

Understanding and Working With Complicated Grief.

**The Therapeutic Relationship: A literature review with
clinical illustrations.**

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Stop All The Clocks, Cut Off The Telephone

Stop all the clocks, cut off the telephone,
Prevent the dog from barking with a juicy bone,
Silence the pianos and with muffled drum
Bring out the coffin, let the mourners come.

Let aeroplanes circle moaning overhead
Scribbling on the sky the message He Is Dead,
Put crepe bows round the white necks of the public doves,
Let the traffic policemen wear black cotton gloves.

He was my North, my South, my East and West,
My working week and my Sunday rest,
My noon, my midnight, my talk, my song;
I thought that love would last for ever: I was wrong.

The stars are not wanted now: put out every one;
Pack up the moon and dismantle the sun;
Pour away the ocean and sweep up the wood.
For nothing now can ever come to any good

W.H Auden

Remember Me

Remember me when I am gone away,
Gone far away into the silent land;
When you can no more hold me by the hand,
Nor I half turn to go, yet turning stay.
Remember me when no more day by day
You tell me of our future that you plann'd:
Only remember me; you understand
It will be late to counsel then or pray.
Yet if you should forget me for a while
And afterwards remember, do not grieve:
For if the darkness and corruption leave
A vestige of the thoughts that once I had,
Better by far you should forget and smile
Than that you should remember and be sad

C. Rossetti

I think these two poems capture beautifully the grief continuum.

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Attestation of Authorship

“I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material which to a substantial extent has been accepted for the qualification of any other degree or diploma of a university or other institution of higher learning, except where due acknowledgement is made in the acknowledgments.”

Amanda Gabrielle Hannaford Marks
November 2004.

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Abstract

This dissertation is a modified systematic review with the purpose of exploring the following questions: What is grief? What is complicated grief? How do we work therapeutically with complicated grief?

Theoretical perspectives on what constitutes normal grief have evolved from one of placing a time frame for the conclusion of grieving, to accepting that grieving is a unique and varied experience that may take a lifetime to resolve. The significance of this can be demonstrated during periods of loss in adulthood when old bereavements and losses from childhood can be revived. How an individual deals with grief in response to loss is also dependent on a wide range of variables, including the type of relationship to, or nature of, the attachment to what is lost, the circumstances surrounding the loss and whether there has been support from others after the loss. In this the power of community in transitioning through grief is an important part of the grieving process.

Ironically, part of the increased use of therapists to work through grief is a result of changes in society and family and social supports being less available. Factors complicating the grieving process include the presence of prior traumatic loss in childhood, individuals with psychiatric illness, and the lack of social support at the time of loss. Often separation distress is at the core of complicated grief. The importance of a good relationship between therapist and client is a strong indicator of a successful outcome where the therapist needs to be mindful of unrealistic assumptions about the process of grieving.

CHAPTER ONE

Introduction and Method

In my experience both personally and professionally, grieving and coming to terms with loss is one of the most extraordinarily difficult processes to go through in life. Grief is an experience that will be experienced by everybody at some point in life. As a result, some people may engage in psychotherapy as they struggle to come to terms with their losses.

Many scholars and theorists have addressed the grieving process. From the literature I searched I became aware of a vast range of psychotherapeutic literature in the area of grief. What stood out for me initially were how the impact of loss and grief may continue throughout life rather than necessarily being fully resolved, and the importance of support from others whilst in the grieving process.

My interest in the topic of grief has been life long as I have always felt troubled by loss. Many years ago, I experienced a significant loss that I struggled to process fully. Subsequently, it remained painful and present within me for a long time. At that time I was stuck in a painful world that prevented me from enjoying my life. Since then I have learned to process loss by connecting with what I have lost and attempting to make meaning out of my suffering. This is the difficult part of grief as pain and change are challenging yet necessary for personal growth.

I have observed similar pain in my clinical practice. I was struck by the fact that about eighty percent of my clients seemed to struggle with some form of grief, some from issues originating decades ago, that they had not been able to process fully. As I witnessed my clients' painful struggle with engaging in their grief, I connected again with the difficulty of loss and wondered "what prevents us from engaging in the process of grieving?"

This ever-present issue in my clinical work encouraged me to use this dissertation to understand more fully the impact of grief, and more so, to

understand what is required to complete the grieving process when grief has become complicated.

To do this I require an understanding of ‘normal’ grief before I can consider what is ‘abnormal’ or complicated grief. I would then be better placed to understand how to work with clients stuck in their grief. My research of the literature was guided therefore by the research questions:

- 1) What is grief?
- 2) What is complicated grief?
- 3) How do I work with complicated grief in a clinical setting with special emphasis on the therapeutic relationship?

In order to answer my first question I needed to grasp what theorists and researchers understand normal grief to be. I am attending to this in my second chapter, which defines grief and provides an outline of selected theorists who have written on the topic.

In my third chapter I will use theorists to explore the connection between loss and the process of grieving.

In my fourth chapter I will address the area of complicated grief and examine what is presently understood to explain why people get stuck in completing the grieving process.

In my fifth chapter I will examine the literature relating to working with complicated grief to comprehend what is considered therapeutic in working with grieving clients.

Chapter six concludes this dissertation with reflections on my work with my clients. I discuss insights, learnings and limitations of this dissertation.

The appendices include ethics approval (Appendix A), participation information sheet (Appendix B) and consent to participation in the research (Appendix C).

Throughout this dissertation I will demonstrate with clinical vignettes my clients’ struggles with grief over time and demonstrate how their experiences with complicated grief reflect the theoretical concepts addressed in this dissertation.

Systematic Reviews

Over recent years systematic reviews have firmly established themselves as a significant tool to understand clinical research. They are designed to present the best available evidence in relation to a specific area. According to Dickson (1999, p.42), systematic reviews, “locate, appraise and synthesise evidence from scientific studies in order to provide informative, empirical answers to scientific research questions”. The key components of a systematic literature review include a clearly formulated research question, a clearly defined inclusion and exclusion criteria of participants, access to relevant literature and studies, and a synthesis of the data (Dickson, 1999). Synthesis of the data might include meta-analysis, a statistical procedure combining data from independent studies. This process is called evidence based practice and is often useful for health workers when evaluating the best treatment option for a particular client group (Dickson). The literature review is a form of meta-analysis in that information is processed along similar lines without any reference to quantitative measures (Higgins, 1996). Higgins writes that we carry out analyses at two levels: an analysis of our relation to the works we are reviewing and an analysis of the relations within these works themselves. However, this dissertation is a modified systematic review. This is due to the fact that psychotherapy research is often based on the subjective understanding of the therapist. As qualitative research cannot be controlled, as data is subjective, objective comparison of different research is difficult. Hence, my systematic literature review is modified as my work deals with a subjective area of understanding.

My research question was unclear initially, however, I realised I needed to have a comprehensive understanding of ‘normal’ grief to be able to grasp the concepts of complicated grief. I became aware that the area of complicated grief is ‘complicated’ partly because of difficulty in delineating between the two areas. This helped me to develop a question to include what is complicated grief as opposed to focussing in on one area, such as, grief from divorce or grief after the death of a parent. I wanted to understand complicated grief in relation to any significant loss and I believe that significant loss is not only that of

bereavement. I have taken research from the death literature that I considered relevant to the general issue of loss however the literature on death is vast and I did not go through it to any great extent. I also excluded different cultural perspectives as that is a dissertation in itself and I am of European decent as are the clients used in this dissertation. I believe there are common issues in grief that can be explored independent of culture and bereavement - specifically the emotions that we all experience Also, my intent was to use a range of theorists who were psychodynamic in their approach because that is where my interest lies and also the approach I have spent several years studying. However, I have also included literature that supports the use of other paradigms.

As I sourced the literature on complicated grief, often the literature included ways of working clinically with clients. Hence I was able to clarify my third question with how to work therapeutically with complicated grief.

I have used the work of two clients who struggled with their grief and who were willing to be a part of this dissertation. Other clients who may have been suitable participants were unable to be part of this dissertation because of issues with confidentiality and a sense of being too vulnerable where they were at in their therapy. Both John and Hazel, (not their real names) who will be discussed shortly, were suitable for highlighting aspects of my research question.

Over the months I searched for literature and evaluated and synthesised it using client vignettes to illustrate the integration of theory within the context of the therapeutic relationship. This was a huge process for me in several ways. Firstly the sheer thought of contemplating this dissertation felt overwhelming. As I began my search, the use of varied and competing terms for grief and mourning meant that it took some time to get to grips with what constituted different categories of complicated grief. I underestimated how vast the area of grief is and how it can be written about in many ways yet writers are often talking of the same things. Also, as I researched this topic, I became aware that I had not taken into account my own grief issues coming to the fore. This was due to the fact that I was reading a lot about people's losses and reflecting on my own for long periods of time. Added to this was the sheer pressure of undertaking a

literature review and also living life at the same time, which meant that living and working with grief took a huge toll initially and brought a sense of overwhelm.

Data Collection

For the data collection I primarily relied on the databases of the AUT library, their books and journals. The main sites I used were primarily psych lit, Proquest 5000, and PEP. I found the Omega site useful but limited because it deals with death as its main focus. Many search words were used because of the scope of words used to describe grief. I started out using key words, such as grief and mourning that led to identifying a wide range of labels for these terms.

Grief	Mourning
Pathological Grief	Pathological Mourning
Grief Therapy	Unresolved Grief
Abnormal Grief	Abnormal Mourning
Absent Grief	Delayed Mourning
Complicated Grief	Complicated Mourning
Chronic Grief	Inhibited Grief
Exaggerated Grief	Masked Grief
Delayed Grief	Disenfranchised Grief
Traumatic Grief	Blocked Grief
Ambivalent Grief	

I checked the reference lists from authors of books or articles. I imagine that what I know now on the subject would allow me to explore the issue of grief from another angle if I was to attempt this exercise again. However for this dissertation, I needed to understand the fundamental concepts of grief. I included theorists, such as, Freud and Bowlby because their thinking has shaped contemporary knowledge. Knowledge has evolved and our cultural

understanding has changed over the last decades and therefore I have included papers that demonstrate this change in the concepts on grief. As I searched the literature I discovered that a considerable number of scholars have referred to Worden extensively and he stands out as a foremost figure in the area of grief and I found his writing extremely accessible and clear and hence he is a consistent reference in parts of this dissertation.

Vignettes were chosen to illustrate clearly particular theoretical concepts as found in the literature and how they present in the therapeutic setting. They were collected under formal AUTEK guidelines. See appendix for AUTEK letter of approval.

I will now introduce two clients who illustrate areas of complicated grief. - Putting the clients' introduction here may mean that the reader forgets details by the time they get further into the writing, however, this way there is less of a start and stop, chop and change feel which can add confusion to an already complicated organisation of material around grief.

Introduction of Hazel

The first client, a woman I shall call Hazel, is in her mid thirties. Hazel entered therapy because of depression and suicidal thoughts six months after her relationship of fifteen years ended. She did not grieve the break up of her relationship, instead she moved to the other end of the country and 'partied hard' with alcohol and drugs. This pace of life culminated in Hazel having a confrontation with her boss on the anniversary of her father's death and then spiralling into a depression where she could not stop crying for days.

Historically Hazel describes a childhood where her father abandoned her, and she remembers her mother and stepfather as emotionally distant. In her late teens Hazel recalls being affected deeply at her father's bedside when he passed away. He had remarried and was not a big part of her life and she only just made it home in time for his death. After that she headed overseas where alcohol and drugs became a big part of her life. I learned that this is how Hazel avoids feeling her grief- withdrawing or fleeing from her losses and emotions either

through drugs or physical distance.

Hazel's grief around her father's death is still palpable today. Presently there are other stressors in Hazel's life which include: nursing a dying friend over several months before she passed away whilst Hazel was in therapy and her elderly mother voicing frequently her desire to die. Hazel is also unable to work at this time due to suffering a break down. This seems significant as up until then Hazel had always been able to work and keep busy so that she did not have to face her pain but could ward it off.

It is apparent that throughout her life Hazel has learnt to stifle her pain. She coped with her losses by avoiding them, explaining that her family avoided any displays of sadness or grief. Over the years Hazel has experienced losses in her life that have never been mourned because she "found it too painful". Hazel once told me that at her father's funeral she wore dark glasses so no one could see her red eyes and at the time of the break up of her sister's marriage, her mother told her to "dry your tears and move on". This is significant as perceived family support system indicates a successful outcome of grief and that lack of support is more important than neurotic symptoms as an indicator of pathology in complicated grief (Rando, 1993; Staudacher, 1987; Worden, 2002).

