and is one of many successful practices for those combating anxiety, depression, and other psychological disorders. Counselors are the paid professionals people come to for guidance. Winokuer and Harris (2016) express counseling as dynamic experience and personal relationship between the client and counselor. Counseling guides people through their emotions and experiences and helps people practically apply strategies and tools to improve their emotional and psychological state (Winokuer & Harris, 2016). Counseling is a broad practice that covers just about all psychological issues addressed in the DSM-V. But what about grief? "Grief and loss are ubiquitous in the human experience" (Doughty Horn et al., 2013, p.70) yet several studies reveal grief and loss curriculum are overlooked in academia (Eckerd, 2009). The lack of training may lead to insufficient counseling to grieving clients (Breen, 2010). This paper will reveal the underrepresentation of grief therapy teaching, techniques, and in academia and offer solutions to help recognize grief as a nosology of psychology.

## Underrepresentation of Grief

### Psychological Organizations

Grief was recently added to the DSM-V in 2013 and recognized by The World Health Organization in their 11th edition, the ICD-11 (Boelen et al., 2018). These organizations have made specifications for grief, such as Prolonged Greif Disorder (ICD-11) and Disturbed Greif, and Complex Bereavement Disorder (DSM-V) under psychological stress disorders (Boelen et al., 2018). Grief diagnoses, similar to stress and anxiety disorders, require clients to experience pervasive emotional distress for at least 6 months after the death of their loved one, two

separation destress related symptoms, and one additional symptom related to grief (Boelen et al., 2018). Recognition and education about grief will help society normalize grief (Eckerd, 2009). Hopefully due to acknowledgement of grief in these major publications there will be more applications of grief training in graduate programs for counselors, or even make a specialized practice for grief therapy.

**Academia**

Evidence shows that counselors do not receive adequate training as they achieve their graduate degrees (Ober et al., 2012). Death and loss curriculum is either excluded from counselors' coursework (Servaty-Seib, 2004) or not required for the degree (Ober et al., 2012). "Fewer than 50% of graduate programs in clinical psychology even cover death-related topics" (Eckerd, 2009, p.768). Grief is very complex and the path someone takes to relocate their attachment to the deceased is dependent on many factors such as "age, family structure, circumstances of bereavement, previous bereavements, concurrent stressors, relationship with the deceased, previous crises, social support, and culture" (p. 289) that counselors are ignorant of if they are untrained (Breen, 2010). Research shows that adequate training is positively related to confidence in providing care for clients (Ober et al., 2012). But unfortunately, counselors either receive little or no formal training in grief counseling strategies (Ober et al., 2012).

The closest training related to death and dying that is more available in academia is curriculum on trauma therapy. Trauma therapy addresses intense emotions of fear and calamity that coincide with a traumatic event such as a car accident or near-death experiences (Marzillier, 2014). Trauma therapists assess tactics to better understand a client's vulnerabilities towards the traumatic event in hopes the client reduces their levels of fear (Marzillier, 2014). But trauma is

not synonymous with grief, they are independent psychological experiences. Clients who's loved one died from a traumatic death or witnessed the death causing a traumatic experience, are sent to trauma therapy before receiving grief therapy (C. Taverner, personal communication, November 2, 2021). Overall, there is lack of access to the education necessary to know what it takes to be a grief counselor (Breen, 2010). If there is evidence to show counselors are poorly educated on grief, if at all, then how well can licensed counselors understand and treat grief?

Not all people who have experienced loss go to grief counselors. Many people go to general licensed counselors (Breen, 2010; Ober et al., 2012). Breen (2010) in their study, hoping to find how licensed counselors who are untrained in grief understand grief and how they apply their understanding to their practice, found that counselors without training believe that grief is bound within the limits of time and stages with the end goal of finding closure in which the client can either be successful or unsuccessful. … This frame of mind is scarily close to the original mind of Freud who believed in complete detachment from the deceased. While in Ober's study (2012), licensed professionals with no grief training, but had good awareness of death (from personal experience) expressed confidence in their ability in grief therapy practices. The more personal experience a person has the more confidence a counselor has in their competency with grief clients. But Ober and colleagues (2012) also find that counselors with professional grief training were most confident in their professional practice over those that did not receive training. Personal familiarity is not synonymous with professional understanding. Counselors who are trained in grief are aware of specific "theories of grief counseling, terms and definitions, crisis intervention for grief, community-based psychoeducational grief-programming methods" to reduce than those who are self-aware in their abilities (Ober et al., 2012, p.156-157). In order to have optimal self-efficacy counselors should stay current and familiarize themselves with the

practices and models that are being utilized (Breen, 2010; Doughty Horn et al., 2013; Ober et al., 2012).

