



**Mindful**  
Continuing Education

# Understanding Grief And Loss



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## Introduction

Unfortunately, there is no way to escape suffering. Suffering is a normal part of the human experience. It is difficult and requires coping skills that many of us were not taught as young people nor did we inherently know. Mental health professionals are helping to support individuals in their experience with grief and loss.

This lesson provides an overview of grief, looks critically at both normal grief and complicated grief, and offers mental health professionals tools to utilize with their clients during the process of navigating and healing from grief.

## What is Grief?

Grief is a natural reaction that occurs after someone experiences loss (American Counseling Association, 2020). While it is most commonly thought of to occur after a person experiences a death, it often occurs after a person loses a job, ends a relationship, loses a home, or any other situation that causes sudden and unexpected change. People who experience the most grief typically do when a situation occurs that they were not prepared for. For example, someone who has been watching his/her aging parent pass away after a long life may experience less grief than someone who loses a parent young in life when it's unexpected.

Many people who experience grief seek support through mental health counseling, psychiatry, or other mental health professionals to best cope with and be supported during grief.

## *Symptoms of Grief*

Grief is a personal experience that will change depending on situations. Even how individuals grieve one loss will be different from how they grieve the next loss in their lives. The grief experience can change based on the type of loss, the relationship to the lost individual or experience, and the general status of a person's life when they experience loss.

As a mental health professional, it is important to be able to recognize the symptoms of grief. They may be easily masked as anxiety or depression but the treatment and healing process of grief is different than these disorders. The mental health professional should engage in a thorough assessment when identifying grief.

**Common symptoms of grief include the following:**

- Feeling numb, shocked, or disassociated (NHS, 2020)
- Feeling overwhelmed with sadness and despair
- Crying
- Feeling exhausted by the world and tired, even without having been very active

- Feeling angry towards the loss. Anger is often directed at the person who is most easily to “blame” for the loss
- Feeling guilty. Guilt is a very common symptom of grief that presents typically after a person was angry about the loss. It also occurs when looking back at the behavior a person had before the loss occurred. For example, if someone’s parent died, the child may look back and regret a previous conversation or action that no longer seems appropriate. This can often occur even when past behavior was appropriate. Individuals might feel guilt for setting a boundary that needed to be set at the time but may now be devastated because they think they could have or should have spent more time with that person before the loss occurred (NHS, 2020).
- Physical symptoms such as nausea, fatigue, sickness, weight changes, pain, night sweats, heart palpitations, and insomnia are common (Ackerman, 2020)

Symptoms of grief may come and go at both appropriate and expected times and in unexpected moments.

### ***Normal Grief vs. Complicated Grief***

As mentioned above, there are different types of grief. They are outlined below:

#### **Anticipatory Mourning**

This type of mourning occurs when a person or family is expecting death to occur (National Hospice and Palliative Care Organization, 2020). They can prepare and seek support from a variety of sources before death occurs and during the process. People will use strategies such as imagining their life without the person alive and imagining how they will manage or cope. They do this before the death occurs so that when it does happen they are already somewhat prepared for how they will experience the grief that follows. There will still be difficult feelings that occur during anticipatory mourning. It should not be assumed this will be easy - this will still be difficult for anyone experiencing it. Feelings of concern for the dying person will come up that need to be navigated. Because anticipatory mourning can be a long process (weeks or months), grief will be complicated by the time constraints and conflicts that will arise for the family member or friend who is beginning mourning. For example, most people cannot take a month off of work or away from parenting small children to be present with their dying loved one all the time. Additionally, people may feel as though they have “unfinished business” to navigate. Examples of this include coming to a resolution over a longstanding issue or supporting the family member to finalize his/her living will.

#### **Sudden Loss**

This is the kind of loss that prompts unexpected grief. This grief cannot be anticipated ahead of time. The unexpected loss typically overpowers the coping skills that a person had prior and therefore makes it very difficult for him/her to cope with the experience. The result of sudden loss is most often a severe feeling of being overwhelmed as well as the inability to function at the same level as the individual was prior to the sudden loss. The grief from this specific type of loss may take much longer to process and heal from as compared to anticipatory loss.

## Complicated Grief

This kind of grief occurs when a person does not transition through the grief cycle as anticipated or expected. Their grief is prolonged and significantly impacts the individuals' functional abilities. For example, they may lose their jobs or a relationship because of the difficulty in just functioning as normal adults. The individual's behavior, thoughts, and feelings will be consistently impacted over time and will likely not improve without the added support of mental health services (National Hospice and Palliative Care Organization, 2020). It is estimated that approximately 7-10% of people struggle with complicated grief (Marshall, 2020). It is more likely for individuals who are in the military or parents who have lost children to experience complicated grief. It is suggested that women are more likely to experience the symptoms of complicated grief than men are. Men are more likely to grieve acutely but not as consistently over time as compared to women.

People experiencing complicated grief have biological experiences different from those with normal grief. Their bodies create higher levels of cortisone, also known as the stress hormone. They also tend to have an imbalance in oxytocin, which promotes bonding. Finally, their reward systems fire more often than others. Perhaps because they are yearning for relief (Marshall, 2020).

### *Grief Case Studies: Anticipatory Mourning*

Joshua is a 15-year-old boy who is a freshman in high school. He has been working with a mental health therapist for the past three years because his mother has breast cancer. She has undergone several procedures over the last few years for cancer. At one point she was in remission but two years ago her cancer came back and the doctor reported it was spreading to other areas of her body.

Joshua and his mother are very close. They have always enjoyed spending time together in the outdoors and have similar interests in music and movies. Joshua has been devastated over the future death of his mother and his father has had him in therapy for almost two years because of this.

Joshua's mother is coming close to the end of her life. She has been placed in hospice care and is at a local hospice facility. She is no longer residing at home. Joshua visits his mother several days per week and is enjoying spending their final time together. He is watching her suffer and this makes him very sad. There are moments where he wishes for her suffering to end because he sees how much pain and sadness she is experiencing.

In therapy, Joshua is processing these feelings. His therapist is very supportive and kind. They have developed a cope-ahead plan for how to navigate his mother's death. His mother wants to be cremated. Joshua plans to have her ashes spread with his father on one of their favorite family hiking trails. He plans to continue to watch their favorite shows with his father as a way of staying connected to his mother. At first, he found discussing these things really difficult and even morbid in therapy, but now he is comforted by the fact that he has a clear plan for the future after his mother dies.

Joshua also knows how to get in touch with his mental health therapist on an emergency basis when his mother does pass away because she is near the end of her life, and while he sees the therapist weekly, he wants to be able to get in to see him right away after her death.

Joshua reports: “I feel like I’ve been grieving my mom dying for two years now. I’m ready when she’s ready because I know I’ll see her again someday and I know she doesn’t need to hurt anymore. Of course, I wish I had more time with her, but I’ll always love the time that we did have together and I know how I will celebrate her when she’s not here anymore.”

Joshua’s case is a good example of anticipatory mourning.

After his mother died, Joshua followed the plan he developed with his therapist. As an adult, he looks back on this time in his life with gratitude for the careful planning that occurred and feels no guilt or shame about how everything happened. He only has joy for the years he did get to spend with his mother.

