

When Grief Is Sitting Before You

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Introduction

A grieving person is sitting before you. Is the presenting issue one that solely deals with the death of a loved one? It may seem there is only one immediate problem. However, there may be others. Various counselling constructs are available to chart a course to reveal more issues than presented. Some techniques, including the use of early recollections, not only enhance the therapeutic alliance, but open a view to a private world beyond the initial presentation of grief, (Clarke, 2002). With these strategies, the counsellor is able to understand the grieving person, through many viewpoints. While grief is universal, it is unique for your patient.*

** NOTE: The descriptive word "patient" is used here, rather than the often-used term "client". Client was used in the nineties; however, "patient" is regaining favor. The author believes that the person before you is suffering from a passage of life that is more like an illness of the psyche, than a life circumstance. No independent study supports this view.**

Overview

A patient may say something like "my mom has passed away. I can't believe this happened ..." or "this is the worst time of my life, why can't I get over it:...", or "I lost my sister over four months ago and I can't stop crying ...". The value and implementation of active listening and curiosity will be explored as a possible opening to the private world of your patient.

Grief is one of the greatest transitions in life. In this article, grief will be explored with specific examples from past and current theories of grief. For example, Alfred Adler, MD, wrote little of grief; however, the psychological structure of his theories blends with newer grief theories. This article concludes with some tips on creating and using a specific, unique clinical plan for your patient.

Stroebe and Walter provide ample proof that grief is idiosyncratic.

Adler: The lifestyle of the bereaved will, in large measure, determine their response to the death.

The term Grief Work Freud coined is used with stage theories to this very day.

Wortman and Silver: Widowers are often treated simply as male widows even though their experience of loss is clearly different from those of women.

Kübler-Ross Never subjected her five stages of grief model to field studies or scientific analysis.

Coleman and Neimeyer: Not all forms of sense making are helpful.

Listening

Listening, where to start? First, listen to the words, their presentation and narrative of meaning. "listen" to the body language that accompanies them. Throughout the ongoing counselling sessions, it is imperative for the counsellor to listen with his or her ears and eyes, remaining open to clues. These strategies will assist in deciphering the real meaning immersed in the language of the patient.

Active listening takes patience and practice. One is required not to interrupt, but to analyze, patiently and in depth, in mere moments, what the patient is saying or, not saying. It is no less important to watch for clues in body language, as it is to take in the words that are spoken. Moving one's feet from in front of a chair to under the chair, more than casually, foot bouncing, as well as self-soothing, where the patient strokes his face or plays with her hair, are all signs of stress. Leaning forwards then backwards or being open with arms and hands are signs of openness to the situation. A patient may go on far-ranging stories, reluctant to be in the present. All of these signs, and subtler cues as well, should be noted as a guide to progress. Active listening is the open door to curiosity.

Curiosity

Be curious as to why this person is sitting before you. What really brought him or her to you? Curiosity is a subject with which many counsellors have difficulty even though it is fundamental to the process of healing. Being a curious, empathetic and interested questioner gives the patient comfort in understanding the counsellor has a caring, yet professional, interest in him or her. It opens up dialogue and brings insight and enlightenment to the patient: the "I get it!" Moment that should reappear throughout the sessions. The active listening and in-depth curiosity of the counsellor also serve to strengthen and maintain the necessary therapeutic relationship between you and your patient.

Grief theories: Old and New

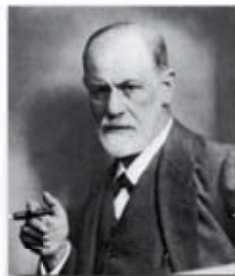
Faced with grief, many counsellors drift backwards to their college days and focus on Kübler-Ross's 1969

book, on death and dying, where she outlined the five stages of someone who is dying. The notion that this construct could be grafted onto the grieving process as a five-stage



experience has been severely disputed. Kübler-Ross never subjected her grief stage model to field studies or scientific analysis.

Grief "stages" are often implemented by counsellors and physicians, as "rules" that must be followed. If not, the assumption is made that the grieving person will not have grieved "properly." Walter (1996) went further and wrote that the rigidity of classic grief theories are flawed in the theory and in the application.



Grief work was a term coined by Sigmund Freud and is commonly incorporated with stage theories to this very day.

Stroebe and Schut (1999), in an in-depth text, make a good case for understanding that the notion of grief work suffers from lack of clarity and absence of clear evidence that it is required for adaptation to grief. In this context, grief work must be considered individually and not universally.

Newer theories that dispute stage theories, no matter how deeply researched are often dismissed as rogues. For example, recent fieldwork indicates it is more like an idiosyncratic roller coaster. Emotions go up and down, back and forth, upside down and eventually find their way back to the beginning. The process will continue yet again, but with subtle or wide distinctions. There is no planned cycle, linear stage, or universal formula. Grief is uncharted and unique: unique, as to attachment style, age, experience, cognitive ability, gender and any past experiences of loss. The grief journey is a lonely, solitary one.

A person's grief is an eye print to that person's view of the world and that person's personality. What we might observe or diagnose as a pattern, may not always be as it appears. There may be love or there may anger and myriad emotions between these two opposite poles. Words not said, and now regretted when it is "too late." Death may be a relief or seem like a curse. There is no "one size fits all."

You may discover that your patient is unable to express grief, as the death was "more than six months ago": that erroneous myth signaling the end of the passage of grief. You may also find that your patient has not dealt with, in some transformative way, a death that occurred many years previously. In these cases there has been insufficient time to "rebuild...the narrative of loss so as to integrate the life story (of the deceased) into a life moving forward incorporating a revised mental representation of the deceased..." (Neimeyer, 2010).

