Practitioner Perspective

A Journey through Grief – Integration of Theory and Practice

By Mary Spring

Sometimes the therapy room becomes a safe environment where the many shades of a client's grieving is released and honoured. As it is counter-intuitive not to mourn loss, it is necessary that the therapist has knowledge of the phenomenon of bereavement and loss and the different models and patterns and is able to distinguish between a client's content and its accompanying process

Introduction

Dying and death are existential truths. We lose people in our lives to death and, someday, we too will die. Grief, bereavement's inescapable companion, enters the therapy room when significant people in the client's life die. Thus, the therapy room frequently becomes a safe haven where present-day and, sometimes unexpectedly, past bereavements are mourned and where feelings, sometimes ambiguous, are released and validated. In this tender place, two hearts meet – the listening heart of the therapist and the listened-to heart of the client.

Because it is counter-intuitive not to mourn loss, it is imperative that the therapist has a knowledge of the phenomenon of bereavement and loss and the different models and patterns and an ability to be able to distinguish between the client's content and its accompanying process. Equally important is the need for the therapist to be familiar with and have explored her or his own experiences of bereavement and loss. This article will examine significant theories that underpin bereavement and loss and explore the journey of grief from the perspective of clinical practice.

Different models and perspectives of grief

Freud's 1917 paper *Mourning and Melancholia* (2005) suggested that the purpose of grief was to withdraw emotional energy from the deceased (cathexis), thus enabling the griever to become detached from the loved one (decathexis). He believed the bereaved person had to work through his or her grief by reviewing thoughts and memories of the deceased (hypercathexis) and by expressing emotions, especially pain and anger. By this painful process the bereaved could relinquish the attachment to the deceased. Unresolved grief was understood to lead to depression.

Without attachment there would be no sense of loss and Bowlby's four Phases of Grief Model (1998) was the first theory based on empirical evidence. It provided a predictive bereavement framework born from an adult person's early life attachment - be it a secure, avoidant, anxious or ambivalent attachment to the principle caregiver. In phase one, the bereaved experienced shock, numbness and emotional distress. This period was then

followed by yearning and searching for the deceased. Despair and disorganisation were experienced in the third phase and then, if the aforementioned three phases were completed, the fourth phase was encountered – this was a period of reorganisation where the mourner let go of the attachment and began to invest in the future and in a new identity (for example, the bereaved person no longer being part of a couple but now a single entity).

Elisabeth Kübler-Ross' five stage grieving process (1969), initially intended to reflect the anticipatory path experienced by people who were dying of a terminal illness, also detailed a sequential model. This framework was later adapted to assist people who mourned the loss of another - not just those who were themselves facing death - and saw the griever experience: (1) shock and denial (the conscious and unconscious refusal to accept the reality of the loss was understood as a natural defence mechanism to protect the griever from being overwhelmed); (2) anger (with self, with the deceased, with others including medical personnel); (3) bargaining ('If only' scenarios are played out in the mind); (4) depression; and (5) acceptance. Significantly, when Kübler-Ross later co-authored *On Grief and Grieving* (2005) with David Kessler, she proposed that "We do not enter and leave each individual stage in a linear fashion. We may feel one, then another, and back again to the first one" (2005, p. 18).

Subsequent thinking in the field of bereavement moved away from the aforementioned predictive models that emphasised the severing of bonds with the deceased and pathologized the loss if one deviated from the model or if one did not "let go" of the deceased and complete the process of survival and recovery.

> *"Grieving is a process of reconstructing a world of meaning that has been challenged by loss"*
>
> *(Neimeyer, Burke, Mackay & van Dyke Stringer, 2010, p. 73)*

Recognising the complexity inherent in grief, each person's journey through the universal experience of loss began to be understood as unique.

Worden's Task-Based Model (2008), rejected what he saw as "a certain passivity" (p. 38) in the stage and phase models. In echoing Bowlby's attachment theory, Worden emphasised the relevance of exploring the nature of the attachment between the deceased and the griever and outlined four tasks for the therapist that worked with the griever: (1) to help the client actualize the loss; (2) to process the client's emotional pain; (3) to support the client in adjusting to a world without the deceased; and finally (4) to support the client in finding an enduring connection with the deceased person in the midst of embarking on a new life.