### ***Grief Case Studies: Sudden Loss***

Jamie is a 45-year-old woman who was married for 22 years. Her husband, John, recently left her for another woman. Jamie thought that they were perfectly happy in their marriage and was shocked by John’s decision to leave her. Jamie’s grief is more complicated by the fact that John and Jamie could never have children together but that John’s new partner is now pregnant. Jamie is devastated by the loss of her marriage and feels such shame. She does not want to tell any of her friends, family, or coworkers.

Jamie begins to drink alcohol often. She feels sadness every day and depression on most days. Before her divorce, Jamie was an avid runner and biker. Now she finds it difficult to leave her house to go grocery shopping, let alone to bike or run. She knows she needs to move on with her life but she is so overcome by the grief related to the end of her marriage that she has no clue how.

After six months of trying to cope alone with little success, Jamie finally decides to see a mental health therapist. Jamie’s therapist teaches her about grief after long relationships and she realizes that she isn’t crazy but that she is mourning the loss of her marriage. She begins to process her grief in therapy through Cognitive Behavioral Therapy (CBT) and realizes that her initial thoughts about the end of her marriage were that the divorce was her fault because she was not able to get pregnant. After several months in therapy, she can retrain/reframe her thoughts to be that her marriage was not successful because her ex wanted something different and that was okay. She also reframes the thought that she wasn’t good enough, which caused the loss, to the realization that he wasn’t able to live a life consistent with her values, and that is why he cheated.

After two years of processing her grief and depression in therapy, Jamie finally feels ready to date again and feels a true grasp on her grief. She no longer misses her ex daily and she believes that she deserves better than someone who cannot maintain the monogamy that she wants in a relationship. Several years after her divorce and after feeling much more confident in herself than she did even in her

previous marriage, Jamie meets someone kind and loving who also wants to practice monogamy. This is very important to her. Together they adopt a child and Jamie is grateful for the direction that her life has gone, despite how different it was from the plans that she originally had for herself.

Looking back on her therapy and grief, Jamie acknowledges that the grief turned into depression and she wishes that she would have gone for support from a professional earlier. Regardless of this, she is happy that she received the support she did and overall feels confident that she can manage discomfort and sadness much better than before.

### ***Grief Case Studies: Complicated Grief***

Emma is a 34-year-old parent of three. She has a 15-year-old, a 12-year-old, and a 5-year-old child. Her life has been generally comfortable and pleasant. She enjoys parenting and her second marriage is very safe and comfortable. Things had been going very well for Emma and her family until recently. Emma's 15-year-old son, John, died by suicide a few months ago. Emma's grief is complicated and her life feels out of control.

John had not been showing any signs of depression, anxiety, or planning for suicide before he died. It was another regular day in their household when Emma found John dead in the morning with a suicide note left on his bed. John admitted in his note that he is gay and does not feel safe coming out of the closet and cannot live with fear and depression anymore. He said he was so very sorry for his family, especially Emma, but that he couldn't live anymore.

Emma went from being a happy stay at home mother to a woman with significant depression overnight. In the last few months, her life seems to have spiraled out of control. She had her 12-year-old go live with his father and stepmother and Emma's husband has been primarily caring for her 5-year-old. She hasn't left the bed in weeks and experiences severe guilt, anxiety, sadness, and shame daily. She even contemplates suicide for herself occasionally. Emma's grief is compounded by the fact that she had thought perhaps that John was gay but had never asked him. In her mind she feels that had she asked John about his sexuality and if they had an open conversation about it, he would have never ended his life.

Emma's husband is so concerned about her health and safety that he's asked her siblings to come to visit her to discuss the possibility of going into inpatient treatment for depression. He does not feel that he alone could convince Emma to go to treatment and he isn't sure how to manage their household on his own without her help as he owns a business and works over 40 hours per week but now has to operate his business from home to care for their five-year-old, who is not yet in daycare or kindergarten.

Emma's family agrees and they decide to have a kind of intervention with her. Emma, who is so severely depressed, agrees to go to treatment. She honestly chooses to go to get away from her household but eventually realizes that her grief was so complicated and she did not have the skills to process her child's suicide. Emma attends two months of inpatient therapy and six months of an intensive outpatient program afterward. For the next few years after that, she joins a group

of parents who have all lost children to suicide. She finds a community of people here who understand and can provide support.

Three years after John's suicide, Emma begins to participate in her household again in a way that she was before John's death. She realizes that life will never be the same and she mourns John still, but she has coping skills and tools to navigate the daily sadness and grief that occurs still. Emma and her two children are closer now than they have been in the last few years because she engaged in treatment and was able to repair the relationship she had lost with them after John's death.

Emma's case is a good example of complicated grief and the extensive process of healing that occurs afterward.

### ***The General Coping Strategies for Grief***

Mental health professionals should teach individuals about basic coping skills for grief. More intensive coping skills are detailed below, however, these are basic skills that everyone should utilize:

1. ***Allowing space and time to feel the loss that was experienced*** - to grieve a person must feel the pain and loss (American Society of Clinical Oncology, 2018). They should allow themselves to grieve without judgment. It is important to cry and even isolate to an extent as this allows for processing. However, too little or too much can become disordered.
2. ***Be patient*** - Trying to speed up the grief process can just confuse or prolong it. It is important to not judge a person's grieving, even if it is longer than what another person might require.
3. ***Talking openly with others*** - Communicating about loss can help promote the grieving process and support individuals to feel less alone and more normal in their grief. People who are best supported in their grief are reassured that they can take as long as they need in the grief and that the supporters will always be there to listen.
4. ***Be creative*** - Creative activities, such as journaling and artwork, can be helpful during grief.
5. ***Physical activity*** - Exercise is often helpful for difficult feelings. Regular exercise can help reduce depression or anxiety that can go hand-in-hand with grief.
6. ***Maintain routine*** - Keeping a normal routine can help prevent isolation or losing effective functioning.
7. ***Connection*** - Staying connected to whatever it is that was lost and caused the grief can be helpful. For example, when losing a parent, people can put photos of the parent around them or their favorite piece of artwork to feel connected to them.
8. ***Get support*** - Accessing support, whether one-on-one or in a group setting, can be especially helpful for individuals. It can provide comfort, guidance, and a

safe place to process difficult feelings (American Society of Clinical Oncology, 2018).

The following are generally not helpful for coping with grief. Mental health professionals should provide psychoeducation regarding these strategies to grieving patients:

1. Do not focus on what cannot be changed and instead put energy into healing tasks (NHS, 2019)
2. Do not tell yourself that nobody understands - they might not understand the exact situation that the patient is experiencing, but everyone knows pain to some degree
3. Do not use alcohol, drugs, sex, gambling, or other reckless and unsafe activities to attempt to reduce difficult feelings
4. Do not take on other life changes during grief if possible - try to avoid high-stress transitions and situations when grieving (NHS, 2019)

## Research On Grief

### *Stages of Grief*

There have been many different ways that professionals think about grief. Most notably, perhaps, were the five stages of grief identified by Elisabeth Kubler-Ross in her 1969 book *On Death and Dying* (Marshall, 2019). Elisabeth identified the grieving process as having five main stages. She concluded this through years of research. The stages are defined as follows:

1. **Denial** - in this stage people most often avoid their feelings (Gregory, 2020). They are confused and shocked by the loss they are experiencing and they may experience a great amount of fear. People most often feel denial as a way of coping. They become numb so that they can continue to function, whereas if they are hysterical they may not be able to function. They may feel out of touch with reality and this can bother people around them who worry about them or need their support as well.
2. **Anger** - in this stage a person will likely feel frustration, irritation, and anxiety. People often feel and say things such as, “why do bad things always happen to me.” They might have all-or-nothing thinking that presents as feeling like their life is destroyed, terrible, or ‘over’. Anger is a natural response to grief because nobody prefers to experience loss. People often look to anger as well to blame others instead of recognizing accountability toward loss. For many people, anger is easier to feel than sadness or devastation.
3. **Bargaining** - in this stage people will likely have trouble with identifying purpose and meaning in their life. They will perhaps reach out to others with similar experiences to form a sense of community in their grief. They begin to talk more openly about their grief and story. This is often a time when individuals will wonder if they could have changed the outcome that resulted in

their deep sense of loss. For example, a person might wonder “what if I had never gotten in that car, then the accident might not have happened.”