Introduction of John

John is a male in his mid forties who has experienced depression and severe anxiety in social situations and difficulty with expressing his emotions and needs. When I met John he had already been in therapy for several years to work on his self worth. Historically John's father left when John was a young child and John describes being brought up in an enmeshed, emotionally cold family environment. He describes his mother as self-involved and his stepfather as verbally and physically abusive to him, belittling him often. This may have resulted in John struggling with forming a cohesive sense of self and developing a very critical inner voice or harsh superego. John's grief has gone unacknowledged because of a dynamic in his family where he was required to

be a narcissistic extension of his caregivers. In therapy, tears spill but his grief never gets resolved because he quickly swallows them for fear he will be overwhelmed. John fears that if he starts to cry he may not stop and that he may fall into a depression that he won't be able to get out of. His grief is now revealed during vulnerable times when John notices that he will drink in the evenings to stop feeling. John feels "tired a lot more and drained" which we have discussed could be partly related to John keeping everything in. At this time, John has commenced a course of study that frequently exposes him to other's stories of pain, which trigger his own experiences, and he will often end up in uncontrollable tears in inappropriate situations.

A present stressor in John's life is coming to terms with his mother deteriorating from an illness that prevents her remembering him. This is significant as literature suggests that those who experience dramatic change in a significant other experience grief reactions just as powerfully as those bereaved (Doka, 1987). Also, years ago, when John's birth father died, John felt alienated at the funeral service when his father's second wife and children spoke about their full life with John's father. "It's like their loss and we were pushed out of the picture really. I didn't feel a right to Dad because people had taken my place". This experience of disenfranchised grief (refer page 27) and inability to acknowledge his pain has impeded the mourning process for John as will be demonstrated later.

CHAPTER TWO

The Terminology of Grieving

Firstly, in this chapter I introduce the main terminology used in the literature pertaining to grief and the mourning process. Secondly, I present fundamental psychodynamic understanding on grief and mourning using the concepts of Freud, Deutsch, Lindemann, Klein, Bowlby and Kubler-Ross.

Loss, grief and mourning are important words used when we talk of the death or loss of someone or something. Whilst researching the body of literature in this area I found these terms were often used variously, sometimes ambiguously and interchangeably. I will define these terms to clarify and avoid ambiguity.

Loss

Grieving or mourning is a response to a significant loss - either temporary or irrevocable (Viorst, 1998). These losses can be social or psychosocial (Bloch, 1996; Doka, 1989; Rando, 1993). A physical loss is the loss of something tangible, for example, a loss of one's home, the surgical removal of a breast, the loss of a pet, a memento that is misplaced. Death is but one example of loss albeit the most dramatic one (Parkes, 1996). A psychosocial loss is a 'symbolic' loss- something intangible, for example, getting a divorce, developing a chronic illness or having a dream shattered, feeling unsafe in the world, loss of self confidence or self reliance, the loss of trust in others, aging (McWilliams, 1994; Parker, 1981; Rando, 1993).

Grief

The *Collins Paperback English Dictionary* (1991) defines grief as "deep or intense sorrow, something that causes keen distress" (p.368). Grief in its widest and most universal sense is the emotion we associate with the experience of loss. It is the personal experience of loss and deprivation, which leads to the

process of mourning and therefore can be conceptualised as the beginning stage of mourning (Rando, 1993). I think this is useful as understanding grief as being a part of mourning, combines the two and makes them inseparable yet fluid. Indeed the literature indicates that similar experiences are happening when either of these words is being used (Jacobs, 1993; Parkes, 1996; Rando, 1993; Stern, 1985).

Grief affects us all if not sooner then later and by the very nature of our humanness, grief is very much a part of our lives. By the very nature of losing something, the process of grieving is complicated and hard work. C.S. Lewis, a theologian who wrote extensively on Christian suffering, was overcome with grief at the death of his wife and wrote, “No one ever told me that grief felt so like fear” (Lewis, 1976, p.1). Grief requires us to relearn the world- by putting our lives back together after the loss, and by coming to terms with the pain and anguish that accompany the devastation caused by it in our lives (Attig, 1996). Attig believes that over time we move from *being* our pain, being totally absorbed in it, to *having* our pain, where there is some residual pain and sadness in our hearts.

Mourning

Traditionally, mourning has been defined as the cultural or public display of grief through one’s behaviours indicating that it may not as much take place in isolation but in the company of others (Hagman, 2003; Schina, 2002). Mourning is defined by Hanks (1991, p.551), as “the period of time during which a death is officially mourned...to feel or express sadness for the death or loss of someone or something”.

“Mourning involves the transformation of the meanings and affects associated with one’s relationship to the lost person [and] involves a reorganisation of the survivor’s sense of self as a key function of the process” (Hagman, 2003, p.24).

Throughout the literature I found that the terms grieving and mourning were often used interchangeably. Followers of Freud feel that the term mourning

involves the task of detaching the person's memories and hopes from the dead. Therefore the term should only be used for such a precise psychological task (Bowlby, 1980). However Bowlby argues that this creates an unacceptable restriction on the term and does not allow for the evolution of new facts, such as the fact that we now know that mourning is never necessarily completely attained. Therefore in this dissertation the terms mourning or grieving are used interchangeably and refer to the process of experiencing the psychological, emotional, behavioural, social and physical reactions to the perception of loss.

Many have written on the subject of grief, and for the scope of this dissertation, a few authors will be mentioned who have added to our understanding of the nature of normal and complicated grief and who stand out for me as having offered significant insight into the grief process.

Freud

Freud has led the way for the diversity of ideas that followed him and was one of the first to write on the subject of mourning. He defined mourning as: "...the reaction to the loss of a loved person, or to the loss of some abstraction which has taken the place of one, such as fatherland, liberty, an ideal and so on" (1925, p.153). Originally, he wanted to compare a normal grief reaction and its expression in mourning to understand depression. He found that the features of melancholia (depression) and grief were the same, except that the loss of self-esteem is not present in grief. He observed that the reaction to the loss of a loved one (mourning) implies profound pain. When faced with a loss, the individual loses interest in the outside world due to the fact that the loss cannot be revived.

The individual cannot adopt a new love object (which would mean a replacement of the one mourned), and focuses exclusively on the loss. At this time, the individual's interest in other purposes or the outside world is lost.

Freud (1925), noted that attachments are never relinquished willingly and when confronted with loss the individual will rather forgo reality, (by believing for example that the loved one is not really dead or has left), than acknowledge the loss of the loved one. It was his opinion that it is inadvisable or even harmful to interfere with this process (so that nature is left to take its course) as the

individual will eventually overcome the loss after a period of time, as ‘reality passes its verdict that the object no longer exists’ (p.166). Then, the individual will disengage from the lost and loved object and withdraw emotional investment from each link in the complex chain that connected them.

Ninety years on, there is now general agreement that people do not decathect (detach) from the dead or lost object, but find ways to stay connected even if that means that the individual’s quality of life is significantly diminished since there is often a gap that remains (Neimeyer, 2003; Worden, 2002).

Deutsch

A contemporary of Freud was Helene Deutsch who wrote *Absence of Grief* (1937). She expanded knowledge of the grieving process by exploring the link between childhood losses and the emotional difficulties in adult life. She was concerned with the prolonged absence of conscious grieving in adults and observed that people may suffer severe personality difficulties or even episodic depressions if loss experienced in childhood has never been mourned. Her concepts influenced thinking around the absence of grief in bereaved individuals and became a hallmark of pathological mourning. Even to this day there is a belief that in order to be considered normal bereaved people have to express sadness and grief (Hagman, 2003). Sixty-five years on this thinking is contested by contemporary research. Instead, complicated grief is more related to intensity or duration of a reaction rather than to the presence or absence of a specific symptom or behaviour (Neimeyer, 2003; Worden, 2002).

Lindemann

Erich Lindemann was a psychiatrist who conducted a study of relatives who had lost loved ones to a fire at Coconut Grove in Boston. In my literature search, Lindemann (1944) appears to be the first to focus on acute grief. He distinguished between normal and pathological grief and identified repressed or delayed grief as a common problem. He saw acute grief as a syndrome with

observable symptoms, such as: somatic distress, preoccupation with the image of the lost object, guilt, hostile reactions and loss of patterns of conduct, which may reveal themselves immediately or be delayed, exaggerated or apparently absent.

In order for the individual to readjust to a life without the lost object and to be able to form new relationships, Lindemann stressed that individuals need to free themselves of ties with the lost object. Working through grief might prevent problems in the individual's social adjustment as well as serious medical problems, namely, psychosomatic conditions such as ulcerative colitis, rheumatoid arthritis, and asthma (Lindemann, 1944).

Klein

Melanie Klein was influential in the British school of object relations (which places the mother-infant relationship at the centre of personality development). She based her theoretical development of grief on Freud's paper and agreed to the close connection between normal mourning and the testing of reality. Klein experienced significant grief in her own life with the loss of siblings in childhood, a divorce in later life, the death of her analyst and the death of her own son.

She observed that in mourning the adult individual goes through a "modified" and transitory manic depressive state of extremely painful affects and fantasies which she compared to the depressive position of early life a child normally goes through in its early development (Klein, 1986). Klein explains that experiences from childhood are reactivated when grief is experienced in later life. Grief issues resolve, according to Klein, over time as the individual surrenders the relationship whilst cultivating memories, changing images from the past into psychic keepsakes that may nourish and sustain the individual (Klein, 1986).

Bowlby

John Bowlby was a psychoanalyst influenced by the work of Melanie Klein.

He was interested in the effect maternal deprivation had on childhood development. He saw that attachment theory “facilitates a new and illuminating way of conceptualising the propensity of human beings to make strong affectional bonds to particular others” (Bowlby, 1980, p.39). It also sheds light on why grieving is such a significant and difficult part of the human experience.

He believed that one of the most primal fears we experience as humans is separation anxiety and he interpreted reactions by children to unwilling separation from their mothers or caregivers as protest, despair and detachment. These three primary responses to separation are expressed through distress, anxiety, anger, depression and emotional detachment. This is in line with new research that shows that early separation can have lasting effects on the sensitivity of brain receptors, leading to permanently raised anxiety levels, (Van der Kolk, McFarland & Weisaeth, 1996). Schore (1994) notes the effect of a secure attachment relationship on affect regulation and infant mental health.

Bowlby (1980) concluded that these primary responses are also characteristic of the stages of the mourning process. He saw these stages as the “basis for key emotional processes that govern our psychology” (Karen, 1998, p.100). Protest is seen as a depiction of separation anxiety, despair as an indication of mourning and detachment as a form of defence. Because bereavement is an irreversible form of separation, Bowlby conceptualised the grief reactions as a form of separation anxiety. The first stages of adult grief are essentially the same as childhood reactions. First there is a period of numbing, followed by searching, yearning and anger (Bowlby). If all goes well this is followed by the working through disorganisation and despair in order to turn to a reorganisation of the self. The pain of loss is faced repeatedly, until the reactions are sufficiently weakened to lose their effect. Bowlby was one of the first writers to identify anger as an important vehicle to recover from the loss of a loved one. He wrote,

“Only if he can tolerate the pining, the more or less conscious searching, the seemingly endless examination of why and how the loss occurred, and anger at everyone who might be responsible, not even sparing the dead person, can he gradually come to realise and accept that loss is in truth permanent and that his life must be shaped anew” (Bowlby as cited in Holmes, 1993, p.91). This is a

process that may take years or even a lifetime.

Kubler-Ross

The work of Elisabeth Kubler-Ross (1969) focussed on death and dying and the grief experienced by the dying person and the survivors. She developed a well-known model of five definitive stages of grief in death and dying. They are: denial and isolation, anger, bargaining, depression and acceptance. She believed that these stages could be equally applied to any other form of significant loss and identified hope as the one thing that persisted through all stages.

More recent scholars have disputed Kubler-Ross' model (Benjamin, 1996). Over the last fifteen years as more is understood about the mourning process, Kubler-Ross' belief that mourning unfolds in stages has been criticised as it does not recognise the complexity and uniqueness of each mourning experience (Hagman, 2003). Other writers point out that her model is not concerned with intrapsychic dynamics, describing only external processes and therefore does not take up the problem of unresolved grief or loss in a way that addresses it in any depth (Burch, 1989; Schina, 2002).

This chapter began with defining the terms, loss, grief and mourning and then explored the understandings that scholars bring from a psychodynamic perspective. Each writer has developed concepts that indicate that in uncomplicated grieving or mourning the individual goes through distinct stages that culminate in the individual moving from being overwhelmed by the loss towards accepting the loss and ultimately finding new meaning for life without the lost object.

CHAPTER THREE

The Grieving Process

This chapter addresses the ‘normal’ grieving process with exploration of the stages of loss and the tasks required to resolve grief. Cognitive, emotional and behavioural responses to grief are examined. It will be demonstrated that although the responses to grief are unique, the tasks required to work through grief are the same.