Rando (2000) posited that anticipatory grieving occurred when there is an opportunity to anticipate the death of a loved one. In the midst of present-time mourning, the bereft is supported to prepare for the loss - this potentially offered the benefits of improving family communication, dealing with unfinished business, reinforcing the reality of the anticipated death, and allowing respectively for the saying of goodbye and the planning for the future without the deceased.

Stroebe and Schut's Dual Process Model of Grief (1999) similarly stepped away from the stage movement in grieving. Instead, it offered a dynamic framework by which the bereaved copes with the loss by oscillating between two hugely different coping processes or strategies: "loss-orientation" and "restoration-orientation" (1999, p. 211-216). The former process - an emotion-focused coping perspective - acknowledges, explores and processes the varied experiences of feeling that accompany loss and the continuing-relocating of bonds. The latter process - a problem-focused coping perspective - reflects "a struggle to reorient oneself in a changed world without the deceased person" (1999, p. 277) and involves adapting to the many external adjustments required by the loss (for example, the bereaved may now need to assume a different role in the family and undertake tasks and duties that were the responsibility of the now deceased).

The social constructivist perspective on bereavement proposed that "grieving is a process of reconstructing a world of meaning that has been challenged by loss" (Neimeyer, Burke, Mackay & van Dyke Stringer, 2010, p. 73). Humans are "inveterate meaning-makers" (Neimeyer, 2006, p. 184) and in experiencing death of a significant other this model encourages the bereaved to make sense of what has visited them, reconstruct meaning and meaningfulness in their lives, and to maintain a continuous bond with the deceased.

Martin and Doka's Adaptive Grieving Styles Model (AGS) (2010) advocated diverse coping strategies for what they saw as different types of grievers. In contrast to previously mentioned paradigms, which saw the expression of emotion as an exclusive mode in grieving, the AGS model proposed four different patterns in grief: the 'Intuitive Griever' expresses and explores grief "in an affective way" (Loc. 278) and benefits from social support that is found in community,

friendship and counselling; the 'Instrumental Griever' expresses grief consciously or subconsciously through a cognitive, a behavioural and/or physical approach, for example in building a seat or a flower garden which commemorates the deceased; the 'Blended Griever' shares the adaption strategies of both intuitive and instrumental reactions and responses. The fourth pattern of grieving is found in the 'Dissonant Griever' who experiences conflict between the experience of grief and its expression.

Contemporary thinking also acknowledged that grief is implicit in the journey of ambiguous loss. As proposed by Boss (1999), ambiguous loss "is the most devastating because it remains unclear, indeterminate" (Loc. 49). Boss suggests that there are two types of ambiguous loss - there is the physical absence of a loved one accompanied by a psychological presence (as in the case of divorced parents or when people go missing) and, secondly, there is the psychological absence of a loved one accompanied by a physical presence (as in the case of a parent who succumbs to a stroke or Alzheimer's) and whose death is silently and anxiously anticipated and grieved long before it happens. In a process that is both complex and unresolved (until it is resolved), ambiguous loss is a death in "slow motion" (Kübler-Ross and Kessler (2005, p. 194).

The journey through grief and loss from the perspective of clinical practice

"So, we live here, forever taking leave," poignantly observes Rilke (1989, Loc: 2850). Perhaps loss emanates from nearly every therapeutic session, nestling within the exploration of life stages, aging, physical decline, change in work circumstances, relationships, separation, divorce, bereavement or children leaving home. Because, it is counter-intuitive not to mourn loss, it is imperative that the therapist has a knowledge of the phenomenon of bereavement and loss and the different models and patterns and is able to distinguish between the content of therapy and its accompanying process. It is equally important for the therapist to have explored her or his own experiences of bereavement and loss and to acknowledge what Jeffreys (2011) gently defines as the therapist's "cowbells" and the therapist's own attachment style in loss, both which stir the countertransference. Questions worth addressing in this context might be:

Prompted sometimes by a word, a scent, a taste, a sound or a touch, frozen memory can re-awaken and the invisible becomes visible

1. If each person has "a history of separations and losses" (Holmes, 2001, p. 14) can the therapist distinguish between the two voices of loss - the client's and their own?

