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Grief Management:

An Overview for Funeral Professionals

3 CE Hours

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Final Exam – Grief Management: An Overview for Funeral Professionals (3 CE Hours)

1. Erich Lindemann observed grief reactions when he was chief of psychiatry at Massachusetts General Hospital in the 1940s. Which of the following is NOT one of the five signs and symptoms which characterize normal grief that he described?
   a. Guilt relating to the deceased or circumstances of the death
   b. Preoccupation with the image of the deceased
   c. Somatic or bodily distress of some type
   d. The ability to function as one had before the loss

2. Cognitions are thought patterns that mark the experience of grief. For example, _____ can include obsessive thoughts about the deceased, and sometimes even how to recover the lost person. It can take the form of disturbing thoughts or images of the deceased suffering or dying.
   a. Confusion
   b. Disbelief
   c. Preoccupation
   d. Sense of presence

3. Today, we believe that grief looks very similar to depression, and in fact grief and depression might overlap, but they are not the same. With depression, there is _____ that is not found with a grief reaction.
   a. A loss of self-esteem
   b. Appetite disturbance
   c. Intense sadness
   d. Sleep disturbance

4. "People can experience a state of overload when several stressful events occur at or around the same time. Someone who experiences a death while going through another stressful event in their life such as divorce, losing a job, etc. may not react to the death of their loved one in the same way that they might normally." Which determinant of grief does this describe?
   a. Concurrent stressors
   b. Grief overload

c. Normal coping behavior
d. Secondary losses

5. J. William Worden's Tasks of Mourning encompass four individual tasks, all of which the grieving person must address in order to adapt to their loss. "To Adjust to a World without the Deceased" is considered _____.
a. Task I
b. Task II
c. Task III
d. Task IV

6. Unlike survivor grief, which occurs after the death of a loved one, _____ refers to grieving that occurs prior to the actual death.
a. Absentmindedness
b. Anticipatory grief
c. Denial
d. Predictive grief

7. Among the purposes of a funeral described by _____ are "Provides a face-to-face confrontation with death which confirms its reality," "Meets the needs theologically, psychologically, and socially, of those who mourn," and "Shows respect to the deceased's family and friends."
a. J. William Worden
b. R. L. Klicker
c. The American Board of Funeral Service Education
d. The American Psychiatric Association

8. _____ consists of specialized techniques used to help survivors with abnormal or complicated grief reactions.
a. Grief counseling
b. Grief therapy
c. The Task of Mourning
d. None of the above

9. Which of the following is NOT a common symptom of compassion fatigue?
a. Cynicism
b. Hyperactivity
c. Irritability
d. Physical complaints

10. According to Canine (2006), “Stress begins to build, and fatigue and job disappointment begin to set in. The death care professional might start to believe that the company which he or she is part of does not share the same level of commitment to the work and how important it is,” describes _____ of burnout.

a. Stage 1
b. Stage 2
c. Stage 3
d. Stage 4

CONTINUING EDUCATION
for Professional Funeral Directors & Embalmers

Grief Management: An Overview for Funeral Professionals

3 CE HOURS

Course Content & Objectives

This course walks the funeral professional through the complicated process of recognizing and understanding grief. It considers both grief experienced by the client, as well as grief experienced by the funeral professional. It is not intended as a "how-to" or a substitute for treatment; rather, it allows learners to more easily recognize when clients, coworkers, and even they themselves might need help with the grieving process.

By the end of the course, learners should be able to:

- ❑ Recall definitions and determinants of grief
- ❑ Identify aspects of the mourning process
- ❑ Distinguish between the roles of grief counseling and grief therapy
- ❑ Recognize the signs of stress and burnout

Defining Grief

What is Grief?

Grief can be defined as a deep and poignant distress caused by, or as if by, bereavement. There is evidence to suggest that all humans grieve in one way or another. Anthropologists report that whatever the society studied, in whatever part of the world, there is an almost universal attempt to regain the lost loved one – and in most, there is a belief in an afterlife where one can rejoin the loved one.

Some psychiatrists argue that grief represents a departure from the state of health and well-being, and just as healing is necessary in the physiological realm in order to bring the body back into homeostatic balance, a period of time is likewise needed to return the mourner to a similar state of equilibrium. George Engel (a psychiatrist from the University of Rochester), for example, presents the process of mourning as similar to the process of healing in his 1961 thesis.

Just as with healing, full function or nearly full function can be restored via the mourning process.

However, again similarly to healing, there are some incidences of impaired function and/or inadequate adjustment.

Misconceptions about Grief

In our society, there tend to be many misconceptions about grief and mourning. Alan D. Wolfelt, PhD, founder and director of the Center for Loss and Life Transition, outlined five common misconceptions about grief.

Misconception #1 – Grief and mourning are the same experience. Although most people tend to use the terms "grief" and "mourning" interchangeably, there is an important distinction between them. Grief is the thoughts and feelings experienced internally when a loved one dies. Mourning is taking that internal experience and expressing it outwardly.