Normal Grief

How we mourn and when our mourning will begin or end is influenced by a variety of factors. Whenever someone suffers a serious loss, either through death or through unwanted separation the individual experiences a range of painful psychological and physical states (Hentz, 2002; Rando, 1993; Viorst, 1998; Worden, 2002). There is a range of behaviours that reflect a grief reaction. Physiological responses include hollowness of stomach, tightness of throat or chest, lack of energy, nightmares, insomnia, breathlessness, appetite disturbance, vomiting, rashes, dry mouth, over sensitivity to noise and de-personalisation (Linehan, 1993; Viorst, 1998; Worden, 1982). Common emotional responses are sadness, guilt, anxiety, fear, depression, fatigue, panic attacks, relief, loneliness, hopelessness, helplessness, numbness, anger and absence of emotion (Belitsky and Jacobs, 1986; Bowlby, 1980; Doka, 1987/1989; Lindemann, 1944; Linehan, 1993; Paul, 1986; Stern, 1985; Worden, 2002; Zeanah, 1988).

Some individuals may experience grief very intensely at the time of the loss whilst for others it is a delayed experience (Hagman, 2003; Linehan, 1993). Individuals who are extraverted, open to their own subjective experience, and who have complex belief systems may be more able to successfully cope with loss and to experience growth resulting from their struggle with it (Calhoun &

Tedeschi, 2003). For some, grief lasts a short time and for others it is a long seemingly never-ending experience (Worden, 2002). As mourning is multi determined, there is no so-called normal grieving. Instead, different levels of grieving depend on various factors, for example, different cultures, personality and family background (Neimeyer, 2003; Parkes, 1996; Rando, 1993; Schina, 2002; Spall & Callis, 1997). A number of variables related to the nature of the relationship with the lost object can influence the intensity and resolution of grief (Bowlby, 1980; Doka, 1987/1989; Holmes, 1993; Leick & Davidsen-Nielsen, 1991; Lindemann, 1947; Neimeyer, 2003; Rando, 1993; Spall & Callis, 1997; Worden, 2002; Wortman & Silver, 1989). These variables include: who the person was; whether the attachment style was dependent or ambivalent; the causes and circumstances of the loss; personality variables; concurrent stresses; and social variables. The variables tend to occur in clusters and are difficult to tease apart because they interact in complex ways (Bowlby, 1980).

Stages of Grief

The previous section has highlighted how the grieving process is determined by a number of individual variables. Nonetheless, commonalities have been identified within the human experience that prompted a variety of stage and phase theories of grief (Worden, 2002). These theories have certain aspects in common despite having been described differently by different scholars (Archer, 1999; Bowlby, 1980; Kubler-Ross, 1969; Linehan, 1993; Parkes, 1996; Raphael & Minkov, 1999; Staudacher, 1987).

In the first stage of grief the individual experiences emotional numbing and disbelief to guard against the full impact of what has happened (Malan, 1992; Parkes, 1996). The outcome can be the repression of topics, avoidance of recognising personal implications of the loss and often a “conscious but vague sense of being frozen, insulated, derealized or depersonalised” (Horowitz, 2001, p.166).

This is followed in the second stage by deep yearning for the lost object and the urge to deny the permanence of the loss. Parkes (1996) understands the yearning and pining as separation anxiety and the characteristic feature of the

pang of grief. Pining is the subjective and emotional component of the urge to search for a lost object. There is an oscillation between the belief that the loss has occurred fuelled by the hope that all may still be well, and the pain and yearning for the lost object or loved one (Bowlby, 1980).

The third stage is one of disorganisation and despair and encompasses the depressive phenomena of mourning where the individual finds it difficult to function in the normal environment (Parkes, 1996). It appears that for mourning to have a favourable outcome the individual needs to endure the painful emotions (Bowlby, 1980). Only through tolerating the pining and the endless wonderings of why this happened can there be a gradual recognition of the loss and the awareness that life “must be shaped anew” (Bowlby, p.81).

Less known in the grieving process is the common use of dissociation. Integration and dissociation cooperate, alternate and recur during the mourning process. From the initial reaction to the loss and throughout the mourning process the individual simultaneously believes that the deceased is alive and not alive. In this sense, dissociation is appreciated as a useful defence or coping mechanism during painful experience of deep grief (Kauffman, 1993/4). Evidence for dissociation during the mourning period includes the sense that a part of the self is missing, the sense of emptiness and depression, and the presence of memory flashes and intrusive thoughts that provoke anxiety. (Kauffman, 1993/94).

The fourth and last stage is one of reorganising and reintegration. The individual is starting to accept the loss and beginning to rebuild a life without the lost object (Bowlby, 1980). It takes time as the individual realises and accepts the changes in their life and comes to terms with the loss. This often is the most difficult stage a person has to work through due to the difficulty that arise from adjusting to the changed circumstances, such as embodying a new role (Worden, 2002). The presence of mourning indicates maturity in an individual (Winnicott et al, 1990) and processing loss, (mourning), is pivotal in the development of the self (Kauffman,1993/4).

A lifetime to grieve

It has transpired from the previous section that overall scholars and writers who have studied and explored the grieving process have come to a similar understanding of the stages and tasks involved in the process. This is in contrast to the discussion about the appropriate duration of grieving. There is disagreement amongst writers in that area. The notions of writers range from the acute stage of grief lasting for up to a few years to the grief process continuing through life (Hentz, 2002, Worden, 2002; Wortman & Silver, 1989).

Early theory on grieving was quick to suggest a fairly rigid time frame, but as the complexity of mourning becomes better understood, this view is being reconsidered. According to Gaines, (1997, p.234), “mourning is something that cannot be finished” because working through of significant interpersonal loss cannot reach a fixed end point but is assimilated, and there will always be a link to the deceased (Gaines, 1997; Rubin, 1999). Current thinking allows for the individual to grieve the loss of a loved one for a lifetime. This in itself is not understood as pathological (Attig, 1996; Rando, 1993). Viorst (1998) puts it simply when she writes, “our mourning is pathological when we cannot, and we will not, let it go” (p.249). The difficulty in defining pathological grieving and misconceptions about the resolution and duration of mourning often leads to an inaccurate diagnosis of pathological grieving. For example individuals being judged as exhibiting chronic mourning when they are merely “moving adaptively into the new world without forgetting the old” (Rando, 1993, p.181).

Although we know the acute stage of mourning will subside we may remain inconsolable and may never find a substitute for what we have lost. No matter what may fill the gap, even if it were filled completely, it nevertheless remains something else (Freud, 1961, as cited in Worden 2002). Although the acute stage of grief may be resolved, subsequent temporary upsurges of grief may occur, including cyclic precipitants such as anniversary and seasonal reactions (Hentz, 2002; Rando, 1993). The ongoing and open-ended work of mourning is due to the unconscious meanings we attach to bereavement and loss and the dynamic function of the internal relationship with the lost object (Neimeyer, 2003).

In summary, grief is a natural and adaptive reaction to loss where uncomplicated reactions of acute grief may last from months to years to a lifetime. In addition, it is apparent that being able to accept the reality of the loss takes time as grieving involves an intellectual and emotional acceptance of the loss.

A broad range of psychological and physical grief reactions is common after loss. Initially, there is a period of intense distress with anxiety and yearning for the lost object, followed by sadness and preoccupations that gradually attenuate over time. To adapt to the loss people generally cope with their reactions by working through tasks of mourning so that there is a gradual return of the capacity for reinvestment in new interests, activities, and relationships. As our understanding of the complexity of grief and mourning has evolved, grieving is now viewed as varied and unique to each individual.

CHAPTER FOUR

Complicated Grief

As the parameters of normal grief have been investigated this chapter will explore what happens when mourning goes awry. It begins with looking at the complexity of defining and diagnosing complicated grief given the vastness and variety of terms used to categorise complicated grief. It will be seen that by the very nature of a range of labels and terms for complicated grief, there is a lack of consensus as to the definition and diagnostic criteria of complicated grief. This is followed by outlining the factors affecting a complicated grief reaction with special attention being given to the threat of separation and to anger and depression. I finish by categorising four main categories of complicated grief and discussing two categories in detail. Clinical vignettes from work with two clients illustrate their difficulty in accessing their grief. For the purposes of clarity I use the term complicated grief or complicated mourning as an overarching term referring to grief that is not considered normal or uncomplicated. When I am referring to a specific category of complicated grief, I will make this clear.

Helene Deutsch (1937) observed that the death of an important figure brought about a normal grief response and that the absence of these responses was a variation from the normal grief response when it was excessive in duration or intensity. The grieving process is termed complicated when expressions of grief become so intense that a person cannot function well over a period of time. He or she may not feel competent to handle the loss, may feel weak, abandoned and overwhelmed to such an extent, that there is an inability to progress towards a state of resolution of the loss (Stern, 1985, Worden, 2002). Complicated grief is considered a “maladaptive reaction[s] to [loss] assumed to manifest as psychological and physical impairments” (Tomita & Kitamura, 2002, p.98). It

involves denial, repression or avoidance of the loss and its pain by avoiding letting go of the lost object (Rando, 1993).

This verbatim illustrates Hazel's desire to avoid her grief:

CL. I just want to close up the wound. Sew it up, like I feel like it's a pussy open wound and I just want to sew it up and keep the pus inside.

TH. It's a really good metaphor...

CL. I feel I want to stitch it up and hope it goes away without cleaning it out.

TH. And if you keep cleaning it out... one day it's going to heal. If you stitch it up, it's going to infect other parts of you and feel really yucky. (Pause)... It feels easier to leave it alone or avoid it.

CL. Yeah. Totally.

This piece of verbatim is striking for me, as it was Engel (1961), who asked whether grief could be called a disease. He described how grieving can become complicated just as a wound can become infected. Here too, Hazel describes her grief and it resembles the working through of a healing wound.

Defining Complicated Grief

Whether grief is unresolved and pathological is difficult to define (Melges & DeMaso, 1980; Stroebe et al, 2000) because of the lack of objective criteria to determine when mourning becomes complicated (Jacobs, 1999; Rando, 1993). So far, no empirical studies have been completed that offer standardized criteria for the diagnosis of complicated grief, the absence of which has further handicapped research in this area (Jacobs & Kim, 1990; Tomita & Kitamura, 2002). Another difficulty in defining complicated grief is due to the broad range of terms used. Such labels include: complicated mourning (Rando, 1993); pathological mourning (Belitsky and Jacobs, 1986; Bowlby, 1980; Kernberg et al, 1989, Volkan, 1972), inhibited grief (Linehan, 1993, Jacobs et al, 1994), unresolved grief (Geller, 1985; Piper et al, 2003), incomplete mourning (Malan, 1992), complicated grief (Kauffman, 1993/4; Piper et al, 2003), chronic grief (Arnette, 1996), delayed and distorted grief (Belitsky and Jacobs, 1986); acute

grief (Arnette, 1996); absent grief, (Deutsch, 1937) exaggerated grief (Worden, 2002); unexpected grief (Bowlby,1980); traumatic grief (Jacobs, 1999); avoided grief (Leick and Davidsen-Nielsen,1991); destructive and unsanctioned grief (Pine et al, 1990); disenfranchised grief (Doka, 1989); chronic mourning (Rando, 1993); morbid grief (Anderson, 1949); blocked grief (Bright, 1996); atypical grief (Parkes, 1996); unanticipated mourning (Rando, 1993); ambivalent grief (Bowlby, 1980). This list is by no means exhaustive and more labels can be found.

Thus understanding complicated grief is troubled by the usage of imprecise, inconsistent, poorly defined, and vague terms that offer little demarcation between complicated and uncomplicated grief (Rando, 1993). This is supported by Belitsky & Jacobs (1986) who stress that describing complicated grief is a double-edged sword since psychopathology exists on a continuum with normal grief. It seems that the conceptualisation of complicated grief is determined by a theorist's particular stance and that while differences in labelling do not necessarily mean a difference in conceptualisation, these labels indicate at least a variety of connotations (Rando, 1993; Stroebe et al, 2000; Tomita & Kitamura, 2002). This is of interest as a lack of clarity on what complicated grieving entails would seem to interfere with communication between the person grieving and the therapist and thus could be an obstruction to receiving appropriate treatment.

Defining complicated grief is not only hindered by the vast range of terms in use and lack of standardized criteria. Scholars also disagree on the diagnostic criteria for complicated grief (Stroebe et al, 2000). One side of the argument states that no determination of grief complication can be made without considering the variables known to influence any response to loss (Rando, 1993). She suggests it is more useful to look at complications in the grieving processes than to focus on particular symptoms of complicated grief. Conversely, Parkes (1996) believes we need to study closely the types of symptoms following a significant loss if we are to find out which ones are indicative of pathology. Marwit (1996) writes that researchers are just now beginning to address the sequence of events and variables that lead to styles of

grieving as up until then there had been too much anecdotal and too little empirical attention. Also, there has been little consideration of the role of cultural and societal context in defining complicated grief, despite growing awareness of the need for such inclusion (Stroebe et al, 2000).

The necessity of having unambiguous terminology in this area can be demonstrated with an example using chronic grief. The literature reveals that grief therapy may be effective in the first few years with an individual suffering chronic grief. However, the pattern can become more fixed and set after that time, necessitating a more lengthy individual psychotherapy for the individual (Raphael & Minkov, 1999; Leick and Davidsen-Nielsen, 1991). My observation is that the term chronic grief can be used differently amongst authors.

