Death and Bereavement: What Counselors Should Know

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Death, it has been said, is the last stage of development; one we all must face. In doing so the deceased leaves behind the task of grief for the survivors. Training in death education and grief counseling is not typically a part of a counselor's curriculum, yet the odds of a counselor seeing people in various stages of the grieving process are great. Beginning with Bowlby's attachment theory, this article provides an overview of the grieving process and what counselors should know.

Edward Rynearson, in his foreword to the June issue of Psychiatric Annals (1990), told of a client any counselor might encounter. This client was a woman with small children who was still dealing with the death of her husband, which had happened the previous year. She was referred to Rynearson by her physician because of a “pathologic grief reaction.” When she came to therapy, she was feeling guilty because she had been told she was not grieving properly. Upon further investigation, Rynearson learned that her energies were spent doing everything possible to help the children cope with this tragedy. When Rynearson explained what she might expect in the future and gave her encouragement that she was doing well under difficult circumstances, she began to cry and grieve the death of her husband for herself, not just for her children.

Lewis Thomas (1974) wrote in The Lives of a Cell; Notes of a Biology Watcher:

The obituary pages tell us of the news that we are dying away, while the birth announcements in finer print, off at the side of the page, inform us of our replacements, but we get no grasp from this of the enormity of the scale. There are 3 billion of us on the earth and all 3 billion must be dead, on a schedule, within this lifetime. The vast majority, involving something over 50 million of us each year, takes place in relative secrecy (p. 98).

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Not one of us can escape the certainty that grief will live within our hearts at some time during our lives.

In the absence of, or often in addition to, perceived social support, some of the bereaved will turn to counseling professionals to guide them through the most painful moments in their lives (Lenhardt, 1997; Ruskay, 1996; Worden, 1991). Yet, training in grief counseling is not typically part of a counselor's education. This article provides an overview of the grieving process and what counselors should know.

Bowlby's Attachment Theory and ideas on loss and grieving provide a framework for the counselor to use in assessing grief reactions. Using Bowlby's Attachment Theory as a basis to look at the grieving process is in line with the work of a number of prominent grief researchers. J. William Worden (1991), Beverly Raphael (1983), and Colin Parkes (1990) are among the many who have drawn upon his ideas in the formulation of their own theories of grieving.

Attachment behaviors are instinctive behaviors that have as their goal maintaining contact with another individual (in children thereby insuring survival). It is the purpose of attachment behavior to maintain an affectional bond. Situations that threaten this bond give rise to certain very specific behaviors. The greater the potential for loss the more intense the behavioral response (Bowlby, 1977).

Konrad Lorenz (as cited in Parks, 1972) described grief-like behavior in the separation of a goose from its mate:

The first response to the disappearance of the partner consists in the anxious attempt to find him again. The goose moves about restlessly by day and night, flying great distances and visiting places where the partner might be found, uttering all the time the penetrating trisyllabic long-distance call ... The searching expeditions are extended farther and farther and quite often the searcher itself gets lost, or succumbs to an accident. ... All the objective observable characteristics of the goose's behavior on losing its mate are roughly identical with humans (p. 40).

**NORMAL GRIEVING**

Within normal grieving, there is a wide range of behaviors. Clayton, Desmaris, and Winokur (1968) found that common reactions included depressed mood, sleep disturbance, crying, and difficulty concentrating. Worden (1991) expanded the list of normal reactions to include anxiety, loneliness, fatigue, helplessness, shock, yearning, emancipation, relief, numbness, disbelief, confusion, preoccupation, sense of presence, hallucinations, sleep and appetite disturbance, dreams, and overactivity.

It is important to remember that what may be dysfunctional in one individual may not be in another. Conway (1988) describes a son who thought his mother was going crazy. The woman said that on occasion, her husband,
deceased 2 years previously, still visited her at night in her dreams, and that during his visits she found sexual satisfaction. The woman was well adjusted in her work, social, and family life and active in the community. When the son understood that seeing a deceased loved one and sexual satisfaction in dreams are normal, he saw his mother’s experience in a different and more positive light.

**Phases of Grief**

A death loss is a disruption in the attachment bond a person has with a significant other in his or her environment. As such, the system must reorganize to a different level and that process generally follows in four phases (Bowlby, 1980).

Phase I is characterized by emotional numbing and an initial disbelief that the death has actually occurred. This usually lasts from a few hours to a week and may be interrupted by outbursts of extreme emotion.

Phase II includes yearning and searching. Survivors may be restless, preoccupied with thoughts of the deceased, and prone to initially interpret events (phone ringing, door opening) as coming from the deceased person. Crying, calling to the person, and paying attention to stimuli that suggest the presence of the person are also common. Bereaved persons may or may not be aware of their yearning and searching.