4. **Depression** - in this stage a person will feel overwhelmed, hopeless, hostile, and even engage in isolation from loved ones. People feel empty and struggle to function. For example, they might struggle to get out of bed because the world is too overwhelming to them. People might engage in self-harming behaviors or suicidal planning. This is a period where they will benefit greatly from counseling and support.
5. **Acceptance** - individuals in this stage may feel at peace and begin to explore options after their loss. They begin to feel as though they have “moved on.” This does not mean that they do not miss life the way that it was before the loss but they begin to believe that they will be okay after the loss. Emotions generally stabilize and people can cope effectively. They begin to function again and find some sense of normalcy (Gregory, 2020).

### ***Considerations for the Stages of Grief***

Many people have criticized the work of Kubler-Ross. They have stated that it does not accurately reflect the grieving process for many and that it leaves out important feelings and parts by designating grief to a specific process. Kubler-Ross stated before her death that these general stages are common for people experiencing grief and are not intended to be thought of as a linear process to which a person completely heals after transitioning through the phases.

### ***Four Tasks of Mourning***

Another model to apply to grief and grief work with patients is J.W. Worden’s “Four Tasks to Mourning.” Worden suggested that to heal from grief, a person must go through the following tasks:

1. **Accept the reality of the loss** - generally this includes the functions that occur because of the loss. If someone died, this may include a funeral. If a couple is separating, this may include one of them moving out of their shared living situation. This is when the individual begins to understand the severity of the loss that has occurred. The impact of loss begins to be seen in these tasks, according to Worden
2. **Work through the grief and pain** - in this second stage Worden posits that the individual who experiences loss has the responsibility of beginning to process it. It is acknowledged that this can require a lifetime of work and does not happen all at once, but during this stage, individuals might intentionally begin to talk about their feelings, feel their feelings, and begin to understand the emotions that are experienced
3. **Adjust to life after loss** - in this task, the goal is to adjust to the environment where the loss is primarily felt. This task can take a significant amount of time, depending on the severity of the loss. There will be changes that need to occur in roles often. For example, if a person’s partner died and they were parenting together, the person now has to assume the role of a single parent. This is especially difficult if they were not emotionally prepared for death. Many people have to learn new skills during this period.

4. ***Maintain a connection to what was lost after grief*** - that last task that he identifies is to find a way to remain connected to the loss that occurred while still moving forward with life. This can require creativity at times, depending on the loss that occurs. It is difficult for some individuals to be able to continue to honor the loss and move on with life. For example, if partners who lost their spouse want to eventually date again, they may feel guilt or sadness because they are embarking on another intimate relationship. They want to honor their lost partners while still being able to have love and joy again. Many people choose to celebrate memories and experiences, however, the way that they do this will change person to person and from loss to loss. It is especially different for someone who is grieving a person who died versus a person they simply ended a connection or relationship with. Worden stated that this task was the most difficult and requires the most time to accomplish (WYG, 2020).

### ***Rando's Six R Process of Mourning***

Dr. Rando identified six states to mourning (Frazer Consultants, 2018). They are as follows: recognizing the loss; reacting to the separation; recollecting and re-experiencing; relinquishing old attachments; readjusting; and finally, reinvesting. Dr. Rando identified three emotional categories that the above states were classified into: the avoidance phase; the confrontation phase; and the accommodation phase. The following offers more in-depth information about the model:

***Avoidance phase*** - the main task in the avoidance phase is to recognize the loss that occurred. This is the earliest stage in the mourning process, per Dr. Rando. Reality must be accepted in this stage. After acceptance, a person will transition into the confrontation phase.

***Confrontation phase*** - during the confrontation phase individuals react to the separation. They feel the emotions that the loss prompted. They may experience secondary losses that occur after the initial loss. For example, people may have to move after losing a spouse because they can no longer afford their home. This is a secondary loss. Additionally, they re-collect and re-experience a relationship with their loss. They have memories and experiences that they may remember or tell others about. They do this for the sake of staying connected to the joyful experiences. Finally in the confrontation phase is the task of relinquishing old attachments. This is a task that takes a significant amount of time for most people. According to Dr. Rando, they must accept that life has changed and will likely never feel the same. They begin to process the impact of the loss.

***Accommodation phase*** - in this final phase, individuals begin to identify meaning again. They can move forward and experience joy. This does not mean that they never feel pain or even move back into previous steps/tasks and emotional states. They do as this is not a linear process, but they can feel happiness again, however small. In this stage, there is readjusting that occurs. New roles begin to feel more settled and people have a better understanding of their new responsibilities post-loss. They adapt but they do not forget the loss. Finally, they reinvest their emotional energy. They might begin a new hobby or project. They begin to feel purpose when they previously may not have felt purpose for a long while. Rando described this as “learning to live again.” (Frazer Consultants, 2018)

## ***Parkes and Bowlby's Four Phases of Grief***

Parkes and Bowlby identified four main emotional stages during the grieving process. They are as follows:

1. ***Shock and numbness*** - this is the initial phase they identified (Terranova, 2018). It is marked by feeling numb and shocked by loss as well as the inability to believe the loss occurred. They state that this is a self-defense mechanism to not have to process the loss that occurred.
2. ***Yearning and searching*** - in the second phase the individual who experienced loss has many feelings. They range from anxiety to sorrow, confusion, anger, and despair. Individuals begin to put meaning towards loss in this phase as they yearn for the return of the lost person or situation.
3. ***Disorganization and despair*** - in this phase individuals begin to accept their losses. They accept that reality is now different and will never feel the same. They may feel hopeless and severe sadness. They may become depressed and isolate from individuals and activities they previously enjoyed.
4. ***Reorganization and recovery*** - in this final phase individuals understand that life is different and begin to accept the differences. They adjust to their new normal. While this process is slow, they can see positivity and joy again. They have increased energy and may re-engage in activities and with individuals previously isolated from. While individuals may never truly stop grieving, they state they can be productive, function and feel happiness again (Terranova, 2018).