2. Is the therapist "helping" or enabling the grieving client to follow the unique and individual movement of loss and unearth his or her wisdom in loss?

3. Does the therapist offer the mourning client a structured and safe environment to feel, release and contain the grief?

4. Can the therapist respect and celebrate a client's differing cultural and spiritual belief systems regarding death?

5. Is the therapist able to refer the client on to another professional if she or he feels unable to support a person in grief?

6. Does the therapist attend personal therapy - a process that offers the necessary space to explore the therapist's own journey of support?

In *Macbeth,* Malcolm urges the grieving Macduff to "Give sorrow words: the grief that does not speak whispers the o'er fraught heart and bids it break" (4:3. 211-212). In this liminal space of bereavement and loss, and in the telling and retelling of biography, a myriad of emotions of loss, all legitimate and validated, may be uttered - sadness, numbness, disbelief, a yearning to seek and find the deceased, anger, guilt, regret, anxiety, loneliness, fatigue, bodily pain, helplessness, hopelessness, confusion, desperation, emancipation, relief and aching absence. Prompted sometimes by a word, a scent, a taste, a sound or a touch, frozen memory can re-awaken and the invisible becomes visible.

'Seeing' and 'finding' the deceased in living people is part of this grieving, and I am reminded of the tender words of Patrick Kavanagh in his poem *Memory of my Mother:* "Every old man I see/ Reminds me of my father/When he had fallen in love with death/One time when sheaves were gathered". A Gestalt-type empty chair may be used; the client encouraged to directly address the deceased in the first person and in the present tense or speak the imagined words of the deceased.

The client's euphemisms associated with death (for example: "kicked the bucket", "pushing up daisies" and "gone to a better place", are also worth pondering; new metaphors can be created.

Grief can also be voiced and released in other ways, such as in the exploration of dreams, in expressive art, in journaling and in writing a letter to the deceased.

The exploration of a client's felt sense and the accompanying imagery can be revelatory. The client's body always speaks and, very often, unbeknownst to us, speaks from the disowned, the numbed, and lost feeling self. The therapist will be mindful of the client's silence, the breath, the tone, the constricted throat clearance, the power and healing in the escaping sighs, the journeying hands, the folded arms, the rigid pose, the averting eyes, the body's energy or inertia, and so much more. Gently, non-judgemental awareness of the body can be brought to the awakening attention of the client, he or she learning to explore the sense-filled experience and own the intuitive insight and wisdom the body reveals.

"One cannot deal with a loss without recognizing what is lost" (Klass, Silverman & Nickman, 1996: Loc. 897). A client's losses may be many. Recognising this, the sensitive therapist might empower the client to awaken to the primary loss of the attachment, the accompanying secondary losses and the stirring of old losses that yearn to be heard in the present. Surrendering "to the mystery of grief" (Wolfelt, 2003, Loc. 1373), the fragmented self can be found in the response to questions such as "What do you miss about - ?", "What do you not miss about - ?", "What have you lost?" and "What do you mourn that never happened in the relationship".

Described by Yalom as "the wound of mortality, the worm at the core of existence" (2008, p. 274), bereavement and loss may awaken existential questions regarding life's predictability, our mortality, our finiteness. In the "temporary secure base" (Holmes, 2001, p. 14) of therapy, the reflective therapist might encourage and challenge the client to forego "our hunger for mastery" (Boss, 1999: Loc. 1043) and see bereavement and loss as an implicit companion in life's continuous journey of transition and change.

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For some, however, death and the journey of grieving is profoundly complex. Lives and families are robbed in the most tragic of circumstances and the loss can be deeply and acutely life-lasting. Consider for example, the sometimes disenfranchised grief, as in death by suicide, death by violence, death of an unrecognised same-sex partner, death of an ex-spouse.