When putting this into context, many people in our culture grieve, but they may not mourn. In our society, people tend to keep things inside, when in reality, they should be expressing these feelings. Unfortunately, people are not encouraged to express their grief, but instead are given advice like "move on," "keep busy," etc. So instead of mourning, and expressing feelings externally in the presence of loved ones or those who could help, people tend to grieve within themselves in isolation.

Misconception #2 – There is a predictable and orderly progression to the experience of grief. Thinking about dying and grief according to particular "stages" one must go through has appealed to many people since it was first introduced by Elisabeth Kubler-Ross in 1969 in her landmark publication On Death and Dying. Kubler-Ross did not intend for people to interpret her five "stages of dying" literally; however, many people have done so, and perceive dying, the process of bereavement, grief, and mourning through the filter of these stages.

A consequence of this phenomenon is the idea that people should be at a certain stage a certain time, when in all actuality, nothing could be further from the truth. Each person grieves in their own unique way, and it is rarely predictable or in a certain order. Additionally, the many different dimensions cannot be easily categorized. One should never feel there is a particular way that grief and mourning should be experienced.

Misconception #3 – It is best to move away from grief and mourning instead of toward it. Often, those who are grieving do not give themselves permission, or receive permission from others, to mourn. Unfortunately, our society tends to encourage people to move away from their grief too soon: people who express their grief (or mourn) are often viewed as weak, and instead are encouraged to hide their tears and "be strong." As a result, many people grieve in isolation or avoid grieving altogether, which can cause problems later. To heal, one must move through grief and not repress it.

Misconception #4 – Tears expressing grief are only a sign of weakness. Crying is nature's way of releasing the tension that is built up in the body, and allows us as mourners to communicate the need to receive comfort. However, in our society, tears are often viewed as a sign of weakness, and too many people hide them. Tears are not a sign of weakness, but in fact an indication of that person's willingness to work through the grief and mourning towards healing.

Misconception #5 – The goal is to "get over" your grief. People do not just "get over" grief: instead, the goal is to become reconciled to the grief. People learn that their normal life is now different, and they must move forward with that life, without the physical presence of their deceased loved one. The sense of loss does not completely disappear, but softens with time and with work.

Normal Grief

Normal grief can also be called uncomplicated grief. It includes a broad range of feelings and behaviors common after a loss.

Erich Lindemann observed grief reactions when he was chief of psychiatry at Massachusetts General Hospital in the 1940s. Through his work, he described five signs and symptoms that characterize normal grief:

- Somatic or bodily distress of some type
- Preoccupation with the image of the deceased
- Guilt relating to the deceased or circumstances of the death

- Hostile reactions
- The inability to function as one had before the loss

A sixth trait was also exhibited by many of those he observed:

- Appeared to develop traits of the deceased in their own behavior

Although there are limitations to Lindemann's study, many of the symptoms seen today by the bereaved are very similar to those he described so long ago. His study remains relevant, and is often cited when considering grief reactions.

exam question...

1. Erich Lindemann observed grief reactions when he was chief of psychiatry at Massachusetts General Hospital in the 1940s. Which of the following is NOT one of the five signs and symptoms which characterize normal grief that he described?

a. Guilt relating to the deceased or circumstances of the death
b. Preoccupation with the image of the deceased
c. Somatic or bodily distress of some type
d. The ability to function as one had before the loss

The list of normal grief behaviors we recognize today is very extensive and diverse. Worden (2009) puts them all into four general categories: *feelings, physical sensations, cognitions,* and *behaviors*.

There are several *feelings* associated with grief:

Anger – This is frequently experienced after a loss and can be one of the most confusing feelings for the survivor. It is often considered to be the root of many problems in the grieving process. Anger can come from two sources: a sense of frustration that there was nothing that the survivor could do to prevent the death, or a type of regressive experience that can occur after losing someone close.

Anxiety – This can range from a slight sense of insecurity to a strong panic attack. If the anxiety is intense enough, it might indicate an abnormal grief reaction. There are generally two sources: the fear the survivor will not be able to take care of themselves, or a heightened sense of personal death awareness (the survivor's own mortality).

Emancipation – This is something that can be positive after experiencing a loss. For example, if a person experiences the death of a father who was abusive and mean to the survivors, they may experience this feeling. This is a completely normal response, but the survivor can often feel uncomfortable or guilty for having this feeling.

Fatigue – This is sometimes experienced as apathy or listlessness. It can be surprising, unexpected, and often distressing, especially if the person is very active. If it continues for an extended period, it may be a clinical sign of depression.

Guilt and self-reproach – These are common experiences of survivors, and are usually manifested over something that happened or something that was neglected around the time of the passing.

Helplessness – This is something that makes the event of death even more stressful. Statistically, widows in particular often feel extremely helpless.

Loneliness – Survivors often experience this feeling, especially when they have lost a spouse or they had a close day-to-day relationship with the deceased.