## ***Continuing Bonds Model***

Previous models and grief theories all proposed the idea that grief generally has a conclusion (Terranova, 2018). For example, the phases or stages identified in the various models above all seemed to come to a sort of conclusion or acceptance. The continuing bonds model states: "this model was conceived to give voice to an expanded view of the bereavement process. The idea that the purpose of grief is to sever the bonds with the deceased to free the survivor to make new attachments. We offer an alternative model based on the mourner's continuing bonds with the deceased." (Terranova, 2018)

The continuing bonds model focuses on relationships that change through loss instead of mourning or "getting over" the loss. This model does not identify any steps or phases. It is not linear. It states that when a person experiences loss, in this case specifically death, the individual adjusts his/her relationship with the person that was lost. They believe that everyone does this in their own person-centered and unique way. The goal is to redefine the relationship so that there is a lifelong bond that continues to exist, regardless of the loss that occurred. This attachment is meant to last forever, to end, or transition away from after loss occurs. They identify the following ways to continue the bond after loss:

- Talking to a loved one still. If the person died this could occur at their grave or a place their ashes were spread
- Keeping things to remember the person by. For example, jewelry or clothing

- Maintaining rituals that were previously held with the individual lost
- Actively remembering the person
- Carrying on that person's legacy by putting a charity together in his/her honor or other acts of memory. For example: having a bench named after the person (Terranova, 2018)

### ***Berger's Identities of Grievors***

Dr. Susan Berger presented another theory on grief in her book *The Five Ways We Grieve* (Terranova, 2018). Berger's grief theory is also a bit different than previous theories that assume tasks or phases to transition through. Berger believes that after loss individuals must rediscover their identities and create meaning. They do this in various ways that she calls grief identities. She believes that individuals can experience different grief identities. They are as follows:

1. ***Nomads*** - Berger states that nomads are naturally emotional people. They feel their emotions intensely and struggle to grasp the impact that loss has on their life as a result of this. She states that "nomads have not had the support necessary to acknowledge their grief and go through the complex, yet necessary, steps of the grieving process. The nomad's challenge is to find an identity that will help them heal from their loss and align with a particular perspective and purpose that suits them."
2. ***Memorialists*** - These individuals work diligently to preserve the memory of the person or thing that they lost. They do so through rituals or traditions. This promotes the ongoing connection with loved ones.
3. ***Normalizers*** - Normalizers will generally transfer the love and attention they had from the person or thing they lost to whoever and whatever else is around them. They will give more time, energy, and value to aspects of their life not previously given. This allows them to feel a newfound purpose. An example of a normalizer is an individual whose family died in an accident and he/she is the only living relative. He/she goes on and has another family after the loss to recapture the love and purpose once felt through relationships with those who died.
4. ***Activists*** - This group of people go on to be extremely active in organizations or acts of service for helping others. They seek to improve communities and lives to create purpose. This is often especially true for individuals who lost someone to a chronic disease or another extremely difficult circumstance. For example, a person who loses someone to suicide might commit his//her time and energy to mental health awareness and suicide prevention.
5. ***Seekers*** - This group of people finds comfort and peace in spiritual, philosophical, or religious beliefs. This helps them create a sense of meaning. It also connects them with members of a community who will generally be welcoming and inviting, which is especially helpful during grief (Terranova, 2018).

## How Mental Health Professionals Can Help Support Patients Who Are Grieving

Mental health professionals can support individuals during grief in several different ways and often in a combination of many of the ways. Generally, this looks like the following:

### ***Treat the Symptoms Caused by Grief (Valdimar, 2020)***

Grief will cause a variety of symptoms that will change from person to person. Most people will experience anxiety, depression, anger, and a variety of other emotional states. These emotions can cause symptoms such as avoiding, isolating, trouble sleeping, trouble eating, difficulties in relationships, etc. Cognitive Behavioral Therapy (CBT) and Dialectical Behavioral Therapy (DBT) can help navigate these symptoms.

### **Cognitive Behavioral Therapy (CBT)**

CBT is one of the most common forms of talk therapy (Healthline, 2020). It is a short-term therapeutic modality that works to solve problems. The goal of CBT is to identify the thought patterns that lead to negative thoughts, feelings, and actions. CBT is an objective process. It identifies specific, measurable, achievable, realistic, and time-limited goals where grief processing is concerned. Generally, once one goal has been met the provider and individual will transition onto another. CBT has many strategies that can help navigate grief:

***Cognitive restructuring*** - This strategy helps individuals to identify their negative thought patterns and the impact of them. For example, a person with grief might believe that everything is terrible and he/she will never feel happy again. The cognitive restructuring will change this thought to be more realistic and less negative. The professional might work to reframe this thought from “nothing will ever be okay again” to “I am not okay now but I don’t know what the future has in store and it likely will have happy moments.”

***Guided discovery*** - This strategy identifies assumptions and factual evidence to either support or not support the thoughts. Therapists often give a new perspective on the negative thought patterns that occur. For example, if someone loses a family member to suicide the therapist might have to offer the perspective that the person is no longer in pain when the person experiencing grief can only think about how selfish it was to end his/her life.

***Exposure therapy*** - In exposure therapy, individuals will have to confront the fears and phobias they have related to the loss. They are slowly exposed to the realities that cause them anxiety or fear. This occurs slowly and overtime as they improve their coping skills.

***Journaling and thought records*** - Writing is a helpful way to process thoughts and emotions. Additionally, tracking mood from day to day will allow the therapist to identify negative symptoms that might require additional support. For example, if a person has suicidal thoughts or serious depressive symptoms every day for weeks, he/she needs to be referred to psychiatry for an evaluation and possible medication management.

**Activity scheduling** - When people are depressed or sad they often avoid activities and people they love. Isolating can escalate the grief process and make it more difficult to heal from because if individuals aren't talking about their feelings they won't realize how normal they are. Scheduling time to do activities, even if a person doesn't want to do them necessarily, can be helpful. By trying to engage in activities that once brought the person joy might ensure that he/she maintains healthy routines and experiences joy once again in that activity when ready to do so.

**Relaxation strategy** - CBT teaches mindfulness, deep breathing, muscle relaxation, and mindful imagery techniques for coping with grief. This helps to reduce stress and improve the sense of control the individual has.

**Role-playing** - As discussed earlier, there are situations where people might have guilt or unresolved issues with the individual or situation that they lost. To process their grief, they might benefit from role-playing out those conversations and situations to successfully transition on and reduce guilt. Role-playing in CBT can help with problem-solving, social skills, and improving communication skills.

**Approximation** - Successive approximation is the process of identifying small steps toward success. Often people feel so overwhelmed in their grief they might feel as though it isn't possible to process or cope with it. They might break this process down into things such as learning new skills they need then creating new routines, then completing trauma therapy, etc. They are more likely to accomplish all of these smaller goals rather than the overarching goal of "processing grief." (Healthline, 2020)

## **Dialectical Behavioral Therapy (DBT)**

Dialectical Behavioral Therapy (DBT) is similar to CBT, however, it focuses less on negative thought patterns and more on changing behavior (Marshak, 2015). DBT is made up of the following components: mindfulness and distress tolerance, which focus on accepting emotions, and emotional regulation, and interpersonal effectiveness, which focus on coping with emotions instead of avoiding them or experiencing maladaptive behaviors. It is extremely common after loss to see individuals struggling with regulating emotions. In this way, DBT can be very helpful for individuals during grief. It's especially helpful for those who are predisposed to being highly emotional.

**Mindfulness** - this focuses on staying in the present moment and letting go of judgments.

**Distress tolerance** - this focuses on not worsening symptoms when in crisis and allowing reality to simply be what it is.

**Emotional regulation** - this focuses on the ability to understand our emotions and change them as needed.

**Interpersonal effectiveness** - this focuses on getting needs met, improving relationships, maintaining relationships, and behaving in a values-driven way.