Phase III is the experience of disorganization and despair. It will become apparent that attachment behaviors that were effective in maintaining the attachment bond while the deceased was alive are no longer working. The bereaved person begins to wonder if any part of their subsequent life is salvageable.

Phase IV involves a greater or lesser degree of reorganization. Now that the bereaved individual has come to a realization that life must go on, various changes may begin to take place. Thoughts of the deceased begin to take a different place in the bereaved’s life. Social relationships and responsibilities may also be changing to accommodate a world without the person who was lost.

It should be understood that grief is fluid and most people do not begin with stage one and proceed in an orderly fashion to completion. There is a great deal of movement among and within the stages.

**The Experience of Grief**

In addition to Bowlby’s phases, Westberg (1962) describes ten fairly common experiences for people in grief.

1. **Shock.** The shock of death is to be expected even after a long terminal illness and months of anticipatory grief. People often describe the first few
weeks of grief as having been on auto-pilot. There is little actual memory of specific details, merely the knowledge that one did what had to be done.

2. Emotional Release. It is not uncommon to see intense emotional release at the time of the death, and then have it seem to dry up for a number of weeks. When the shock finally dissipates, the bereaved will often find strong emotions such as anger, fear, remorse, and extreme loneliness.

3. Depression. Depression adds feelings of helplessness and hopelessness to already existing emotions. There may be fears of suicide from friends and family, but the bereaved will usually express it as, “I won’t do anything to myself, but if death comes for me tonight I won’t fight it.”

4. Physical Symptoms of Distress. This is a very common phenomenon, especially in children. If the deceased died of a heart attack, the survivor(s) may experience tightness in the chest, pain radiating to the jaw and down the left arm, and other symptoms associated with a heart attack.

5. Anxiety. The bereaved experience vivid dreams, waking and sleeping, in which they see and or hear their loved one. There is also spiritual anxiety that is expressed as: Where is my loved one now? Is he or she happy? There is also the fear that the anger being felt toward God will bring about punishment in the form of additional losses.

6. Hostility. Anger usually surfaces 6 or 8 weeks after death. This rage is sometimes random; sometimes specific. God, medical professionals, clergy, and the deceased are frequent targets. Usually the individual is confused by the intensity of the anger, seeing it as inappropriate, but feels unable to defuse it.

7. Guilt. Guilt is sometimes real, often imaginary or exaggerated. Death amplifies whatever problems existed in the relationship and little issues that were virtually ignored in life are now insurmountable obstacles for the survivor. The should’s seem to rule the world of the bereaved (I should have done this; I should not have done that).

8. Fear. Fear wears many faces with the bereaved. There may be a fear of sleeping in the same bed or room. There may be a fear of leaving the house or of staying in it. People are afraid of aloneness which comes after a death. There is a fear of never knowing joy again or not being able to laugh without guilt.

9. Healing Through Memories. The bereaved’s memories fluctuate between good and bad. At times it seems that there is a need for self-punishment and so all the negative aspects of the relationship are resurrected and relived. The happier moments often seem too painful, and it may take many months before these can be faced, but there is healing in remembering.

10. Acceptance. There is a difference between accepting the reality of death, (thereby letting go) and forgetting the person who has died. As with the healing of any serious wound, there will always be a scar to remind one of the injury. With time will come a lessening of the pain, until finally the injury can be touched, remembered, and accepted as a new part of the life being lived.
Within the grief experience there is a continuum of behaviors for the person who is grieving that ranges from normal to abnormal or dysfunctional. In differentiating normal from abnormal, it is important to note that grief contains the emotional illusion of regression. In this illusion, movement appears to go backwards when in fact movement is forward. At worst usually one is merely standing still. As long as the grieving process is not dilated or interrupted there is progress.

**FACILITATING THE NORMAL GRIEF EXPERIENCE**

A concept helpful to both the mourner and the caregiver is that of the tasks of mourning. The mourner’s awareness of these tasks of grief work can give a participative, action-oriented outlook to the experience of grief as opposed to a perception of grief being a phenomenon that is experienced in a passive manner. This also provides a framework for outlining a significant portion of the helper’s role.

**Tasks of Mourning**

The first task of mourning is to experience and express outside of one’s self the reality of the death (Lindermann, 1944; Parks & Weiss, 1983; Worden, 1991). This involves confronting the reality that the person has died and will not be coming back.

Questions to ask yourself as a counselor working with the bereaved: Where is this person in terms of confronting the reality that their loved one has died? Do I need to respect this person’s need to avoid the full reality of the loss for a period of time while attempting to help him or her cautiously confront this new reality?

The second task of mourning is to tolerate the emotional suffering that is inherent in the grief while nurturing oneself both physically and emotionally (Parks & Weiss, 1983; Shuchter & Zisook, 1990; Worden, 1991). The thoughts and feelings (pain of grief) resulting from this encounter with death must be absorbed.