Diagnostic Considerations

As the previous section has shown, research on complicated grief is still in its infancy and researchers are just now beginning to address the sequence of events and variables that lead to styles of grieving. Marwit (1996) believes that before grief reactions can be meaningfully integrated into the Diagnostic and Statistical Manual of Mental Disorders IV (1994) (DSM-IV) they need to be understood in terms of their relationship to existing categories.

This raises important questions such as when does the duration or intensity of the grief process become complicated and when do people require assistance in adjusting to their loss (Belitsky and Jacobs, 1986; Stroebe et al, 2000; Tomita & Kitamura, 2002).

Although in some cases the intensity, reaction or duration of the grief could be labelled 'mental disorder' complicated grief does not have a separate diagnostic category in the DSM-IV (Arnette, 1996; Stroebe et al, 2000).

It is important for the therapist to be aware that the bereaved individual with a complicated grief reaction may display symptoms that merits a diagnosis in several disorder categories of the DSM-IV, for example, mood disorder, personality disorder and adjustment disorders. This is not only a reflection of the complexity and multidimensionality of bereavement and loss (Belitsky and Jacobs, 1986; Stroebe et al, 2000) it also highlights the danger that clients are

misdiagnosed and do not receive the therapeutic attention needed.

Over the last five years it seems that there has been the addition of the concept of traumatic grief in the literature (Jacobs & Prigerson, 2000). Presently, studies are being developed with the aim of identifying criteria for a traumatic grief diagnosis (Melham, 2001). A traumatic grief response has two underlying dimensions, separation distress and trauma distress (this includes feelings of numbness, fragmented sense of security and trust) (Raphael & Minkov, 1999).

Although the experience of grief is universal and an integral part of our lives, not everyone experiences an increased risk for a complicated grief reaction. Whether such complication takes place depends on a range of factors that I will explore in the following section.

Complicating Factors in the Grieving Process

A main factor complicating the grieving process is the accumulation of several losses, in particular the presence of prior traumatic loss in childhood which may increase an individual's vulnerability to some aspect of complicated grief (Deutch, 1937; Bowlby, 1980; Horowitz, et al, 1980).

Equally, individuals with established psychiatric illness are more likely to experience complicated reactions to loss (Belitsky & Jacobs, 1986; Bright, 1996). Bowlby (1980) notes that there is "little doubt that much psychiatric illness is an expression of pathological mourning or that such illness includes many cases of anxiety states, depressive illnesses, hysteria, and also more than one kind of character disorder"(p.23).

As it is well known, humans are intrinsically social beings and therefore social circumstances are prominently associated with complicated grief reactions. For example, literature suggests that loss of a job is often noted as a precipitant life event because hidden and deferred mourning is often uncovered previously kept at bay by occupation (Paulley, 1983). A main risk factor for developing symptoms of complicated grief is the lack of social support at the time of the loss (Morgan, 2002; Rando, 1993, Staudacher, 1987). This is John's experience in relation to his father remarrying into another exclusive family and this continuing with John feeling left out or disenfranchised from his father's funeral

as well as being excluded from caring for his dying mother. 'Disenfranchised grief' refers to loss of a significant other when it is experienced in a non-traditional relationship, one that can be considered to exist outside of the traditional institution of marriage (Doka, 1987; Pine et al, 1990). John is not fully welcome into the new family his father has created and therefore it is more difficult for him to complete the tasks of grieving. This is because the normal emotions associated with loss are often intensified in non-traditional relationships where the individual experiences strong feelings of guilt, shame, anger, embarrassment, loneliness and isolation, which result in grief being 'disenfranchised' (Doka, 1989). In the absence of social support John's grief has had to remain private and this has interfered with the resolution of his grief. This is a double-edged sword for John as not only did his father have a new family that John was not involved in but also John was not a part of the process when his father passed away. This was also his experience when his mother passed away whilst he was in therapy and his stepfather excluded him from the process. The significance of this is demonstrated by Doka (1987), who writes that it is harder for an individual to accept the reality of the loss if they are excluded from the dying process, restricted from the funeral rituals and inhibited from acknowledging the loss. Since the resolution of the tasks of mourning is impaired, grief can become chronic or with the lack of social support can lead to delayed or a masked grief reaction (Worden, 2002) (refer pages 38 and 41).

Another complicating factor in the grief process is the lack of social sanction, for example the presence of a family culture of prohibiting the public display of sadness (Belitsky & Jacobs, 1986; Doka, 1987; Lindemann, 1944; Paul, 1986; Taylor and Rachman, 1991; Worden, 2002). Doka, (1989) asserts that our society generally does not sanction or value deep grief and thereby disenfranchises individuals from the deeper emotional and spiritual healing and growth that are possible. In turn, individuals often feel shame about their own lack of acknowledgement and recognition of their grief. He notes that shame proneness is a far more common factor inhibiting the experience and the expression of grief than is recognised. The individual is likely to feel self-conscious, a failure, inadequate, inferior, abandoned and exposed (Doka). In

addition to intense negative affect these individuals are often inhibited from behaviours that are therapeutic.

This is Hazel's experience as she feels too ashamed to reveal her sadness and she will guard against it constantly in therapy when we talk about her dying friend. Hazel keeps busy and will not accept that her friend is deteriorating because it is too painful to bear. Doka (1989) writes that as we are faced with the loss of a significant other, our grief response is dependant on the level of disability or change in the dying person, the connectedness of the individual to the ill person and the degree to which the knowledge of the change is shared. He suggests that the underlying condition causing death can be viewed along a continuum of reversibility to irreversibility. John and Hazel both experience hopelessness and guilt as both their loved ones have illness that is irreversible and the loss is certain. In addition, relationships marked by heightened dependency, ambivalence or unexpressed hostility may also predispose someone to a course of complicated grief (such as a divorce triggering the mourning of an older unmourned loss) (Bowlby, 1980; Horowitz et al, 1980; Leick & Davidsen-Nielsen, 1991).

Separation Anxiety

The exploration of the literature has revealed that separation anxiety is a significant aspect of complicated grief (refer page 15). Indeed, the manifestations of separation distress are at the heart of grief and a core phenomenon for recognising complicated grief as an adult form of prolonged, unexpressed unresolved separation anxiety (Bowlby, 1980; Holmes, 1993; Jacobs, 1993; Parkes, 1996; Rando, 1993; Worden, 2002). Hazel once said, "I do think of things in terms of people leaving me, you know everything is leaving me". Bowlby (1980) writes that this attachment dynamic continues throughout adult life whenever the parent-child, adult-spouse or adult companion relationship is threatened.

Belitsky and Jacobs (1986) described studies that demonstrated how vulnerable individuals are unable to cope with the insecurity of separation and

the tension created by it. As a result they experience dysregulation in the form of anxiety. These individuals fear 'losing their minds' and feel overwhelmed. This seems to fit for both Hazel and John who have both experienced extreme distress over losing significant others. Indeed, Jacobsen, (1986) notes that the fear of losing control may be a non-specific symptom of complicated grief and an indication that separation distress is extremely severe. Such distress can be revealed in a persistent yearning for recovery of the lost object, and an over identification with the deceased, including somatic symptoms mimicking the deceased and severe anniversary reactions (Melges & DeMaso, 1980; Worden, 2002).

Observable symptoms

As has been observed in chapter three, loss is a major life stressor (Jacobs, 1993; Jacobs et al, 1994) and studies (Parkes, 1996) have shown that the death or loss of a loved one can increase the risk of a complicated grief reaction such as physical or mental ill health. Although these symptoms may be observable, they may not be connected with unresolved grief by the health professional.

This is also the case with other visible signs, which are identified as tenseness, short temper, and wooden and formal body language, insomnia and bad dreams (Linehan, 1993).

Other symptoms are of a more self-destructive nature that manifest in behaviours such as the overuse of alcohol, self-harm, over work, over exercise and eating disorders (Linehan, 1993; Viorst, 1998). Themes of loss and grief may be apparent in the clinical setting with the client not being able to speak of the loss without experiencing fresh grief, or a relatively minor event may trigger off an intense grief reaction, which is usually a clue to delayed grief, or a reaction on the anniversary of the loss (Hentz, 2002; Rando, 1993; Worden, 2002). The grieving individual may force cheerfulness or withdraw. Literature also suggests that an individual may experience a form of complicated grief when there has been evidence of a long history of subclinical depression often revealed by persistent guilt and lowered self esteem, a phobia about illness or death often related to the specific illness that took the deceased and radical

changes in their life style such as avoiding friends who remind them of the deceased (Bowlby, 1980; Lazare, 1979, Worden, 2002).

Anger and Guilt Reactions

The literature reveals that a major characteristic of complicated grief is the individual's inability to overtly express the yearning and anger over the loss that is a part of the grieving process (Bowlby, 1980). Frequently, there is a wish to rage or cry at the loss coupled with an inability to do so which frequently stems from the individual trying not to fall apart at the time of the loss and then later it seems inappropriate to do so (Worden, 2002). Also, grieving can be inhibited because the death was stigmatised (for example with suicide), experienced as a relief from pain (for example as with a terminal illness) or the grieving individual guards against their own expression of affect through identifying with and caring for others (projective identification) in the form of misdirected anger and ambivalence toward the deceased (Melges & DeMaso, 1980; Worden, 2002). Such emotional reactions may start shortly after the loss and continue to preoccupy the mind of the individual years later.

Both Hazel and John struggle with feelings of anger and guilt. As far as their anger is concerned, Hazel will project her anger on to me frequently and John will deny his anger and turn it against himself. Hazel's desire to turn her anger against me as she comes to terms with the death of her friend she has been nursing can be understood by the idea that I represent the loss of hope that her loved friend might still be alive. Bowlby, (1980) writes that if someone can be blamed for the loss, then this allows the secret hope that perhaps in some miraculous way seeking out the villain will lead to recovery of the loss.

According to the literature, intense anger occurs in the absence of other reactions, such as sadness. This is not to be confused with uncomplicated grief where anger is a stage (Raphael & Minkov, 1999). In John's case it seems that, instead of a healthy outcome, his strong and ambivalent feelings become split off and repressed. The result is that John experiences distressed feelings and disordered behaviour evidenced by times when he has wanted to self-harm. Raphael & Minkov (1999) explain that the individual feels deserted and

perceives a threat to his or her survival that results in a desire to punish the lost object. The significance of this is that left untreated the anger can disrupt the individual's life by destroying present or future relationships (Rando, 1993).

When Hazel's friend passed away Hazel became preoccupied with self-blame and self-punishment because of her conflicted relationship with her deceased friend. Such a sudden loss of a relationship that symbolised something special and irreplaceable is a type of loss that can cause an anger response with extreme and intense guilt (Raphael & Minkov, 1999). This can be demonstrated with Hazel experiencing little direct anger, a lot of projected anger and no genuine mourning. She blamed herself for not doing enough for her friend and desired to punish herself. It seemed partly as if Hazel relished the painful nature of her guilt as an attempt to appease her dead friend. Raphael & Minkov (1999) note that extreme guilt feelings such as an unrealistic sense of responsibility for events happening to others are clinical indicators of guilt.

Over the months Hazel began to get on with her life after her friend passed away but she would feel guilt about being happy again. This vignette illustrates this phenomenon.

CL. I don't deserve to be like that yeah. You know what I mean. I'm too happy too quick, is that all she was worth. A few weeks of a couple of tears is that it.

TH. Feels like you feel a bit guilty.

Hazel continues that she should be mourning for a long time even though months have passed. We explore whether there is only one way to mourn.

TH. Is it possible to be joyful and still miss her?

CL. I think of the good things that have gone on in the last couple of months. I think whoa I shouldn't be happy, that's so wrong to be laughing and having fun when that's happened you know. How can you be happy and jumping for joy when your friend has just died?

TH. There's that fear that if you are that happy you may actually forget about your friend?

CL. That's it, that's exactly it. I just think...(Hazel deepens to talking about her close relationship with her friend).

Leick and Davidsen-Nielsen, (1991) note that it is important to be aware of the feeling of guilt in an individual who is enjoying life, seemingly having forgotten the feelings of grief for the lost object. They note that the individual may feel that they have let down the lost object. Such guilty feelings can then bind their energy to the lost object and inhibit an otherwise healthy grieving process so that they are unable to work through their grief (Bowlby, 1980; Jacobs et al, 1994; Raphael & Minkov, 1999; Worden, 2002).

I am aware that Hazel's friend has only recently passed away however I have used this vignette as it equally applies to the dynamics over the death of her father over a decade earlier and where Hazel still feels guilt about it. It seems that Hazel's desire to perpetuate mourning keeps her loved one's memory alive but the pain she feels as she is working through her grief demonstrates that she still feels the loss. Years after the death of her father, Hazel had a break down on the anniversary of his death. Winnicott (1994) explains that anniversaries or chance events that recall the relationship with the object re-emphasise this 'failure' of the object that has disappeared.