## ***Help Understand Grief by Providing Psychoeducation (Valdimar, 2020)***

Grief can be very confusing for people. It is especially confusing for young people or individuals experiencing loss for the first time. Psychoeducation regarding the symptoms and grief experience can be helpful. Often a mental health professional might teach the individual about some of the theories assumed about grief that were discussed above. Psychoeducation will help individuals to identify what grief responses they are having and the impact of those responses. Then the mental health professional and the individual can develop a care plan for the best way to process the experiences.

## ***Process Trauma Related to Grief***

Processing trauma is necessary for those experiencing complicated grief. The way people process trauma will be different depending on their trauma, preferences, and their relationship with the mental health professional. The best trauma processing experiences occur between individuals who have established a strong and trusting relationship with their provider. This needs to be an essential component of the work together at first: establishing trust.

Eye Movement Desensitization Reprocessing (EMDR) is one of the modalities used for processing the trauma that comes from grief (American Psychological Association, 2017). EMDR is an intervention to reset emotional pathways, emotions, beliefs, and sensations that negatively occur after trauma. It does so in a supportive and instilling environment that processes trauma through eye movements and bilateral stimulation while recalling the memories. EMDR supports grief by helping the individual begin to feel “unstuck.” The purpose of EMDR is to pass through experiences and therefore have less negative impacts from them after treatment. It supports individual coping abilities and offers them relaxation and meditation practices. It restores the relationship between the body and the mind. Thoughts and feelings are less intrusive and anxious after EMDR. Finally, it gives patients a sense of empowerment and path forward for individuals (American Psychological Association, 2017).

The EMDR process goes as follows:

### **Phase 1 - History taking**

During this phase, the individuals work together to identify goals for treatment.

### **Phase 2 - Preparation**

During this phase, the treatment plan is explained and the client is introduced to the process and plan.

### **Phase 3 - Assessment**

During the assessment phase, the patient is asked to recall the memory and then assess the distress that it causes. This assessment is used to measure progress as the patient gets further into the EMDR treatment. By the end, the memories should be significantly less distressing than they were in the initial treatment

phases. The memories are rated by the Subjective Units of Distress scale: 0 (no disturbance) - 10 (worst possible disturbance).

#### **Phase 4 - Desensitization processing**

During this phase, the client and therapist work together to focus on the memory and use eye movements and bilateral stimulation. As new thoughts emerge during the memory, the therapist and patient navigate them together. The memory is explored over and over with bilateral stimulation and eye movement until the memory is no longer distressing to the level that it was before or barely at all. During this phase, the patients will use body scanning to identify how they physically respond to the treatment and to recalling the memories. The body will respond more significantly when the memories are more distressing. Less distress should cause less physical body symptoms. This is a good way of measuring progress.

#### **Phase 5 - Evaluating treatment results**

The final phase, or the reevaluation phase, occurs at the end of treatment to identify if the effects of the treatment are sustainable for the patient or if he/she should go through more rounds of EMDR to reduce distress even further (American Psychological Association, 2017).

### ***Prevent Future Symptoms Related to Grief***

When individuals are navigating the recovery process from grief a component of the work for the mental health professional is how to safely plan for the future and prevent additional difficult symptoms, if possible. This can be done in many different ways. Medications can be prescribed to prevent serious mental illnesses such as Major Depression. Implementing lifestyle changes such as ensuring the person exercises, eats well, and has strong psychosocial supports will be a protective factor against future negative symptoms.

Some individuals might benefit from going into inpatient or intensive outpatient services to navigate the major impacts of grief. Mental health professionals must consult with other professionals as needed to identify the best plan of care (Valdimar, 2020).

### ***Grief Case Studies: Cognitive Behavioral Therapy***

Jennifer is a 13-year-old girl whose parents recently divorced. She moved with her mother from New Jersey to New York and while she can see her father two weekends a month, she is struggling with the grief of losing every day in-person contact with her friends. Her mother reports that Jennifer is grieving the loss of her previous life and this is complicated by the anxiety of trying to make new friends in the city and navigate a very different pace of life than what she had before.

Jennifer begins therapy after expressing sadness and self-harming behaviors that are superficial but require monitoring. Jennifer and her therapist begin using a CBT model. The first thing that her therapist asks her to do is to monitor her mood in a tracking document. Every day Jennifer identifies her mood on a 1 (depressed) - 5 (experiencing happiness) scale.

Jennifer and her therapist quickly identify a theme. Most days Jennifer has a mood somewhere in the 1-3 range, indicating moderate depression, however on Thursday's Jennifer's mood is a 4-5. Her therapist asks about why and identifies that on Thursday's Jennifer has the opportunity to swim at her local gym for lap swimming.

Jennifer's therapist suggests that she join the school swim team but learns that Jennifer is anxious about joining the team because she does not want to feel like an outsider. Together they develop a plan to engage in conversation with her peers. They roleplay in therapy so that Jennifer feels comfortable. Eventually, she joins the swim team and makes several good friends.

Jennifer eventually begins to feel less sadness and more purpose. She is happy with her friendships and reports feeling grateful she is still connected to her past friends. After one year in therapy using a CBT model, Jennifer feels comfortable returning to life without therapy. She has stopped self-harming and knows that she can ask her mother to return to therapy whenever she needs it.

She no longer feels the depression and her mood is consistently in the 3-5 range. This is an example of successful Cognitive Behavioral Therapy.

### ***Grief Case Studies: Dialectical Behavioral Therapy***

Charlie is a 26-year-old woman who struggles to regulate her emotions. This has been an ongoing struggle for her after the death of her best friend several years back. Her friend died in a car accident and Charlie has experienced sudden loss type of grief. She initially processed her grief with a mental health therapist but the last few years she has had lingering struggles to regulate her emotions.

Every once in a while Charlie will just seem to have what she calls an "episode." In these "episodes" she will yell at people when they ask her questions or she will feel very overwhelmed with her emotions. She isn't able to put a finger on exactly why this happens but she knows it began after her friend's death.

Charlie recently decided to go back to therapy and her new therapist wants to use DBT with her. Charlie agrees. They first implement a daily mindfulness practice. Every day Charlie starts her morning with a body scan and journal prompt. This helps her connect with her body and her wise mind. She begins to notice and name her emotions more easily.

After a month or so of implementing mindfulness, Charlie and her therapist begin to work on taking an adult time out. As a result, when Charlie feels flooded or overwhelmed or experiences the desire to yell at someone, she holds herself accountable for walking away for 20 minutes to calm down before she re-engages in the conversation. During these 20 minutes, Charlie decides to take a walk and perform another body scan. This gives her the chance to calm down. In therapy, she and the clinician also practice naming her emotions and identifying the causes of them. Once she understands her emotions on a more intimate level like this, she begins to behave in a way that is more consistent with her values.

Over about a year in DBT therapy, Charlie is no longer having these “episodes” very often at all. She realizes she hasn’t had one in months. She feels much more confident about her ability to engage with others appropriately and is happy for the work she’s doing. She realizes that the grief caused by losing her friend prompted her to struggle with emotional regulation because she felt so overwhelmed by the loss that these overpowering feelings started to take over her life. By implementing mindfulness practices in her life, she begins to feel calmer and less stressed daily.

This is a good example of DBT being used in grief and emotional regulation work.

### ***Grief Case Studies: Eye Movement Desensitization Reprocessing***

Charles is a 50-year-old man who recently lost his way in a highly traumatic way. He was in the vehicle with his wife when they were hit on her side of the car and she died instantly. Charles held her until paramedics arrived. Charles’ grief has been so very difficult and the traumatic way that she died only adds to that.