The death of a family member or close friend, not grieved, or only partially grieved, may not lead to the reconstitution or transformation of the grieving person, which would have allowed the deceased to be seen as a distinct memory, yet left behind, so the bereaved may form new attachments. It is the role of the counsellor to help the patient find "an appropriate place for the dead," (Worden, 1991). A continuing sense of the dead person's persona can be the benchmark of healthy mourning as this "gives the bereaved a sense of identity," (Bowlby, 1980).

A modern approach to grief places a strong focus on "meaning and sense making." However, in a new study by Coleman & Neimeyer (2010) it was concluded that unless care was taken, the interview process by a counsellor could serve to only screen for meaning-related distress. They noted that while there can be a crisis of meaning, to the observer, the circumstances of a loss might be deemed not traumatic. Thus, they concluded that not all forms of sense making are helpful.

Attempts may have been made by your patient to make sense out of this loss. In a wide-ranging randomized

study the author conducted over three years, it was rare to find other than broad commonalities amongst those surveyed, despite gender, age, or geographic location. While some evidence was discovered, no conclusion could be reached Clarke (2009). Research by Wortman & Silver (1990) shows that not only do widowers have more negative bereavement outcomes than widows, but also that most surveys are skewed in favor of widows. Therefore, widowers are often treated simply as male widows even though their experience of loss is clearly different from those of women.

As opposed to those such as Freud and Kübler-Ross, who have proselytized "normal categorized grief," Stroebe and Walter (2001) provide ample proof that grief is idiosyncratic where the deceased "live" not just as a mere memory, but as a "selective presence," subject to wide ranges of ebb and flow.

Understanding the foundation of grief from an Adlerian perspective



The Adlerian trained counsellor looks into the purpose of the bereaved. The lifestyle of the bereaved will, in large measure, determine their response to the

death. It is helpful to remember that simply because a person does not process his or her grief as we would want or hope for as counsellors does not mean these people will have future problems (Hartshorne, 2003). This negative assumption leaves no room to look for and respect the unique personality of the patient in all matters.

A proven method for answering any "why" of a presenting problem is to uncover the family constellation (FC) or family system of the patient. Similarly, when a patient's cardinal personality trait has not developed and common sense is lacking, death cannot be perceived as a potential opportunity for self-growth and enhanced community feeling, as it is typically viewed in Adlerian terms.

Another method for uncovering the many "whys" of your patient is through the use of early recollections (ERS), memories of past, early life experiences, as metaphorical statements, and how they reflect the worldview of your patient. The utility of the ER is as a projective technique. Predictive information may be uncovered that supports what has been discovered from an investigation of the FC. The ER is not a diagnostic tool but rather an indication of personality. It reveals the life theme of the patient. It is not for interpretation but as a window into the world of the patient. Selecting and implementing appropriate diagnostic strategies does not lead to a definitive clinical diagnosis, but it does lead to a guiding line of your patient's world, and their mistaken goals of life. Using these and other tools, the counsellor can discover the foundation for their grief response.

Other theories on grief and loss should not be ignored. Eclectically "picking" from proven clinical techniques of other theorists greatly assists in discovering and working with the basic causality for each individual. You may then work through and achieve the goal(s) of the patient. In particular, systems theories closely align with Adlerian philosophy, as do hope and positive psychology constructs. The practitioner is unwise to be obsessed with one theory when other disciplines may serve to better support the patient as they start a new life. Take care when applying your favorite theories to the patient.

Conclusion

Indicate in words and action that you really want your patient to achieve their desired goal.

Active listening and directed curiosity encourage your patients. They help them to be more open to you than previously believed. Openness may reveal undisclosed family or personal information that you may use to gain further insight.

Consider melding grief theories with other theories you value clinically, that suit the life transition of your patient. All theories have some value; however, not all may fit the grief protocol.

Encourage visualizing and attaining small steps to achieve realistic goals. Then build on them.

Although seemingly effective and tempting, resist boxing and labeling grief, by tasks, stages, or phases.

Amend your counselling plan to coincide with greater insight into the patient's world. Pay attention; your patient's world may still be on that roller coaster.

Create an abstract of the previous session, reframe it and ask your patient for comments. This is helpful in bringing the patient back to deal with the current issues that stem from the past. Use the ERS to reinforce progress and change.

Use clear simple, uncluttered language, free from psychological jargon. Common sense should prevail at all times.

Remember, you are the guide, not the "fixer." Your patient takes the journey.



The author's references list for this article is posted online at <http://bc-counsellors.org/jicc-magazine>.

After many years in the practice of family law, Digby Clarke transformed his knowledge of the loss issues in family law into loss issues in clinical counselling. He earned his master's degree in counselling psychology, in 1994, a certificate in thanatology in 1995, and his PH.D. in thanatology in 2009.

Digby maintains a private practice and is a volunteer adjunct clinical counsellor at BC families in transition in victoria. He was the founder and facilitator of hospice based support groups, in southern maine and has recently been selected as a moderator for the cancer community on www.cancerconnect.com, an online network, offering support and encouragement to those dealing with cancer and its psychological effects. Active in funeral service in the usa as a counsellor, he is a trained disaster response team member (MFDA and FEMA).

His popular website can be found at www.drclarkecounselling.com, where he publishes a monthly blog on problems and issues that have common sense solutions.