Depression

Because depression is such a significant phenomenon in the grieving process, it seems important to elaborate further on how to distinguish whether a client is depressed or actually in the process of grieving a loss. This obviously has an impact on how a client is treated and will influence the outcome of therapy

Not only is there a substantial overlap of the symptoms of both complicated grief and depression but also many of the normal grief behaviours can be mistaken as expressions of depression (Bright, 1996; Worden, 2002). This has fuelled the debate as to whether symptoms of a major depressive episode after the death of a loved one should be viewed as a form of depressive illness or as a form of grief. Tomita and Kitamura (2002) believe that the issue may not be one of "either or" but "to what degree" (p.99)

Complicated grief is neither depression nor PTSD (Raphael & Minkov, 1999). Indeed the state of the ego in true pathological grieving is one of chronic hope

and a continuing effort to regain the lost object, whereas, in depression, it is one of helplessness (Volkan, 1972). Significantly, Belitsky and Jacobs (1986) quoted studies to demonstrate that severe disturbance of self esteem and suicidal gestures are rarely observed in uncomplicated bereavement. They studied bereaved widows who exhibited typical grief reactions, such as crying, fatigue, sleep disturbance, and somatic symptoms, which disappeared by the end of the first year. Other symptoms such as depressed mood, restlessness and hopelessness; worthlessness and suicidal thoughts persisted longer.

In his article, *The Linking Objects of Pathological Mourners*, (1972), Volkan noted that in some instances linking objects are involved in the non-resolution of grief. Pathological mourners adopt and use these inanimate objects to externally maintain object relations with the deceased. Thus the mourner symbolically establishes a link between them and the deceased person. He believes that the more ambivalent the relationship with the deceased, the more likely it is for the inherited object to become a linking object. The linking object belongs to both the individual and the lost object and evokes both the desire to destroy and preserve it. This way the two opposing impulses can be maintained externally in a dynamic conflict, which is not a dominant feature of depression. Volkan differentiates them from inherited objects - someone who has completed mourning successfully may wear a ring previously worn by the lost object without anxiety or a compulsion to protect it or without concern about whether to show it or keep it out of sight. Therefore it is a keepsake and not a linking object. After her friend had passed away, Hazel began to wear her deceased friend's clothes and jewellery that was an attempt to maintain a link with her friend.

Categories of Complicated Grief

As discussed previously, complicated grief can be delineated in many ways (Jacobs et al, 1994; Leick & Davidsen-Nielsen, 1991; Rando, 1993). I will use Worden's four-category paradigm of complicated grief, as it is clear and unambiguous. I think this paradigm, in contrast to more traditional models

recognises the idiosyncratic nature of grieving.

According to Worden (2002), the four categories are: chronic grief reactions, delayed grief reactions, exaggerated grief reactions and masked grief reactions. I will elaborate in detail on the first two categories as both my clients' reactions best fit here.

Chronic Grief

Chronic grief is also known as prolonged grief or protracted mourning. It is extreme in duration and does not progress normally or diminish throughout the first year with any satisfactory resolution (Jacobs, 1993; Worden, 2002). The grieving individual presents as if the loss happened only days before, even though the loss may have taken place years ago. The individual is not aware of avoiding or feeling fearful of experiencing grief (Rando, 1993) because the individual's grief is split off from cognitive awareness (Kauffman, 1993/4), although the individual is aware of not getting through their grief. In chronic grief the individual has not accepted that the lost object is gone. Confused and ambivalent feelings towards the lost object remain as they have not been processed, which prevents the formation of new relationships over time (Worden, 2002).

Individuals predisposed to chronic grief have often shown life long dependency on parents and partners and feel seemingly forever obligated to provide care for their attachment figure (Bowlby, 1980; Holmes, 1993). They cannot progress in their grieving process and experience intense separation anxiety in connection to the lost object, which is revealed in symptoms such as: grief, depressive symptoms, sorrow, anger, guilt, self-hatred and blame (Jacobs, 1993; Rando, 1993; Viorst, 1998).

An under appreciated aspect of chronic grief is the negative effect on the physiology and physical health of the individual, especially cardiovascular and immune systems and can worsen pre existing medical conditions (Doka, 1989; Frankiel, 1994; Paulley, 1983; Wortman & Silver, 1989). Others may succumb to dependencies on drugs, alcohol or food that also could then lead to significant deterioration of their health (Frankiel, 1994). Such problems have been verified

empirically and may potentially evolve into a serious psychological problem (Arnette, 1996). Hazel has regularly used alcohol and drugs in an effort to ward off her pain. She confided that she had never talked about her pain to anyone her entire life before coming into therapy. Heavy use of alcohol or drugs can intensify the experience of grief and depression and impair the grieving process (Frankiel, 1994; Hentz, 2002, Linehan, 1993, Worden, 2002).

As mentioned earlier, Hazel suffered a physical and mental breakdown on the anniversary of her father's death, six months after the break up of her long term relationship. She had avoided any grieving over this. It is significant that she broke down on the anniversary of her father's death who had died more than fifteen years previously. I have observed this phenomenon equally with other clients.

Unfortunately, little research is being carried out to understand how the body experiences loss and the memories encoded in it (Hentz, 2002) although scholars are aware of the significance of anniversary reactions (Worden, 2002; Viorst, 1998). Interestingly, in a study on women's stories of loss and how loss manifested physically in their bodies, Hentz observed that the body experience around the time of the anniversary of a significant loss is relived as it was at the time of the actual loss. Frankiel (1994), notes that consequences of object loss can be displayed in enactments with conscious denial of death or complete unconscious denial covered by conscious acceptance, as well as accident proneness, disruptive anniversary reactions, compulsive wandering. These are indicators of preoccupation with traumatic absence and hoped for reunion with the lost object. Queen Victoria fits the chronic grief category demonstrated by her decision to wear black for fifty years after the death of her husband.

Delayed grief

In delayed grief the central issue is the absence of separation distress expressed by pangs of grief and yearning and searching phenomena. Also, individuals suffering from delayed grief do not experience the emotional progression of grief for more than a few weeks after the loss (Jacobs, 1993). The first task of mourning has been done purely on an intellectual level where the individual may

have had an emotional reaction at the time of the loss but not to any depth (Leick & Davidsen-Nielsen, 1991). However, because of insufficient processing of grief individuals often experience intense grieving when faced with subsequent losses. Typical manifestations of grief are diminished in situations where clinicians would expect to be able to observe them (Belitsky and Jacobs, 1986; Deutsch, 1937; Leick & Davidsen-Nielsen, 1991; Raphael & Minkov, 1999; Worden, 2002). Thus the absence of any signs of grief is of clinical concern because, “the grieving person can delay his grieving period but not avoid it” (Lindemann, 1944, p.143) and is at risk of developing pathological or disturbing symptoms at a later time (Bowlby, 1980; Lindemann, 1944; Raphael & Minkov, 1999). Parkes (1996) confirms this in a study where he observed that all of his patients with delayed grief reactions eventually developed depression or even experienced suicidal ideation. In other words, individuals respond with too little emotion at the time of loss and when faced with subsequent losses experience intense excessive grieving, such as, feeling intense emotion when watching someone else go through a loss on television or in the media (Parkes, 1996; Rando, 1993).

This can be illustrated in the following verbatim where John begins to talk about what happens to him as others around him in a class share sad experiences. It demonstrates the struggle of not working through the pain of loss. John does not see a connection between his sadness and his feelings over his father.

TH. ...Holding that emotion in that's been touched by the experiences you've been hearing about sounds draining.

CL. Yeah I spose it is...

TH. When you feel like that, where do those emotions go, when you're feeling close to tears ...what happens for you?

CL. Yeah well... I go... you know fight myself to um keep control of myself and change from that really (mm)... yeah avoiding that I spose (he laughs). I tend to feel.. tight in the stomach and stuff.. tense.. And stuff (he laughs again)...

TH. Mm I wonder what that tightness and tenseness is about

CL. I think it's wanting to control... not let my feelings out

John explains that he feels stuck at the moment in that it feels easier for him to keep his emotions inside. He notices how he feels stressed and alert when he starts going to his emotions and is unable to cry easily. This is significant as anger and weeping are necessary biologically ingrained responses leading to recognition that the loss is final and a way to relieve the ache of loss (Bowlby, 1980; Viorst; 1998). Where the individual begins to feel their pain, weeping has a therapeutic effect; tears heal both physically and mentally. Indeed, Leick and Davidsen- Neilsen write that profound grief and profound sobbing belong together and emphasise the usefulness of differentiating between the “letting go weeping” that occurs when someone begins to let go of the lost object and Bowlby’s “calling weeping”, a shallow weeping accompanied by rapid breathing that does not bring the sense of relief and is an attempt to hold on to the lost object (1991, p.10). This differentiation helps distinguish between grief and complicated grief. In John’s case it helps me to understand how John swallows his grief rather than letting it go.

CL. Yeah, when something like that happens and I'm feeling like that before and something like a switch switches me to being unhappy and that and.. Changes my mood and puts a heaviness on me (he laughs) and it's like a stuck place I pose. Yeah. It's easier for me to keep it inside and shut it down.

In both chronic and delayed mourning, people may hold on to their memories, as painful and even harmful as they may be, in an effort to maintain some kind of connection with the deceased or lost person (Worden, 2002). The individual believes either consciously or unconsciously that the loss is still reversible and as the individual’s representational models of self and the world remain unchanged and unaffected by reality, the completion of mourning is impeded (Arnette, 1996; Rando, 1993).

Exaggerated Grief

According to the literature, it is difficult to define exaggerated grief because of the varied manifestations that uncomplicated grief can take and in the absence of clear criteria the clinician has to make a judgement as to when grief expressions are no longer normal but exaggerated (Worden, 2002). Individuals understand that their symptoms are related to a loss but they experience them as excessive, disabling and difficult. Symptoms include excessive depression, anxiety or other features usually associated with uncomplicated grief (Worden, 2002). Yet here they manifest in a way that the individual becomes dysfunctional. Drug and alcohol overuse, mania, PTSD symptoms or panic attacks are all possible expressions of exaggerated grief (Jacobs, 1993; Worden, 2002).

Masked grief

Deutsch (1937) explains the absence of grief reactions as a narcissistic self-protection when our egos are not developed enough to bear the effort of the work of mourning. In contrast to chronic or exaggerated grief, the individual is not aware that unresolved grief is the cause of his or her symptoms (Worden, 2002). The symptoms are revealed physically through mental illness such as depression, or in maladaptive behaviour thus masking the grief (Jacobs et al, 1994). Helene Deutsch (1937) explored this phenomenon in *Absence of Grief*. She explained that facsimile illness is a situation where the individual may experience physical symptoms similar to the deceased. She wrote that unexpressed grief would ultimately be found expressed in some other way.

This section has explored the complexity of defining complicated grief. There is a continuum of normal and complicated grief rather than an obvious clear-cut separation. What emerged are the need for standardized criteria to describe grief as complicated and a delineation of the overlap between complicated grief and depression. Although depression is a symptom of grief it is different from complicated grief as there is a state of helplessness whereas in complicated grief

there is a continuing effort and hope to regain the lost object. Factors complicating the grieving process include the presence of prior traumatic illness in childhood, psychiatric illness and lack of social support at the time of the loss. Separation distress is at the heart of complicated grief and there are observable signs that may reveal grief that is unresolved. These signs can be overlooked when diagnosing someone with a complicated grief reaction. Four main categories of grief are identified as a way of conceptualising complicated grief. They may be overly simplified but at least lessen the confusion as to the main theme of each category of grief.

CHAPTER FIVE

Working therapeutically with complicated grief

In the previous chapter I explored complicated grief identifying chronic, delayed, exaggerated and masked categories of grief. The question is now how to translate the knowledge of the different aspects of grief for effective therapeutic practice. To do this, I will explore the tasks in grief therapy, evaluate how effective various approaches are in working with clients, and discuss issues for therapists and interventions that are useful.

Typically, because we are social animals, we seek others to share painful emotions and for support at times of loss (Zerbe, 1994). This period can be filled with sadness or depression; it can be a time of alienation and devastation. When a grieving individual reaches out for support and understanding, they need to be received by caring individuals who are sensitive to the depth and complexities of their feelings. It seems, however, that family support can no longer be taken for granted when mourning the loss of someone and other social supports needed during this time may also be unavailable (Morgan, 2002). Changes in society, family constellation, and overall life-style have deeply affected and altered our mourning habits. Psychotherapy has increasingly been able to fill the void for those with insufficient support and taken over an important role in providing the supportive structures needed for the process of mourning (Burch, 1989; McWilliams, 1994; Parkes, 1996; Schina, 2002, Worden, 2002).