Since his wife died, Charles has been waking up several nights per week sweating and crying out for his wife as he dreams of her death. He has not been able to drive a vehicle for several months and has relied on his adult children to transport him to appointments that he needs to attend. He chose to take early retirement after her death because he no longer feels that he can remain employed. Charles feels as though his life is completely out of control and does not know what to do to remain functional. His life feels like one cycle after another of flashing back to the accident in which Charles feels at fault because he was driving. Even though Charles did nothing to cause the accident, he blames himself.

Charles’ adult children have recommended that he undergo trauma therapy. He agrees and meets a trained trauma therapist near his home. He can walk to and from appointments. Together they agree that EMDR is a good plan to address his trauma. While he is hesitant to have to imagine the accident more than he already does, he trusts that his therapist knows how to best support him. Together they utilize EMDR over six months. His assessment shows that he is highly distressed by imagining the accident at first. Over the first two months of using eye movement and bilateral stimulation, his distress units go down by two points. By six months of treatment, Charles’ distress units are down by four points. He feels confident that he may be able to begin to drive again. He no longer has dreams several nights per week about the accident. He has identified a goal of returning to work in the next six months to a year on a part-time basis. He has contacted his long time previous employer and they are excited to have him return.

Over the next few months, Charles and his trauma therapist continue EMDR. He is less triggered by the accident and begins to cope with his wife’s death and new life. On a Saturday afternoon, he decides to try driving with his adult daughter. They drive a few miles without Charles having a panic attack or flashback.

Eventually, Charles can return to work part-time and he has only 1-2 dreams per month about the accident. After waking up from a dream, he now chooses to exercise and practices mindfulness as a healthy way of coping. He feels as though his life is now functional and not completely lacking meaning. He is regularly

driving short distances again. He can take himself to his appointments and drive to his grandchildren's sporting events.

Charles' case is a good example of EMDR being successfully used in grief and trauma work.

### ***Complicated Grief Treatment***

Mental health professionals must support individuals who have complicated grief differently than identified above. Complicated grief causes significant impairments in functioning and therefore requires intensive and focused treatment.

Complicated Grief Treatment (CGT) was designed to promote adaptive coping and resilience (Suicide Prevention Resource Center, 2017). It includes seven processes that mental health professionals and individuals go through. The work is administered in traditional therapy sessions from 45 to 60 minutes in length.

According to research administered in CGT, the therapy is effective in addressing trauma and stress symptoms; improving general functioning and well-being; reducing depressive symptoms; and reducing suicidal thoughts and behaviors. The processes identified are as follows:

1. Psychoeducation about complicated grief and the treatment process
2. Administering assessments and learning about self-regulation strategies
3. Identifying goals for future living
4. Working to re-establish connections
5. Revisiting the loss story
6. Revisiting the way that life was changed through the loss
7. Addressing memories and ways to continue to feel bonded (Suicide Prevention Resource Center, 2017)

### **Self-Care for Mental Health Professionals When Supporting Patients with Grief**

Mental health professionals who work with individuals experiencing grief and trauma should be aware of their health and wellness. Professionals need to take care of themselves to best support others.

Generally speaking, self-care programs should include exercise, healthy eating, engaging in clinical supervision, engaging in activities that bring joy and happiness, accessing educational opportunities to enhance skillsets for navigating grief work, and taking regular breaks as needed (Brickel, 2015).

The following are warning signs for mental health professionals to engage in deeper self-care:

- Spending time working when at home
- Thinking about clients when not at work

- Dwelling on therapy or care plan thinking “I could have done this better” or “I should have done this” or “If I had done this they would feel better”
- The inability to focus on clients when at work
- Noticing a lack of healthy habits when at work. For example: forgetting to eat and being hungry when working with a client

Mental health professionals who engage in self-care in their lives will be more balanced and comfortable when at work. They will see better patient outcomes and feel less responsible for the experiences of the patient. They will understand that patient outcomes are directly related to the work and investment that patients have and not their own ability or inability to engage the patient in the process (Brickel, 2015).

### ***Compassion Fatigue***

Compassion fatigue, which is commonly thought of as extensive burnout, is very common for patients who are doing grief or trauma work. This is because the nature of the work is highly intimate and professionals are engaging with clients during the most vulnerable and often painful moments in their lives. It is essential for professionals to notice their fatigue or burnout and to honor it and address it.

Compassion fatigue is a stress reaction to secondary stress or trauma (GoodTherapy, 2020). It is a result of wanting to help people during significant stress or trauma. Its symptoms include emotional exhaustion, depersonalization, irritability, difficulty sleeping, weight loss, headaches, and poor job satisfaction. People with compassion fatigue have a difficult time feeling compassion, when regularly they would not struggle to do so.

Mental health professionals are at high risk for compassion fatigue if they experience the following:

- Working with patients under severe stress often
- Feeling threatened by patients
- Supporting someone who has been impacted by suicide
- Working with children who experienced abuse
- Specializing in trauma, grief, or bereavement
- Supporting someone who has experienced the death of a child or who has a child who is actively dying

Mental health professionals can reduce the likelihood of experiencing compassion fatigue by implementing the following strategies:

- Reducing workloads that are high stress
- Monitoring sleeping habits and improving them as needed
- Taking breaks and vacations regularly
- Practicing meditation

- Practicing journaling
- Seeking therapy as needed to manage work stress
- Exercising regularly

If a mental health professional is experiencing compassion fatigue, it can be treated by the following:

- Talking about feelings and symptoms with another mental health professional
- Attending clinical supervision
- Learning about compassion fatigue and recognizing it early
- Committing to exercising consistently
- Eating healthy regularly
- Engaging in activities that bring joy regularly
- Sleeping well and often
- Identifying helpful coping strategies and using them
- Reaching out to support groups and professional networks who can offer support

If mental health professionals recognize compassion fatigue in themselves, it is their ethical responsibility to manage and treat it. If compassion fatigue goes untreated, it can significantly impact the services that the professional offers (GoodTherapy, 2020).

### ***Boundary Setting***

Boundary setting is also a necessary part of grief and trauma work for mental health professionals. Boundaries help to provide a sense of personal space in the therapeutic relationship (GoodTherapy, 2017). They act as a buffer to ensure the professionals are not emotionally triggered greatly by the work that they are doing. Boundaries also help to hold patients accountable for their recovery process and ensure that the professional isn't unfairly to blame for progress or lack of progress that the patient makes. Mental health professionals may notice the need to provide boundaries if the following occurs:

- They feel the patient's progress or lack of progress is directly related to their work
- They are willing to accept calls and emails from patients outside of business hours
- They spend excessive amounts of time thinking about their patients
- They feel a desire to become friends with their patients

The boundary setting process can be as follows:

1. Identify what behaviors are acceptable and are not acceptable in the therapeutic relationship - only the therapist can identify preferences and hard limits

2. Identify what causes distress, stress, or resent for the therapist
3. Communicating what is and is not appropriate in the therapeutic relationship to the patient
4. Communicating what will occur if a boundary is crossed in the therapeutic relationship (GoodTherapy, 2017)

### ***Managing Personal Grief***

It is essential for mental health professionals who are doing grief and trauma work to navigate their trauma and grief. Individuals who do this work may need to take breaks at times to process their own traumas and grief to ensure that they do not impact the therapeutic relationships with clients.