**Requirements to be a Grief Counselor**

Counselors may not be exposed to death education because of lack of "lack of time to source, read, and retain information" (Breen, 2010, p.292). It could be hard to keep up to date with the latest models and techniques because of lack of resources to attain such information. Those who did receive little grief education did not find their training useful (Breen, 2010). Lack of recent knowledge can lead to misapplication of theories and coping mechanisms that can be detrimental to a client's conception and recovery from their grief (Ober et al., 2012). In Breen's study counselors were asked what grief models they were familiar with, and the most reported model was Kübler-Ross. As chapter one points out, current grief practices are based on cognitive and behavior strategies that focus on the individuality of grief and are moving away from stage models (Doughty et al., 2011; Doughty Horn et al., 2013). Inadequate training can result in underprepared counselors, misrepresentation of grief, and unsuccessful treatment of clients (Ober et al., 2012).

Counselors must assess coping mechanisms to fit their client's needs (Ober et al., 2012; Worden, 2009). Addressing unresolved losses are different than assessing complete suicides and disenfranchised deaths (Nolen-Hoeksema & Larson, 1999; Ober et al., 2012). Counselors must also consider cultural influences. All these factors on top of demographics, secondary losses and relationship lost, attribute to the appropriate strategies and medications to refer to clients (Nolen-Hoeksema & Larson, 1999; Ober et al., 2012; Rando, 1993). It is imperative for death and dying curriculum to be recognized in academics to better prepare counselors to address grief and loss.

## Solution

### Make Courses Available in Academia

One main reason people are not educated on death is because they fear death, therefore avoid talking about it like it is the plague (Eckerd, 2009). This could be since death is still a subject that no one knows how to talk about, and it is easier to avoid than to discuss awkwardly (Eckerd, 2009). Education on death can combat these fears. Studies show that exposure to death and dying curriculum will lead to 1) openness to talk about death and dying 2) clarity in personal stance on death 3) reduced fear of death (Doughty Horn et al., 2013). The more people who are educated on death the more comfortable, and less stressed they will be when coping with their own grief (Doughty Horn et al., 2013; Eckerd, 2009). Education should not stop after the classroom, because of the ever-changing strategies, counselors should continue to educate themselves to improve their practice (Breen, 2010). And for licensed counselors that have not received proper grief training should seek such training (Breen, 2010). It is also important to include understanding of personal experiences of grief in grief training to reinforce a counselor's confidence and ability to help those who are grieving (Ober et al., 2012). As Ober and colleagues (2012) found, people's confidence in their work increases if they are aware of their own values of death. Grief counselors "must be comfortable with their own losses, comfortable listening to and talking [with children] about death" (Heath et al., 2008, p.261).

### Application in Grief Counseling with Children

It is imperative that counselors understand how to communicate with children about death. Children and adults grieve differently. The first interaction a counselor has with a child will determine whether a child will open up and trust the counselor with their emotions (C. Taverner, personal communication, November 2, 2021). Counselors must give accurate

information to children. Children do not understand metaphors they become more confused by this terminology than benefit from someone trying to protect them (Silverman, 2000). Children need to be told in concrete terms what happened to their loved one, not half-truths or avoiding the subject altogether (Heath et al., 2008). Counselors must not be silent or avoid talking about death with children because they do not believe they can handle or understand the pain. Children are more aware of death than we believe (Silverman, 2000). If counselors demean the understanding of children or try to protect the child from the "hard truth" the counselor is blocking the trust and communication with the child (Heath et al., 2008).

Experience and exposure are also moderators in comfort with death (Doughty Horn et al., 2013). Attending workshops, training sessions, classes have the potential to reduce anxiety around death (Doughty Horn et al., 2013). Counselors must also understand that the moderators that aid counselors to feel more confident in their grief counseling skills also applies to the clients. Young children have little experience, and are not as educated in life, therefore would need to be told basic concrete information about the death of their loved one (Heath et al., 2008; Silverman, 2000). Compared to adolescents who have a better understanding of life, due to more experience and development, they can be told and are able to understand more specific details of the death (Heath et al., 2008; Silverman, 2000). There is a positive relationship between experience and the ability to understand death (Doughty Horn et al., 2013; Heath et al., 2008; Ober et al., 2012).

**Conclusion**

Death, dying and bereavement education should be taught early in undergraduate years to combat challenges and universality of death that students will face (Eckerd, 2009). The sooner

one learns about death the more comfortable and prepared one is to face death. But because the subject is still taboo to talk about in society it could be perceived as difficult to educate on because the subject could resurface uncomfortable and vulnerable emotions (Eckerd, 2009). But research shows that death and dying education develops the exact opposite feelings towards death (Breen, 2010; Doughty Horn et al., 2013; Ober et al., 2012). The ultimate goal of grief counseling is to "help the survivor adapt to the loss of a loved one and be able to adjust to a new reality without him or her" (Worden, 2002, p.84) and to maintain the bond with the deceased (Bowlby, 1969,1982; Stroebe & Schut, 1999; Worden, 2002). No matter who the counselor is, it is important that they receive enough education to give them the sufficient knowledge to help those in need.

**Chapter 4 redacted to remove personal reflections and any identifying information.**

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