Consider the often, silent grief in still births, miscarriages and abortions. Such pain invariably makes the search for meaning much more difficult. Where there may be an absence or exclusion from formal rites, ritual and symbolism can be respectfully evoked in therapy - the therapeutic space offering a place where the relationship and its loss can be honoured and where "a sense of reconstruction and renewal" (Neimeyer, 2006, p. 186) can be enabled.

The rhythm of bereavement and loss (and consequently the rhythm of therapy) is invariably uneven, unpredictable and unique for each person. Holidays, birthdays, anniversaries, the oftentimes disorientating shift in the family dynamic, and subsequent deaths, potentially trigger an awakening of jagged emotion. Grief does not come to a conclusion. The client will invariably need time to dismantle what Grosz notes as the fantasy and fiction of mourning, that "we can love, lose, suffer and then do something to permanently end our sorrow" (2014, p. 209). The loss remains a loss but is experienced at a different level of intensity as time passes. Freud's evocative reflection (1929), in a letter to his friend the psychiatrist Ludwig Binswanger, who was grieving the death of his eldest son, captures this truth: "No matter what may come to take its place, even should it fill that place completely, it yet remains something else. And this is how it should be. It is the only way of perpetuating a love that we do not want to abandon".

In the milieu of loss, the client's need invariably is 'Is my experience normal?' and, in an affirming response, the therapist may encourage the practice of healthy coping techniques, such as trusting in the healing power of time, resting, seeking re-engagement in routine work, feeling one's vulnerability and expressing the reality and the significance of the loss in various forms.

Personal thoughts

As I reach my 60th birthday, bereavement and loss are constant companions. My first encounters with death or near-death occurred when, as a sick little baby, I spent many months in both Crumlin Hospital and University College Hospital Galway. At times, bereavement and the various hues of loss speak quietly like a zephyr; at other times pronouncing with the volume of thunder. Living, as we all do, in the shadows of leave-taking and loss, and reminded of John McGahern's moving depiction of his continuing bond with his mother who died when he was nine years old: "When I reflect on those rare

moments when I stumble without warning into that extraordinary sense of security, that deep peace, I know that, consciously or unconsciously, she has been with me all my life" (2006, p. 272), I momentarily pause to honour my late mother and father, Mary, the sister I never saw, my good friends Jemma and Jacqui, my fellow-year head John, and Sara, a former pupil.

Conclusion

Theories referred to in this article suggest that there is a journey of grief to travel in bereavement and loss. Early-stage theorists considered a linear, even staccato-like movement, towards negotiating loss and achieving separation and detachment. Newer paradigms and contemporary therapy recognise, not a sequential journey, but a journey that honours the unique pathway of each griever. It is a journey of the heart, the mind, the body and the soul.

Purpose and meaning are found in the tasks that require attention following the death of a loved one. Social connection with others is valued and grief is no longer seen exclusively as a negative life event; instead, it can in time be a transformational experience. The telling of narratives is seen as healing. A continuing bond with the deceased, albeit different from the earlier lived connection, is encouraged - a bond that acknowledges the irreversible nature of death yet also honours relationship and memory. Interdependence in death is sustained and in the words of the poet and mystic John O' Donoghue in his poem *For Grief*: "You will learn acquaintance with the invisible form of your departed".

Within each of us the tension of our impermanence nestles between the inhalation of our first breath and the exhalation of our last breath. Counselling and psychotherapy in loss is a journey of two connecting hearts - the listening heart of the therapist and the bereaved heart of the client. The therapist can be an "exquisite witness" who "enters the sacred space between two human souls" (Jeffreys, 2011, p.3). Here in the unfolding journey of ever-changing life, mystery unfolds in the harrowed heart. Sense can be made of absence and the organic flow that is inherent in bereavement and loss can be embraced. New life-fulfilling identities can emerge - the client awakening to its own innate wisdom and power, and learning, as suggested by Kübler-Ross and Kessler, to "Live with it [the loss], both in the foreground and in the background" (2005, p. 158). The ever-becoming journey continues.

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