There are risks to not managing personal grief as a mental health professional. One risk is that professionals might be compelled to engage in self-disclosure. Generally speaking, self-disclosure should be used as needed and rarely to build trust and strengthen the therapeutic relationship (Bray, 2019). When therapists use self-disclosure too often because they are struggling with their grief or trauma, it can take the focus off of the client and place it onto the professional. This can make the client feel responsible for taking care of the professional and may greatly impact the relationship and healing process. Patients should never feel as though they need to take care of their therapists. If therapists feel as though they should self-disclose, they should ask themselves these three questions:

1. Is the disclosure helpful for the therapy?
2. Is there another way to keep the focus on the client that does not involve self-disclosure?
3. How will the self-disclosure impact the relationship?

Therapists who are self-disclosing regularly may need to navigate their mental health before returning to work (Bray, 2019).

Professionals should notice the impact that their grief and trauma have on their work and take ethical and responsible steps to mitigate any impact it has. That may require the professional to take a break from working and come back when he/she can be whole in the work again. This is okay and to be celebrated because the professional made the best decision not only for his/her own mental health but for the health of the patients as well. If this occurs, professionals should ensure that the patients they are seeing are transferred to other providers who can effectively meet their needs. This continuity of care is crucial.

Most mental health professionals who work in an agency setting will have access to an Employee Assistance Program (EAP). The clinicians that work in EAP programs often have specific secondary trauma and work-related stress training to offer. This is a program to consider when first identifying that work and the professional's personal grief or health are impacting one another.

## ***Grief Case Studies: Self-Care***

Jessica is a grief therapist who works primarily with parents who lose children to chronic illnesses. She has done this work for many years and over the years learned a great deal about herself. She has at times noticed when her mental health is impacted by the work and at other times noticed when she is most energized and excited by the work.

Jessica has a general self-care plan that looks like this: only carrying 10 families at once on her caseload; exercising on Monday's, Wednesday's, and Friday's; meal prepping her food so she always has food for work; attending her clinical supervision appointments two times per month. Jessica has set the standard for herself that she always has an hour in between sessions so that she never has back to back sessions. These are all important practices for her self-care.

Jessica recently noticed that she is working with a family that is triggering her. She does not often feel this way and has chosen to see a therapist to navigate and explore why. She realizes this family reminds her of her own. She is having a hard time separating the mother from her mother and the relationship she has with her own mother.

After a few weeks of really struggling in the relationship, Jessica realizes that to best support this family she feels she must transfer them to another therapist. Jessica, the family, and the new therapist meet to discuss the best way to transfer their case and plan for the future. The family Jessica was working with felt they were better supported by the next therapist and Jessica was able to meet her own mental health needs in the process.

This is a good example of how a mental health professional can practice self-care.

## ***Grief Case Studies: Compassion Fatigue***

Tyler is a mental health professional who works in trauma therapy with children. He recently noticed that he is struggling when he gets home from work. He seems to do well during his workday but when he gets home he's unable to think about anything but work. He struggles to have compassion for his friends, partner, and family because he is giving so much compassion in his workday. Tyler recently started losing weight, isn't sleeping well, and has noticed he's getting sick more easily.

Tyler decided it was time to see his therapist who asked him if he's having compassion fatigue. If Tyler is being honest with himself, he feels he is.

Most of Tyler's work is with young children who have been removed from their primary homes as related to abuse and neglect. Tyler has been doing this work for many years, however recently he has begun taking on more and more sexual trauma cases with children and the work is very emotionally taxing. With his therapist he identifies the plan for caring for himself moving forward, which includes: asking for less sexual trauma cases from his supervisor, taking a full lunch break every day, exercising a few days per week with his partner, and leaving his work phone at work every day so that he cannot check his emails or respond to his patients after hours.

After a few months of this new routine, Tyler's health is much more stable and he feels present and happy outside of work. His relationship has improved, he is sleeping better, and his weight has leveled out. Tyler feels overall healthier than before.

### ***Grief Case Studies: Boundary Setting***

Jasmine is a school counselor. She sees teens who are referred to her when they have family difficulties that prevent them from being fully engaged in school. Jasmine recently started working with Juan. Juan is an 8th grader whose father recently died in a work-related accident. Juan's mother is now a single mother of four who is struggling to support all of her children. Because Juan is the oldest sibling he has taken on more responsibilities at home.

Jasmine has been seeing Juan once per week during his homeroom period for processing and planning to ensure he's still engaged in the learning occurring at school. Jasmine assured Juan that she will be here as he needs support and encouragement and to process his father's death. Recently, however, Juan has begun trying to see her multiple times per week. He is stopping by her office during his lunch and before and after school. It appears that Juan simply likes the validation and compassion that he receives from Jasmine. This is likely because his mother is unable to give him the kind of attention he needs at home right now.

Jasmine wants to support Juan but she has a caseload of other students and she doesn't want Juan to get dependent on her. She realizes that she needs to set a better boundary with Juan about him dropping by her office and trying to miss classes to come to talk with her. Jasmine feels as though a morning check-in on Monday's can be added to her schedule for 15 minutes as well as their regularly scheduled session on Thursday's during homeroom.

Jasmine discusses this with Juan. She assures him that she is here to support him but that she worries he is trying to see her more than she can currently support him and she wants him to try to use his skills for self-soothing before coming straight to her office. She reminds him that during the summer she will not be as available to him as she has been during the school year and she wants to set him up for success and independence. She offers him the extra check-in on Monday's and asks him not to come to see her outside of this and their Thursday meeting unless it is an emergency. Juan agrees and thanks her for reminding him to self-soothe. Together they come up with a list of activities he can do to self-soothe.

Moving forward, Juan is very successful in not crossing Jasmine's boundary and she feels comfortable because he is no longer stopping by and trying to visit as often as before.

This is a good example of a boundary setting for mental health professionals.

### ***Grief Case Studies: Managing Personal Grief***

Rebecca is a new mental health therapist. She is in her first year of practice and still developing her skills. She enjoys providing grief therapy and generally finds it to be a fulfilling focus of her work. She recently experienced the death of her mother, however, and this is making her work difficult. Her mother's death was unexpected and Rebecca is not managing her grief well. Her mother and she had a

tumultuous relationship because of her mother's substance use history and difficulties managing her general responsibilities. There were times that Rebecca had to work as a teenager to ensure they could pay their rent and meet basic needs when her mother was drinking more than normal. Rebecca and her mother have not been very close because of her continued alcohol and drug use, despite multiple attempts to get sober.

Rebecca's grief is making it difficult for her to provide grief therapy to others. She recognizes that she is seeing herself in her patients and that she has guilt associated with her mother's death occurring before that he reconciled their differences.

Rebecca's supervisor approaches her because she can see that Rebecca has been talking more and more in their clinical supervision periods about her grief difficulties. Her supervisor offers for her to transition to working in case management rather than in one-on-one therapy so that she can do her grief processing work. Rebecca initially was upset that her supervisor felt she wasn't appropriately managing her workload, but after a few days of thinking about it, Rebecca was relieved. She realized that she was constantly being triggered at work. She decided to focus on case management work for six to twelve months and engage in her grief therapy.

After the time passes while learning boundary setting and continuing to discuss her grief in clinical supervision, Rebecca feels ready to return to grief counseling. She does so with stronger boundaries, a stronger understanding of her triggers, and a great amount of coping skills for herself.

Rebecca's story is a good example of how to navigate personal grief as a mental health professional when doing work in grief and trauma.