The challenge of grieving

In dealing with my own grief over the years and sitting with my clients and wondering why it is so distressing (demanding and frightening) to grieve I

looked to the existentialists, particularly American Psychiatrist Irvin Yalom (1980) and his existential approach to psychotherapy for answers. He believes that each person needs to face the universal conflicts of death, freedom, isolation and meaninglessness over their lifetime because they are the givens of human existence. With the process of grieving it is no wonder then that it is so difficult because the mourner has to confront all four conflicts at once. We are not helped by the fact that in our modern world society seems to express our terror of death by suppressing anything that reminds us of it. The dilemma then becomes one of expressing our personal grief in the context of social prohibitions that discourage public expression of it (Paul, 1986).

Almost fifty years ago Van Gennep (1960), observed how society responds to loss in a crisis with a sense of denial or undoing. He believes that mourning is the necessary transition out of crisis or trauma but that social mores teach us to ignore mourning or hope it will go away. He states that we need to acknowledge that there are parts of ourselves that will no longer exist; that there are roles that will never be ours again.

It seems that modern western culture no longer provides extensive traditional support for mourning, such as religious doctrine, mourning periods and mourning dress (Schina, 2002). The effect of this has been a burden for the individual who must struggle to make sense of loss without traditional support that our ancestors enjoyed centuries ago. As contemporary theory now makes clear the power of community and public rituals in smoothing the progress of transitions (Neimeyer, 2003; Worden, 2002), perhaps we could learn from other cultures such as Maori culture where tangis are held for the deceased and where mourners can grieve and keep revisiting their pain over time in a supportive community environment.

What is Grief therapy?

In the psychotherapeutic context of working with the bereft person, grief therapy is central in the adjustment to loss with the aim to “identify and resolve conflicts of separation which interfere with the completion of mourning tasks in

individuals whose grief is absent, delayed, excessive or prolonged” (Worden, 2002, p.101).

In the past complicated grief has been seen as regressive and asocial (Neimeyer, 2003). However, as understanding of grief has evolved, a different point of view is taking hold. Emotional reactions to grief are now more understood as an effort to communicate, while the individual is struggling to maintain relatedness - whether to the internal representation of the lost person or to external support (Attig, 2003; Neimeyer, 2003; Wortman & Silver, 1989). This change in position is encouraging as it substitutes the pathological connotation of complicated grief with acceptance.

Initially, the therapeutic process needs to focus on differentiating between the different types of grief reaction because there is more than one way to work with complicated grief and more than one appropriate treatment. Parkes (1996) gives the example of clients suffering from chronic grief who could go on expressing their grief in therapy indefinitely without improvement. Here he sets targets carefully negotiated with the client to restore their self-confidence and find new directions in life. The therapist’s attunement to the client’s expression of grief and responsiveness to the need for comfort and protection is central to the facilitation of mourning (Golden & Hill, 1991; Hagman, 2003). Golden and Hill write of the therapeutic space where the therapist gives a measure of care and attention, “a token of love” (1991; p.29).

In the clinical setting it is important that the therapist understand whether the client’s response to a loss is leading to normal grieving or toward defending against the pain of loss (Worden, 2002; Wortman & Silver, 1989). The grieving process may need fortification both against the client’s desire to minimise pain by denying loss and so seeming to make grieving superfluous and also from the therapist’s own issues around dealing with loss (Akhtar, 2001).

Tasks of Grieving

The tasks of grieving are not a sequential series of distinct events, but a complex process that requires an enormous effort often accompanied by a waxing and waning of emotions by the grieving person. (Gaines, 1997; Jacobs,

1993; Rando, 1993; Worden, 2002). Not only are these tasks not distinct, they also tend to overlap with each other. Thus grieving is not necessarily done once and for all and it is now understood that significant loss may never be fully expunged (Akhtar, 2001, Jacobs et al, 1994; Rando, 1993; Wortman & Silver, 1989).

While the literature reveals that stages or tasks are described with various differentiation (Rando, 1993; Worden, 2002), Worden's four tasks of mourning provide a clear and easy way to conceptualise a framework for psychotherapists and clients alike. He uses the term 'tasks' because it implies that the grieving individual is involved with the process and has to actively work through the tasks. These tasks are not linear and are revisited and reworked over time. They are:

- 1) To accept the reality of the loss. The task here is to accept on both an emotional and intellectual level that the lost object is gone and will not come back. The individual needs to make meaning of the loss rather than minimise it. Loss can result in a crisis of meaning and complicated grief can be seen as meaningful however disturbed and painful it appears (Attig, 2003), where complicated responses may be seen as unsuccessful strategies to maintain meaning and preserve the attachment to the lost object. Common behaviours that indicate a conflicted relationship with the lost object include removing all things that are reminders that the object is gone. Absent grief fits into this category where the interference is linked to recognising the loss. An individual may accept intellectually the finality of the loss long before an emotional acceptance is reached. The therapist needs to focus interventions on breaking through the initial shock grief reaction and reverse the denial (Rando, 1993).

Accepting the reality of the loss can be facilitated with the help of ritual. Rituals acknowledge significant milestones celebrate beginnings, special occasions and recognise endings and help us make sense of and give meaning to our lives (Hoff, 1995). Lattanzi and Ellis Hale (1984-5) suggest that writing about the event can be helpful to express and ease pain especially in the early months of loss and can improve physical health and increase feelings of well being. Other ways of providing a tangible experience include lighting a candle

or planting a tree (Arnette, 1996; Clark, 1987; Doka, 1989; Linehan, 1993; Rando, 1993).

2) To work through the pain of grief. It can be said that both permission and verbal encouragement to mourn are necessary for individuals with complicated grief reactions due to traditionally unacceptable thoughts and feelings that become aroused and the personal discomfort experienced at this time (Rando, 1993; Worden, 1982, 2002). The work includes addressing the emotional, behavioural and physical pain that people can experience after loss. As described in chapter four, unacknowledged pain can manifest through physical symptoms. Worden (2002) writes that allowing the individual to avoid or suppress or deny the pain can prolong the course of mourning and that feeling the pain means that eventually one day it will pass. Delayed mourning fits here where therapy would include the individual reacting to the separation from the loved one. Avoiding painful emotions such as sadness, anxiety, anger, and guilt usually results in a breakdown and some form of depression (Bowlby, 1980, Hentz, 2002; Worden, 2002).

3) To adjust to the environment without the lost object. Here the individual needs to adjust to the loss in terms of everyday functioning in the world. This may entail dealing with how the loss has affected the person's self esteem and self efficacy (Worden, 2002). Furthermore, adjustment also means to explore how the loss has affected the way the grieving individual looks at the world. This requires the revisiting of events that occurred before and at the time of the loss as well as reviewing the relationship to the deceased and the circumstances of the death (Rando, 1993; Raphael & Minkov, 1999). Here, the task of the therapist is to help the client see the dependency issues that have surfaced, so that the grieving individual's relationship to the lost object can be re-evaluated (Neimeyer, 2003). Evidence that someone is not adapting to the loss can be revealed in their withdrawing from the world, promoting their own helplessness and not coping. (Jacobs et al, 1994; Worden, 2002). Where there is a failure to mourn the therapist should look for mixed feelings toward the person who has died (Malan, 1992).

4) To emotionally relocate the lost object and move on with life. We need to

find a place for the lost object that will enable the individual to connect with the lost object and yet to also go on with their life (Attig, 1996; Neimeyer, 2003; Worden, 2002). This includes focusing on memories working toward detachment from the loss yet finding ways to develop continuing links to the relationship with the lost object (Doka, 1987; Hagman, 2003; Neimeyer, 2003; Worden, 2002).

In a study on getting over loss Hentz (2002) found that women uncovered personal meanings when they stayed with their experiences and reflected on their sense of sadness, bad mood and physical distress. Interestingly, Hentz noted that getting over the loss was not a focus for many of the participants, rather the focus was to remember and to hold on to the memory, and to know they were not alone in a society where previously they had individually felt silenced and isolated.

This is the hardest task and the grieving individual manifests the non-completion of this task by holding on to past attachments, incapable of making new attachments. An extreme scenario is the individual who perhaps may never be able to love again (Klein, 1940). The main focus in chronic mourning needs to be on the issues discussed in this fourth task.

An Integrationist approach

Worden's tasks have been used because he names specifically what is required from the tasks and imparts an understanding that a lot of literature omits. Other scholars were less forthcoming on how to work therapeutically with clients. There was a sense for me that authors expected the work to be self-explanatory. Neimeyer (2000) made the same discovery that relatively few of the outcome studies on working with grief specified the principles and procedures of the therapies whose effectiveness they evaluated. He purported that grief therapy demands more than thoughtful and self-critical approaches, and that practitioners share a responsibility to communicate the principles that underpin their practice. He concluded that there needs to be more integrationist rather than specialists in the field of grief.

Indeed, focussing on the whole person, mind and body, is a more holistic approach to grief allowing the individual a place to explore their grief (Hagman, 2003; Hentz, 2002; Servaty-Seib, 2004; Worden, 2002).

In complicated grief, before these tasks can be worked through there has to be a resolution of the conflicts of separation that the grieving individual has experienced (Worden, 2002). Therapeutic procedures include simultaneously establishing a working alliance, ruling out physical disease, talking about the lost object, assessing which tasks of mourning are not complete, dealing with the affect or lack stimulated by memories, exploring linking objects (refer page 33), acknowledging the finality of the loss and helping the individual to say goodbye (Worden, 2002). Significantly, Piper et al (2003) note that in clients with complicated grief the quality of the client's object relations was directly related to a favourable outcome, that is, reduction of grief symptoms. Also, expressing positive feelings along with the negative feelings can make it easier for the client to express distressing emotions without resorting to avoidance (Piper et al, 2003). To me this debunks the long held belief in grief work that focussing on negative emotions was most important.

On a simply human level the grieving person just wants someone to hear them rather than be provided with trite assurances (Hentz, 2002; Servaty-Seib, 2004). Indeed in a study by Davidowitz and Myrick (1984) where they investigated the kind of responses that were perceived as helpful to a grieving person, they concluded that as far as knowing what to say words are often less appropriate than one's presence and willingness to listen in addition to inviting the individual to share their emotions and experiences. Rosenblatt et al (1991) studied the difficulties experienced by a group of adults in giving support to the bereaved and discovered that many participants held back because they did not know what to do and feared making things worse for the grievers. The study revealed that people might be forced to retreat into their world of pain because others do not know how to give support.

Commonly held assumptions in grief work

Over the last half century, there has been a change in the way that the grieving process is understood. Wortman and Silver, (1989), identified five assumptions prevalent in grief work.

- 1) The first assumption is that distress or depression is inevitable. They identified studies that failed to demonstrate the inevitability of depression following loss and that the absence of depression was associated with higher self-concepts.
- 2) The second common assumption is that distress is necessary and failure to experience distress is indicative of pathology (such as believed by Deutsch and Bowlby who suggested that those who fail to respond to loss with intense distress are responding abnormally). Wortman and Silver found that those who are most distressed shortly following loss are among those more likely to be most distressed 1-2 years later. This is significant as the belief that distress should occur is so powerful as to be pejorative and leads to negative attributions to those who do not show evidence of it.
- 3) The third assumption is the importance placed on working through loss. Wortman and Silver's study identified that individuals who avoid or repress grief are not necessarily more likely to become disturbed a year later and that early signs of intense efforts to 'work through' the loss may indicate later difficulties.
- 4) The fourth assumption is around the expectation of recovery. There is more recent evidence that suggests that a substantial minority of individuals continue to be distressed longer than earlier assumptions on recovering from grief.
- 5) The last assumption is on reaching a state of resolution. It is widely believed that as a result of working through over time the individual will reach a state of resolution over what has happened both intellectually and emotionally, by reviewing the events of the death or loss. Several studies have shown that reaching a state of resolution may not always be achieved by coming up with an explanation that is satisfying to the individual especially when the event is sudden.

From their studies, Wortman and Silver (1989) concluded that traditional theories offer little to help understand why some individuals fail to recover or resolve their loss over time. They suggest that some individuals may have spiritual or philosophical beliefs in place before a loss that enables them to cope almost immediately. In this sense spirituality is part of the guiding system that allows us to interpret and make meaning from our experience (Frankl, 1963). Importantly, Wortman & Silver stress that it is dangerous to assume pathology when someone is in intense distress. They point out that this may be a strength of that person and their way of coping with loss.

The implications from their studies are significant. For example, people working with grieving individuals may mistakenly expect clients to go through a period of intense distress or even provoke such a reaction, rather than recognising the absence of grief as a sign of the individual's possible strength.

Wortman and Silver (1989), to my mind correctly, fear that widespread assumptions about the coping process may be particularly resistant to change. The dilemma here is that people working in this area may react negatively to those who fail to recover within a limited time. Hence it is important that the therapist not jump to conclusions but be mindful of a client's resources to understand when a grief reaction could be pathological or not.