Questions to ask yourself as a counselor working with the bereaved: Has this person allowed himself or herself to experience the pain of grief? If so, with whom has he or she shared the grief? Was the person provided with a sense of feeling understood in the expression of grief?

The third requisite of mourning is to convert the relationship with the deceased from one of the presence to a relationship of memory (Linderman, 1944; Parks & Weiss, 1983; Rando, 1987, 1993; Ruskay, 1996; Sable, 1991; Worden, 1991). This requires the bereaved to develop a new relationship with the deceased. The mourner works to modify and detach.
the emotional ties to the person who has died in preparation to live in an altered relationship with the dead person. The mourner should not be expected to relinquish all ties to the person who died. However, an alteration of the relationship must be accomplished.

Questions to ask yourself as a counselor working with the bereaved: Where is the person in the process of converting the relationship from one of presence to one of memory? Is the bereaved resisting any change in viewing the relationship as one of presence? If so, what contributing factors may be influencing this (i.e., nature of the relationship with the deceased, personality of the deceased or of the bereaved). Does the bereaved think he or she must give up all forms of bonding with the deceased?

The fourth task of mourning is to develop a new sense of self-identity based on a life without the deceased (Lindermann, 1944; Parks & Weiss, 1983; Ruskay, 1996; Worden, 1991). Role confusion involves the struggle between the we and the I and fears associated with one's new autonomy.

Questions to ask yourself as a counselor working with the bereaved: Where is the bereaved in the process of forming a new self-identity? Is time a factor that is influencing where this person is currently? What are the role changes that this person is experiencing? Are role models of persons who have gone through similar experiences available to the bereaved?

To complete the work one must relate the experience of loss to a context of meaning. The bereaved will typically question his or her philosophy of life and values in seeking an answer to the question Why? As Nietzsche said, “it was not the suffering that was his problem but that the question was wanting to the outcry, Why the suffering?”

Questions to ask yourself as a counselor working with the bereaved: Where is the person in the process of relating the experience of loss to a context of meaning? What were the persons religious and philosophical beliefs about life before the loss? How has the loss altered these beliefs? What is standing between this person and acceptance of their fate?

Time and the Grief Experience

Time, like the stage of grief, is fluid. People move within the stages quickly sometimes going back to the first hours, and then jumping well ahead of where they actually are feeling as though they have finally finished resolving their loss. The following is a descriptive guide based on the experience of the author working with survivors of a loved one's suicide.

During the first 48 hours the shock of the death can be intense, and denial is often strong in the first hours. However, the initial emotional response can be frightening to the bereaved as well as to friends and family members.
During the first week, the necessity of planning the funeral and making other arrangements usually takes over and the bereaved may function in an automatic or robotic manner. This may be followed by a feeling of letdown and emotional and physical exhaustion.

In the 2nd through 5th weeks there is a general feeling of abandonment as family and friends return to their own lives after the funeral. Employers often expect the bereaved to have recovered and to be fully functional on the job. The insulation of shock may still be in effect, and there may be a sensation of "well this isn't going to be as bad as I first thought."

It is during the 6th through 12th weeks that the shock finally wears off, and the reality of the loss sets in. Emotions range widely and the bereaved feels out of control. Family and friends are often not supportive and think, "that was 3 months ago, why are you feeling bad now?" Experiences during this time may include radical changes in sleep patterns, onset of fear (sometimes paranoia), changes in appetite with significant weight gain or loss, extreme mood swings, changes in libido, periods of uncontrollable weeping, desire for isolation, inability to concentrate or remember, and an increased need to talk about the deceased.

The cycle of good and bad days begins during the 3rd and 4th months. Irritability increases and there is a lowering of the frustration tolerance. There may be verbal and physical acting out of anger, feelings of emotional regression, and an increase of somatic complaints, especially flu and colds, as the immune system is depressed.

Depression sets in as the 6th month anniversary approaches. The event of loss is relived and the emotional upheaval seems to be starting all over again. Anniversaries, birthdays, holidays are especially difficult, bringing about renewed depression.

The first anniversary of the death can be traumatic or the beginning of resolution. This will depend on the amount and quality of grief work done during the past year.

Eighteen to 24 months is the time for resolution. The pain of separation becomes bearable, and the bereaved is able to proceed with the living of his or her own life. There is an emotional letting go of the deceased, a recognition that, while the person will never be forgotten, the pain of his or her death will no longer need to be the focal point of the life of the bereaved. It is during this phase that the terms bereaved and grieving are eased from the vocabulary, and the process of living begins in earnest.