## **Personal and Cultural Dynamics Related to Grief**

Mental health professionals who provide grief or trauma work to clients should have a deep understanding of the different cultural dynamics related to grief. Because mental health professionals work with patients across the lifespan and who come from robust and unique backgrounds, this should be the forefront of the work that they do. Mental health professionals should make it a habit to learn about a person's background, history, and culture when they begin work with a patient. This will shape their care plan because how they view grief, death, and dying will change the treatment process.

There are many different ways to think about the meaning that death plays. In many cultures, death is simply the beginning of a new life that occurs after death (Cancer.Net, 2018). This belief in an afterlife can shape the way that a person heals from grief. In some ways, it can make the healing process more peaceful and less intense. Other cultures believe that individuals who die are simply lived on through their family members and the spirit they hold of that person.

Many cultures enjoy rituals after a person dies that bring them comfort and grief and allow for processing and healing within a family unit. The rituals can provide a

sense of direction and understanding for individuals. These rituals can dictate the following:

- How people are cared for as they are nearing death
- What ceremonies occur before and after death
- How the individual's body is cared for after death (clothing, burial or cremation, etc.)
- If grief is discussed out loud or quietly within family units
- If grief is expressed differently depending on gender or age of the griever or the person who died
- How long the grieving period is expected to last and how people behave during these times
- How people who are dead are honored after their death in the lifetime of the family
- How roles previously held by the person who died are dispersed into the family unit (parenting, remarriage, etc.)
- What emotions are typically expressed during the grieving
- What are the family's beliefs about death
- Who is to attend a ceremony related to mourning
- Are gifts expected to be given after a death occurs (Cancer.Net, 2018)

A mental health professional should learn all of these things to best support the patient. They should also be aware of their cultural understanding and ensure that they are not projecting their cultural expectations and norms onto their patients.

To learn about a patient's culture during the grief process, a mental health professional could ask the following:

1. How did you watch death be handled in your family as a child?
2. What are your personal beliefs about death and how to continue to honor the person who has passed?
3. How can I best support you as a mental health professional in a way that is consistent with your culture and background?

## Overview

Any mental health professional who provides grief or trauma-related work to patients has an ethical and moral responsibility to understand grief and recognize the type of grief the person is experiencing. Once they identify the grief as either normal, sudden loss, or complicated grief, they can effectively plan for the best way to support that person. That could include Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, Eye Movement Desensitization Reprocessing, or Complicated Grief Therapy. Depending on the mental health professional's

training, it could include a variety of other treatment methods. The mental health professional should partner with the patient to identify his/her preferences and ability to commit to therapy because each modality will require time and effort. For example, EMDR must be administered in sessions relatively close together and consistently in order for the desensitization to best occur, whereas CBT can be used less rigidly.

Regardless of the modality identified in grief treatment, the professional should always have a cultural understanding of how to best support their patients and have a personal focus on their health and wellbeing. Culture will impact how the person and their family think about the loss, how to navigate and process the loss, and how to celebrate the loss even after it has occurred. Mental health professionals must honor these cultural impacts and work within them. They must honor their own mental health and grief needs as well to be the most competent and present providers. Self-care, clinical supervision, and managing their difficulties are of the utmost importance.

Grief work is incredibly important in mental health. People who are grieving benefit from support in order to process, cope, and honor the loss that occurred while also regaining the functional abilities that are often lost in grief.

## Sources

Ackerman, C. (2020). *3 grief counseling therapy techniques and interventions*. Retrieved from <https://positivepsychology.com/grief-counseling/>

American Counseling Association. (2020). *Grief and loss resources*. Retrieved from <https://www.counseling.org/knowledge-center/mental-health-resources/grief-and-loss-resources#resources#>

American Psychological Association. (2020). *Eye movement desensitization and reprocessing (EMR) therapy*. Retrieved from <https://www.apa.org/ptsd-guideline/treatments/eye-movement-reprocessing>

Bray, B. (2019). *Counselor self-disclosure: Encouragement or impediment to client growth?* Retrieved from <https://ct.counseling.org/2019/01/counselor-self-disclosure-encouragement-or-impediment-to-client-growth/>

Brickel, R. (2015). *Good self-care for therapists*. Retrieved from <https://brickelandassociates.com/good-self-care-for-therapists/>

Cancer.Net. (2018). *Coping with grief*. Retrieved from <https://www.cancer.net/coping-with-cancer/managing-emotions/grief-and-loss/coping-with-grief>

Cancer.Net. (2018). *Understanding grief within a cultural context*. Retrieved from <https://www.cancer.net/coping-with-cancer/managing-emotions/grief-and-loss/understanding-grief-within-cultural-context>

Frazer Consultants. (2018). *Grief theories series: Rando's six r-process of mourning*. Retrieved from <https://www.frazerconsultants.com/2018/03/grief-theories-series-randos-six-r-process-of-mourning/>

- GoodTherapy. (2017). *Boundaries*. Retrieved from <https://www.goodtherapy.org/blog/psychpedia/compassion-fatigue>
- Gregory, C. (2020). *The five stages of grief: An examination of the Kubler-Ross model*. Retrieved from <https://www.psycom.net/depression.central.grief.html>
- Marshak, M. (2015). *DBT and bereavement: A multiple baseline design*. Retrieved from [https://ecommons.luc.edu/cgi/viewcontent.cgi?referer=&httpsredir=1&article=2644&context=luc\\_diss](https://ecommons.luc.edu/cgi/viewcontent.cgi?referer=&httpsredir=1&article=2644&context=luc_diss)
- Marshall, L. (2020). *There's no right way to grieve*. Retrieved from <https://www.webmd.com/mental-health/features/grieve-no-right-way#2>
- National Hospice and Palliative Care Organization. (2020). *Types of grief and loss*. Retrieved from <https://www.nhpco.org/patients-and-caregivers/grief-and-loss/the-grief-experience/types-of-grief-and-loss/>
- NHS. (2019). *Grief after bereavement or loss*. Retrieved from <https://www.nhs.uk/conditions/stress-anxiety-depression/coping-with-bereavement/>
- Pietrangelo, A. (2019). *9 CBT techniques for better mental health*. Retrieved from <https://www.healthline.com/health/cbt-techniques#what-to-expect>
- Suicide Prevention Resources Center. (2017). *Complicated grief treatment (CGT)*. Retrieved from <https://www.sprc.org/resources-programs/complicated-grief-treatment-cgt>
- Terranova, J. (2020). *Grief theories series: Berger's identities of griever*. Retrieved from <https://www.frazerconsultants.com/2018/03/grief-theories-series--bergers-identities-of-griever/>
- Terranova, J. (2020). *Grief theories series: Continuing bonds theory*. Retrieved from <https://www.frazerconsultants.com/2018/03/grief-theories-series-continuing-bonds-theory/>
- Terranova, J. (2020). *Grief theories series: Parkes and Bowlby's four phases of grief*. Retrieved from <https://www.frazerconsultants.com/2018/03/grief-theories-series-parkes-and-bowlbys-four-phases-of-grief/>
- Valdimar, L. (2020). *4 ways grief can be treated by mental health professionals*. Retrieved from <https://www.soberrecovery.com/addiction/4-ways-grief-can-be-treated-by-mental-health-professionals/>
- What's Your Grief. (2019). *Warden's four tasks of mourning*. Retrieved from <https://whatsyourgrief.com/wardens-four-tasks-of-mourning/>



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