Furthermore in a study conducted by Schut et al (cited in Parkes, 1996) groups of people were assigned either problem focussed behaviour therapy or an emotion focussed client centred therapy aimed at facilitating grief. The most significant results were that widows benefited from the behaviour therapy and the widowers from the emotion focussed therapy. Along with other studies this can be seen to show that men have difficulty expressing their emotions and benefit from therapy that helps them do this whereas women may need more assistance in finding new roles and meanings in their lives.

The therapeutic relationship

It is becoming more obvious that the relationship between client and therapist is one of the most likely indicators of a successful therapeutic outcome

(McWilliams, 1994). Obviously psychotherapy requires a genuine, empathic, and compassionate relationship between client and therapist and this is especially important when working with grieving individuals (Parkes, 1996; Rubin, 1999; Worden, 2002). Therapists not only need to have sound knowledge of bereavement, they also need to be willing to share that knowledge with the client (Akhtar, 2001; Raphael & Minkov, 1999; Spall & Callis, 1997; Staudacher, 1987). Hagman, (2003), believes the therapist should play an active, even central role in facilitating mourning.

Attention to the therapeutic healing elements of interaction is understood as central to the healing and growth experience that psychodynamic therapy can be for most people (Rubin, 1999). Without this, conceptualising grief as an internal private process driven by universal psychological principles can lead to an approach where the client may feel estranged (Stolorow & Atwood, 1994). Hagman, (2003) suggests that the therapist needs to be interested in the meaning of the relationship of the lost object to the client as traditionally one of the effects of the grief therapy has been a fear on the part of the therapist that exploring the positive meaning of the relationship will get in the way of grieving. This is because grief work previously stressed letting go of the lost object, which inevitably led to disinterest in the meaning of that relationship the client had with the lost object. Hagman believes we need to move beyond the assumptions of mourning so that the issue is no longer just what the lost object means to the client but also what the meaning is of this new relationship configuration of which the therapist is now a central part. Thus meanings and subjectivities are no longer private and isolated but intersubjectively based. He writes that the impact of the loss on the self-organisation of the grieving person is significant. He stresses the importance of the self-object as “ positive, self sustaining, self repairing and self regulating” (Hagman, 2003, p.28). He suggests that therapists need to focus on decathexis but also explore the functions of the self object in the areas of affirmation, mirroring and merger needs. By doing so, the therapist helps the client recognise the powerful role of the relationship in the client’s self experience, which allows exploration of the meanings of the client’s mourning (Hagman, 2003). This uncovering of unrecognised or

unaddressed experiences weaved through the client's life story is the essence of therapeutic process (Rubin, 1999).

Resistance and Transference

Rubin, (1999), notes that the avoidance of engaging with the therapist is seen in the use of resistance-defences arising from fear of being overwhelmed, traumatised, retraumatised, losing contact with loved ones, or being confronted with unacceptable aspects of oneself. The task at hand is then to explore the resistance and what is being avoided (Linehan, 1993; Worden, 2002). Schlesinger (cited in Akhthar, 2001) writes that the transference and countertransference of the therapist may interfere with his or her ability to discriminate whether to intervene technically or allow the mourning process to continue uninterrupted. For example Schlesinger notes that it can be 'normal' for the client to mitigate the pain and to dose the mourning; not all such instances of defence require interpretation. He continues that we may intrude on our clients because of wanting to intervene instead of witnessing the client's pain or we may feel impelled to alleviate our distress by intervening to improve their suffering. Leick and Davidsen-Nielsen (1991) observe that in our society, strong emotions have a frightening effect on many people and that is why working with the emotions of grief represents difficulty for many therapists. Considering our own views on death and loss increases the probability of being able to empathise and get alongside our clients. There is also less likelihood that we will avoid having meaningful conversations about death out of fear that our own concerns will be provoked (Spall & Callis, 1997; Worden, 2002).

Both Hazel and John avoid discussing their loss. Hazel did not want to feel her emotions, and she would avoid or change the subject to avoid her grief. Taylor and Rachman, (1991), believe that one way to understand this is to realise that sadness may be feared if it is perceived to be the precursor of more intense reactions, such as intense depression or morbid grief. In this vignette I stay with her anxiety.

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CL. Yeah no I didn't have any expectations that I have to walk in here and cry for an hour, I mean I don't want to do that, if it happens sure but um it was more to close her down and finish it off (mm) if I look at it seriously rather than actually literally no cause I've got to save some sadness for in this room because I've got to walk in sad (mm) so yeah

TH. And there's a part of you that knows how to close things down when they get uncomfortable

CL. (LAUGHS) Yeah I was about to close that one down (laugh) I was just about to go wooo close those curtains

TH. I wonder what would that feeling be that you were closing down

CL. I dunno I can't think any more ... what were we talking about?

TH. We were talking about, you know how to close down situations when someone starts getting a little intimate or a little bit closer to you than you feel comfortable. Sounds like there's a way you've learned to manipulate, not in a negative way but in a way of being able to shift it round so you don't actually have to address it here and now but in a way that removes you from the situation and you can close it down.

CL. (MM) YEAH cause I've done that a lot in here (laughs) I've just changed the subject and I do that all the time with people they're talking about something and I go, 'oh so how's your donkey' (laughs) 'oh good crackers yeah blah blah blah blah blah' ... and then I've got their mind off what they're trying to get out of me (mm)... yeah I do manipulate without thinking about it sometimes but it's to my advantage I guess so I don't have to talk about it... and I'm going overseas and I don't want anybody to know...

This way of being with Hazel is directive but we had developed a good working alliance and Hazel stayed with me. The result was that Hazel's process deepened and she began to talk about how being with grief is for her acknowledging that she wants to hurry her grief but knows that she has to let grief take its course. She was soon able to talk about her mother and her conflicted emotions around loss. Both Hazel and John will often shut down as their emotions come to the fore and be only minimally communicative. Initially Hazel could discuss emotionally charged topics for no more than a minute or

two. I have learnt to approach both Hazel and John by focussing on specific behaviours that will help them reverse their emotional inhibition. This enables them to understand their pattern. Linehan (1993) sees that offering realistic hope that the client can survive the grieving by teaching grieving skills and coping strategies. Without these skills instead of moving through to resolution and acceptance, the individual resorts to avoidance responses. She notes too that an inhibited grieving pattern can be seen as an alternative to the therapist's belief that the client is being hostile. I found this useful as Hazel especially would wear her sunglasses or clench her jaw. Over time my relationship with Hazel developed into supportive, gentle encouragement and prodding confrontations where Hazel and I met to create meaning; I was not merely a spectator watching Hazel explore her inner self.

This chapter has shown the conflict of expressing grief is a complex process that requires effort in a modern world that would rather suppress it. Emotional reactions to grief may be an effort to communicate while the grieving individual struggles with the loss. In addition, therapists and health care professionals need to be mindful of unrealistic assumptions about the process of coping with loss and not be hasty in diagnosing pathology. Assumptions about the grieving process may be particularly resistant to disconfirming evidence health care workers may react negatively to those who fail to recover within a limited time

CHAPTER SIX

Discussion and Conclusion

Hazel and John

It has been over a year since I last saw Hazel, John and I still meet weekly 18 months on. As I reflect on our journey I have learned much about the grieving process in the presence of profound grief. Hazel terminated therapy early (as is her pattern) and went overseas yet the last seven weeks in therapy saw a shift that was profound for her and I. Hazel visited her pain around her father and her friend passing away. She began to identify symptoms and self soothe and she was no longer using drugs and alcohol. She was stronger and had more autonomy.

CL. I feel like some of the times I've come in here and it's been.. I've felt such a balled up wreck and I've left feeling in a different you know cos I really have come I in here you know and dumped it all out a lot of times. I really don't know what I would've done if I couldn't have come here (sobbing)

TH. Yeah (soft and soothing)

CL. You know with (deceased friend) gone I would've lost my mind. Fighting over the house. I couldn't get through the day without collapsing all the time and trying to escape with the odd recreational drugs which I haven't touched for a long time now.

At the time Hazel left, my supervisors questioned me as to why I did not challenge her leaving. I did encourage her to stay, however, Hazel was clear within herself that she had done what she had come for at that point in her life. My sense was that she would take up where she left off revisiting her grief again when she is ready. My work with Hazel illustrates that we may take a lifetime to grieve.

What did I do specifically? As a therapist, I accepted Hazel's pain and anger

and encouraged John when all he felt was numb. As we engaged, both looked at their lives in a way that would help them to understand their past. I provided the social support required for grief work and provided the permission that was denied them as children. Healing came through the secondary support of therapy as Hazel and John began to accept the reality of their loss, by expressing their pain and beginning the process of integrating their losses in their lives. Hazel had the relief of her pain being given a name, 'abandonment'. John is beginning to express and grieve his losses as he begins to accept and make meaning for himself.

Insights, limitations and contributions to the field

In writing this dissertation I have written a lot about the cold hard facts of grief and I do not want to separate from the human side of grief. Grief is not a problem to be solved but is an experience to be shared (Parker, 1981). My dissertation, hopefully, may illuminate the process of complicated grief and can be held in mind when working in the therapeutic relationship with grieving clients stuck in their grief.

After completing this research I realise that I was very ambitious to write a dissertation that could comprehensively explain complicated grief. Hindsight, as they say is a wonderful thing and the literature revealed quite clearly that scholars have been struggling to come to an agreement of how best to conceptualise grief throughout the years. Nonetheless, I have learnt a great deal which will serve me well in my work with grieving clients.

What has stood out for me is that an integrationist approach towards the grieving process characterised by acceptance, balance and flexibility is useful in the work with grieving clients.

It is helpful to understand that grieving is multi determined and there is not one way to so-called grieving, that there are different rates of grieving according to various factors in an individual's life.

The emphasis on support for the grieving individual was a strong theme amongst the literature, however I am struck by the irony of that considering European society is so individualistic. Having spent my training in a

government mental health agency I have seen how these clients can have their grief exacerbated by isolation and lack of family. I think this is a big issue for mental health in New Zealand. In addition, I see a gap in the training of mental health practitioners and tertiary programmes should think about the importance of including in the curriculum the study of the grief process. The relevance of this is highlighted by Wortman & Silver's (1989) study which revealed a tendency to fit grieving clients into a model where those who don't get angry and resolve their grief run the risk of being prematurely labelled pathological. Such unrealistic assumptions about the normal process of coping with loss may exacerbate feelings of isolation and distress amongst clients. Also as psychotherapists we need to bear in mind presenting symptoms that may be overlooked when a client presents with a grief issue. Symptoms may be observable but may not be linked to the grieving process. For example, the literature revealed that with loss comes a range of psychological and physical states ranging from over sensitivity to noise to a lack of energy. In the absence of clear diagnostic criteria the clinician has to make a judgement as to when grief expressions are no longer normal but exaggerated.

Loss may lead to physical or mental ill health without the therapist connecting this to a complicated grief reaction in the client. If I cast my mind back to my training I wonder how many personality disorder diagnoses would be replaced with a grief diagnosis.

We think we know grief when we see it but it is apparent that there is a lot that is not known about grief. Grief comes in many forms and prior to this dissertation I was surprised to see how easily one could miss signs of a complicated grief reaction. Diagnostic decisions ought to be conservative in the circumstances of loss to avoid interference in a normal human process or to be misdiagnosed as depression, which requires a different focus. There are striking similarities between adjusting to the loss of someone and adjusting to a traumatic stressor in the DSM IV (4th ed.) yet bereavement is not included in the definition of a traumatic event. There is an undeniable relation between traumatic death and grief complications

It will require further study to consider the implications of this dissertation in

relation to particular cultural differences and specific grief such as the impact of the loss of a child. For future study I think it would be interesting to explore the differences in grief reactions between men and women and how coping styles may differ. I also would have liked to explore the link between suicidal ideation and complicated grief, and the use of medication in the treatment of a complicated grief reaction because of the client group I have worked with in Mental Health.

Finally, as I conclude this dissertation. I would like to focus on relationship and the human side of grief. Grief is the price of love. One of the central challenges as we grieve and mourn our losses is moving from a life where we loved with the object present to a life where we love in absence of it. Nothing is more difficult; nothing is more important; nothing is more rewarding. Attig (2003) puts it beautifully when he says that we learn to hold those we love in our hearts and we will always hold them in a place of sadness.

I believe that, as society evolves, grief and mourning will become accepted as an unavoidable and integral part of our journey through life, something that can be given more time to. Perhaps then, the sadness that Attig writes about will be replaced with love.