Grief and mourning are uniquely individual processes, and no one has the correct timetable for their completion. The process of healing may take a year or it may take a lifetime. Whatever the time, the bereaved should not have to travel alone.
PATHOLOGICAL GRIEVING: ABNORMAL GRIEF RESPONSE

Mourning is the outward expression of grief and is best dealt with in social settings that provide the bereaved with support and reinforcement in their reactions to the loss. Worden (1991) cited three social conditions that tend to give rise to complications in the grieving process: the loss is socially unspeakable (e.g., suicide); the loss is socially negated, meaning the person and those around him or her act as if no loss had occurred (e.g., abortion, miscarriage); and the absence of a social support network (e.g., isolation that occurs after the loss when everybody disappears).

Horowitz defined pathological or abnormal grief as the intensification of grief to the level where the person is overwhelmed, resorts to maladaptive behavior, or remains interminably in the state of grief without progression of the mourning process toward completion. It involves processes that do not move progressively toward assimilation or accommodation but, instead, lead to stereotyped repetitions or extensive interruptions of healing (Horowitz, Wilmer, Marmar, & Krupnick, 1980, p.1157).

Much of the bereavement literature looks at age, relationship to the deceased, and a variety of other situational factors (Campbell, Swank, & Vincent, 1991; de Vries, 1997; de Vries, Davis, Wortman, & Lehman 1997; Grad & Zavasnik, 1996; Rando, 1987; Rubin & Schechter, 1997; Scharlach, 1991). Research (de Vries, 1997; Worden, 1991) suggests that complicated bereavement has to do with four primary factors:

- Relational factors
- Circumstantial factors
- Historical factors
- Personality factors

Relational factors, according to Worden (1991), define the type of relationship the person had with the deceased. The most frequent type of relationship that hinders people from adequate grieving is one involving extreme ambivalence coupled with unexpressed hostility (Grad & Zavasnik, 1996; Rubin & Schechter, 1997). Worden (1991) noted that highly narcissistic relationships, where the deceased represents an extension of the bereaved, necessitate confronting a loss of part of one's self, thus making for complications. He also saw highly dependent relationships difficult to grieve. In this type relationship, the bereaved loses the source of strength that has sustained her or him. The result is an overwhelming sense of abandonment and helplessness. The sense of helplessness and loss of self-concept tend to overwhelm any other feelings including any feelings related to healthy grief (Horowitz et al., 1980).
Circumstantial factors surrounding a loss may preclude or make completion of the grieving process difficult or impossible (de Vries, 1997; Worden, 1991). Uncertainty of the loss, not knowing if a person is truly dead precludes accurate grieving (e.g., missing children, soldiers who are listed missing in action, or disaster victims whose bodies are not recovered). Where no concrete evidence of death is found, mourning can be unresolved. Situations where multiple losses occur (e.g., Oklahoma City bombing) can make grieving difficult if not impossible, due to the sheer volume involved. Where there are multiple losses in close proximity, it becomes easier to shut down completely.

Historical factors. People who have experienced complicated grief have a higher probability of having complications again (Worden, 1991). Additionally, past losses and separations have an effect on current losses and separations and the capacity for future attachments. History of mental illness can predispose one to complications that prevent adequate grief response.

Grief resolution requires the experiencing of universal feelings of helplessness in the face of existential loss. Worden (1991) notes that personality factors are related to how well or poorly a person copes with emotional distress. Inability to tolerate extreme emotional distress related to bereavement leads to defensive withdrawal and can short circuit the grieving process resulting in an abnormal grief response.

SUMMARY

When the attachment bond is broken, people experience grief. Grief is a normal and universal phenomenon that requires everyone who experiences it to reevaluate and reorganize their attachments to significant others. Bowlby posited that reorganization of attachments progresses through four phases. Within these phases can be identified common grief experiences or behavior patterns generic to all who experience disruption in attachment bonds. However, the duration of the phase and/or intensity of the experience differs from person to person, depending on a number of influencing factors. It is the nature of the influencing factors, duration of the phase and the duration/intensity of the experience that helps differentiate normal from abnormal or pathological grieving.

Reorganization and resolution of the grieving process requires time and successful completion of the tasks of mourning. Phases in the grieving process coincide with tasks related to their resolution. Tasks of mourning connote an active process empowering the bereaved to take control of an otherwise uncontrollable circumstance. However, grieving is not a linear process. Vacillation back and forth in and among the phases
and related tasks is expected. This movement may create the emotional illusion of regression which is usually just that, an illusion. No two people will grieve the same way. Each grief experience represents the bereaved’s unique combination of factors, movement through and between phases, and individual history.

Grief counseling presents a unique challenge to mental health counselors. Recognizing what behavior or experience might be expected at a given time in the grieving process allows the counselor to anticipate, understand, and respond in a therapeutic manner.

REFERENCES