REFERENCES

- Akhtar, S. (Ed.). (2001). *Three faces of mourning: Melancholia, manic defence and moving on*. Northvale: Jason Aronson Inc.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- Anderson, C. (1949). Aspects of pathological grief and mourning. *International Journal of Psycho-Analysis*, 30, 48-55.
- Archer, J. (1999). *The nature of grief: The evolution and psychology of reactions to loss*. London: Routledge.
- Arnette, J.K. (1996). Physiological effects of chronic grief: A biofeedback treatment approach. *Death Studies*, 20(1), 59-72.
- Attig, T. (1996). *How we grieve: Relearning the world*. Oxford: Oxford University Press.
- Attig, T. (2003). Relearning the world: Making and finding meaning. In R. A. Neimeyer (Ed.), *Meaning reconstruction & the experience of loss* (pp33-55). Washington, DC: American Psychological Association.
- Belitsky, R., & Jacobs, S. (1986). Bereavement, attachment theory, and mental disorders. *Psychiatric Annals*, 16, 276-280.
- Benjamin, L.S. (1996). *Interpersonal diagnosis and the treatment of personality disorders*. New York: Guilford Press.
- Bloch, S. (Ed.). (1996). *An introduction to the psychotherapies* (3rd ed.). Oxford: Oxford University Press.
- Bowlby, J. (1980). *Attachment and loss: Loss, sadness and depression (Vol 3)*. London: The Hogarth Press.
- Bright, R. (1996). *Grief and powerlessness: Helping people regain control of their lives*. London: Jessica Kingsley Publishers.
- Burch, B. (1989). Mourning and failure to mourn- An object relations view. *Contemporary Psychoanalysis*, 25, 608-623.
- Calhoun, L.G., & Tedeschi, R.G. (2003). Posttraumatic growth: The positive lessons of loss. In R.A. Neimeyer (Ed.). *Meaning reconstruction & the experience of loss* (pp137-157). Washington, DC: American Psychological Association.
- Clark, E. (1987). Bereaved persons have the rights that should be respected. In A. Kutscher, A. Carr & L. Kuntscher (Eds.), *Principles of Thanatology*. New York: Columbia University Press.
- Crump, R. (Ed.). (1979). *Complete poems of Christina Rossetti*. Baton Rouge: Louisiana State University Press.
- Davidowitz, M., Myrick, R.D. (1984). Responding to the bereaved: An analysis of "helping" statements. *Death Education*, 8, 1-10.
- Deutsch, H. (1937). Absence of grief. *Psychoanalytic Quarterly*, 6, 12-22.
- Dickson, R. (1999). Systematic reviews. In S. Hamer & G. Collinson (Eds.), *Achieving evidence based practice: A handbook for practitioners* (pp 41-60). Edinburgh: Balliere Tindall.
- Doka, K. (1987). Silent sorrow: Grief and the loss of significant others.

- Death Studies*, 11, 455-469.
- Doka, K. (Ed.).(1989). *Disenfranchised grief: Recognising hidden sorrow*. Toronto: Lexington Books.
- Engel, G.L. (1961). Is grief a disease? A challenge for medical research. *Psychosomatic Medicine*, 23, 18-22.
- Frankiel, R.V. (Ed). (1994). *Essential papers on loss*. New York: New York University Press.
- Frankl, V. (1963). *Man's search for meaning*. New York: Washington Square Press.
- Freud, S. (1925). Mourning and melancholia. In J. Riviere (Ed. & Trans.), *The international psycho-analytic library: Collected papers* (Vol. 5, pp 152-170). London: Hogarth Press. (Original work published 1917)
- Gaines, R. (1997). Detachment and continuity: The two tasks of mourning. *Contemporary Psychoanalysis*, 33, 549-571.
- Geller, J.L. (1985). The long-term outcome of unresolved grief: An example. *Psychiatric Quarterly*, 57, 142-146.
- Golden, G.K., & Hill, M.A. (1991). A token of loving; From melancholia to mourning. *Clinical Social Work*, 19,(1). 23-33.
- Hagman, G. (2003). Beyond deathecis: Toward a new psychoanalytic understanding and treatment of mourning. In R.A. Neimeyer (Ed.), *Meaning reconstruction & the experience of loss* (pp13-31). Washington, DC: American Psychological Association.
- Hanks, P. (Ed.). (1991). *The Collins paperback English dictionary*. Glasgow: HarperCollins Publishers.
- Hentz, P. (2002). The body remembers: Grieving and a circle of time. *Qualitative Health Research*, 12, 161-172.
- Higgins, R. (1996). *Approaches to research: A handbook for those writing a dissertation*. London: Jessica Kingsley Publishers.
- Hoff, L.A. (1995). *People in Crisis: Understanding and Helping* (4th ed). San Francisco: Jossey-Bass.
- Holmes, J. (1993). *John Bowlby and Attachment Theory*. London: Routledge.
- Horowitz, M.J., Wilner, N., Marmar, C., & Krupnick, J. (1980). Pathological grief and the activation of latent self-images. *The American Journal of Psychiatry*, 137, 1157-1162.
- Horowitz, M.J. (2001). *Stress response syndromes* (4th ed). Northvale: Jason Aronson INC.
- Jacobs, S. (1993). *Pathological grief: Maladaptation to loss*. Washington DC: American Psychiatric Press, Inc.
- Jacobs, S., Kasl, S., Schaeffer, C., & Ostfeld, A. (1994). Conscious and unconscious coping with loss. *Psychosomatic Medicine*, 56, 557-563.
- Jacobs, S. (1999). *Traumatic grief: Diagnosis, treatment, and prevention*. Philadelphia, P.A: Brunner/Mazel.
- Jacobs, S. & Kim, K. (1990). Psychiatric complications of bereavement.

- Psychiatric annals*, 20, 314-317.
- Jacobs, S., & Prigerson, H. (2000). Psychotherapy of traumatic grief: A review of evidence for psychotherapeutic treatments. *Death Studies*, 24, 479-496.
- Jacobsen, R.H. (1986). Unresolved grief of 25 years duration exacerbated by multiple subsequent losses. *The Journal of Nervous and Mental Disease*, 174, 624-627.
- Karen, R. (1998). *Becoming attached*. Oxford: Oxford University Press.
- Kauffman, J. (1993/4). Dissociative functions in the normal mourning process. *Omega*, 28, (1). 31-38.
- Kernberg, O.F.; Selzer, M.A.; Koenigsberg, H.W.; Carr, A.A.; & Appelbaum, A.H. (1989). *Psychodynamic psychotherapy of borderline patients*. New York: Basic Books.
- Klein, M. (1986). Mourning and its relation to manic-depressive states. In J. Mitchell (Ed.), *The selected Melanie Klein* (pp 147-174). London: The Hogarth Press. (Original work published 1940)
- Kubler-Ross, E. (1969). *On death and dying*. New York: Macmillan Publishing Company.
- Lattanzi, M., & Ellis Hale, M. (1984-5). Giving grief words: Writing during bereavement. *Omega*, 15(1).45-52.
- Lazare, A. (1979). Unresolved grief. In A. Lazare (Ed.), *Outpatient psychiatry: Diagnosis and treatment* (pp. 498-512). Baltimore: Williams & Wilkens.
- Leick, N., & Davidsen-Nielsen, M. (1991). *Healing pain: Attachment, loss and grief*. London: Tavistock/Routledge.
- Lewis, C.S. (1976). *A grief observed*. New York: Bantam Books.
- Lindemann, E. (1944). Symptomatology and management of acute grief. *American Journal of Psychiatry*, 101, 141-148.
- Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: The Guilford Press.
- McWilliams, N. (1994). *Psychoanalytic diagnosis*. New York: The Guilford Press.
- Malan, D.H. (1992). *Individual psychotherapy and the science of psychodynamics*. Oxford: Butterworth-Heinemann.
- Marwit, S. (1996). Reliability of diagnosing complicated grief: A preliminary investigation. *Journal of Consulting and Clinical Psychology*, 64, 563-568.
- Melges, F.T., & DeMaso, D.R. (1980). Grief resolution therapy: Reliving, revising, and revisiting. *American Journal of Psychotherapy*, 34(1). 51-61.
- Melham, N. (2001). Comorbidity of axis disorders in patients with traumatic grief. *Journal of Clinical Psychology*, 62, 884-887.
- Mendelson, E. (Ed.). (1991). *Collected poems of W.H. Auden*. London: Faber.
- Morgan, J. (Ed.). (2002). *Social support: A reflection of humanity*. New York: Baywood Publishing Company.

- Neimeyer, R.A. (2000). Grief therapy and research as essential tensions: Prescriptions for a progressive partnership. *Death Studies*, 24, 603-610.
- Neimeyer, R.A. (2003). The language of loss: Grief therapy as a process of meaning reconstruction. In R.A. Neimeyer (Ed.), *Meaningreconstruction & the experience of loss* (pp261-293). Washington, DC: American Psychological Association.
- Parker, N. (1981). *A time to grieve*. Auckland: Methuen.
- Parkes, C.M. (1996). *Bereavement: Studies of grief in adult life* (3rd ed). London: Penguin Books.
- Paul, N. (1986). The paradoxical nature of the grief experience. *Contemporary Family Therapy*, 8 (1). 5-19.
- Paulley, J.W. (1983). Pathological mourning: A key factor in the psycho pathogenesis of autoimmune disorders. *Psychotherapy and Psychosomatics*, 40, 181-190.
- Pine, V., Margolis, O., Doka, K., Kutscher, A.H., Schaefer, D.J., Siegal, M., & et al. (1990). *Unrecognized and unsanctioned grief: The nature and counselling of unacknowledged loss*. Springfield; Charles. C. Thomas Publisher.
- Piper, W.E., Ogrodniczuk, J.S.; McCallum, M.; Joyce, A.S., & Rosie, J.S. (2003). Expression of affect as a mediator of the relationship between quality of object relations and group therapy outcome for patients with complicated grief. *Journal of Consulting and Clinical Psychology*, 71, 664-671.
- Rando, T.A. (1993). *Treatment of complicated mourning*. Champaign: Research Press.
- Raphael, B., & Minkov, C. (1999). Abnormal grief. *Current Opinion in Psychiatry*, 12(1). 99-102.
- Rosenblatt, P.C., Spontgen, P., Karis, T.A., Dahl, C., Kaiser, T., &Elde, C. (1991). Difficulties supporting the bereaved. *Omega*, 23, 119-128.
- Rubin, S. (1999). Psychodynamic therapy with the bereaved. *Omega*, 39, 83-98.
- Schina, M.A. (2002). Psychoanalytic process and the cultural demise of mourning: Self-transformation and the creation of meaning. *Dissertation Abstracts International*, 63(4). 130.
- Schore, A. (1994). *Affect regulation and the origin of the self: The neurobiology of emotional development*. Hillsdale: L. Erlbaum Associates.
- Servaty-Seib, H. (2004). Connections between counselling theories and current theories of grief and mourning. *Journal of Mental Health Counseling*, 26,125-146.
- Spall, B. & Callis, S.(1997). *Loss, bereavement and grief: A guide to effective caring*. Devon: Stanley Thornes (Publishers) Ltd.
- Staudacher, C. (1987). *Beyond grief: A guide for recovering from the death of a loved one*. Oakland: New Harbinger Publications, Inc.
- Stern, E. (Ed). (1985). *Psychotherapy and the grieving patient*. New York: Harrington Park Press.

- Stolorow, R., & Atwood, G. (1994). *Intersubjective perspectives*. Northvale: J. Aronson.
- Stroebe, M., van Son, M., Stroebe, W., Kleber, R., Schit, H., & van den Bout, J. (2000). On the classification and diagnosis of pathological grief. *Clinical Psychology Review, 20*(1), 57-75.
- Taylor, S., & Rachman, S. (1991). Fear of sadness. *Journal of Anxiety Disorders, 5*, 375-381.
- Tomita, T., & Kitamura, T. (2002). Clinical and research measures of grief: A reconsideration. *Comprehensive Psychiatry, 43*, 95-102.
- Van der Kolk, B., McFarlane, A.C., & Weisaeth, L. (1996). *Traumatic stress: The effects of overwhelming experience on mind, body and society*. New York: Guilford Press.
- Van Gennep, A. (1960). *The rites of passage*. London: Routledge & Kegan Paul.
- Viorst, J. (1998). *Necessary losses*. New York: Simon & Schuster.
- Volkan, V. (1972). The linking objects of pathological mourners. *Archives of General Psychiatry, 27*, 215-221.
- Winnicott, D.W. (1994). *The maturational processes and the facilitating environment*. Madison: International Universities Press.
- Winnicott, C., Shepherd, R., Davis, M. (1990). *D.W. Winnicott: Deprivation and delinquency*. London: Tavistock/Routledge.
- Worden, J.W. (1982). *Grief counselling and grief therapy*. New York: Springer Publishing Company.
- Worden, J.W. (2002). *Grief counseling and grief therapy: A handbook for the mental health practitioner* (3rd ed). New York: Springer Publishing Company.
- Wortman, C., & Silver, R. C. (1989). The myths of coping with loss. *Journal of Consulting and Clinical Psychology, 57*, 349-357.
- Yalom, I. (1980). *Existential psychotherapy*. New York: Basic Books.
- Zeanah, C.H. (1988). Atypical panic attacks and lack of resolution of mourning. *General Hospital Psychiatry, 10*, 373-377.
- Zerbe, K.J. (1994). Uncharted waters: Psychodynamic considerations in the diagnosis and treatment of social phobia. *Bulletin of the Menninger Clinic, 58*, 3-20.