Numbness – Survivors often report a lack of feelings after experiencing a loss. This is frequently experienced early in the grieving process. It often occurs because there are so many feelings and the survivor is overwhelmed: they experience this numbness as a form of protection from all of the feelings.

Relief – After the death of a loved one, especially if they had been suffering, this is something many people feel. This can also be felt if the survivor had a difficult relationship with the deceased. As with emancipation, guilt is often felt along with it, but relief is completely normal.

Sadness – This is the most common feeling recognized. It is not necessarily manifested by crying, but very often is.

Shock – This is something most often experienced after a sudden death. However, it can be occur even when the death is expected, like after a long illness.

Yearning (pining) – This is a common experience of survivors and is a very normal response to a loss. When the yearning begins to go away, it might be a sign that the grieving process is coming to an end. However, if it does not come to an end and continues for a long period of time, it may indicate a more traumatic or complicated grief situation.

Physical sensations are often overlooked; in fact, many survivors do not expect them, and are concerned enough about their presence to go to the doctor. However, they are very common in the grief process. The most frequently-reported sensations are:

- A sense of depersonalization
- Breathlessness or a feeling of being short of breath
- Dry mouth
- Hollowness in the stomach
- Lack of energy
- Oversensitivity to noise
- Tightness in the chest
- Tightness in the throat
- Weak muscles

Cognitions are thought patterns that mark the experience of grief. Certain thought patterns are common early on in the grieving process, but usually disappear after a short time. However, they can continue, and may trigger feelings that lead to depression or anxiety. These cognitions include:

Confusion – People who have recently experienced a loss often report confusion in thinking, not being able to order their thoughts, difficulty concentrating, and/or forgetfulness.

Disbelief – This is often the first cognition one experiences after a loss. The survivor believes it is a mistake or did not really happen.

Hallucinations – These can be both visual and auditory, and are normal occurrences often experienced by the bereaved.

Preoccupation – This can include obsessive thoughts about the deceased, and sometimes even how to recover the lost person. It can take the form of disturbing thoughts or images of the deceased suffering or dying.

Sense of presence – The survivor might think the deceased is still with them. This is the cognitive counterpart of yearning. Some people find this sense of presence comforting, yet others are frightened by it.

exam question...

2. Cognitions are thought patterns that mark the experience of grief. For example, _____ can include obsessive thoughts about the deceased, and sometimes even how to recover the lost person. It can take the form of disturbing thoughts or images of the deceased suffering or dying.

a. Confusion
b. Disbelief
c. Preoccupation
d. Sense of presence

There are several frequent *behaviors* commonly connected to grief reactions, which usually correct themselves over time. These behaviors include:

Absentmindedness – This is something that often occurs after losing a loved one. The survivor may find themselves acting in a way that is absentminded, and might cause them inconvenience or even harm.

Appetite distress – This can manifest itself in a survivor as a problem with overeating or not eating enough. Under-eating is the more common grief behavior. Changes in eating patterns may cause major changes in weight.

Avoiding reminders of the deceased – Some survivors will try to completely avoid things or places that trigger painful feelings of grief. For example, the survivor might try to avoid the location where their loved one died, the cemetery or memorial park, or any object that reminds them of the deceased. It should be noted that a quick disposal of anything associated with the deceased, including the actual body, is not a healthy behavior and should be addressed to prevent it from possibly leading to a complicated grief reaction (we will discuss this further later in the course). If the memories triggered by the deceased's personal effects are painful right after the death, one solution might be to put them away for a time as the survivor grieves, and then take them back out as they begin to heal.

Crying – We know that crying is an effective way to relieve stress, although we are unsure as to the scientific reason as to why this is true. Some researchers suggest that tears have potential healing value: they help remove toxic substances and reestablish homeostasis after stress causes chemical imbalances in the body. These researchers believe that the chemical content of tears caused by stress (from grieving or other emotional issues) is different from those tears produced from something like eye irritation or as a natural reaction to protect the eye. Further research is needed to come up with a definitive answer.

Dreams of the deceased – These are very common after losing someone close. They may range from positive experiences to distressing, including nightmares. These dreams can serve a number of purposes, including helping to understand where the survivor is in the mourning process. Sometimes the insights delivered via these dreams can help the survivor grieve and move through the mourning process.

Restless hyperactivity – Many survivors report being unable to "sit still." They may do mindless busywork and never sit down to relax, or get in the car and drive just to get out of the house, as well as other activities, in order to feel a sense of relief from the restlessness.

Searching and calling out – Survivors often demonstrate these behaviors. The searching might be going on almost endlessly internally, as if the survivor believes the deceased to be lost and is always looking for them. The calling out is the searching expressed out loud: the survivor actually calls out for their deceased loved one, often asking them to come back.

Sighing – This behavior is often noticed among the bereaved, and is a close correlation to the physical sensation of breathlessness. When measured, depression is associated with lowered CO_2R and/or O_2R levels, and studies likewise show that grieving individuals also have lowered CO_2R and/or O_2R levels (Jellinek & Jenike, 1985).

Social withdrawal – It is normal for the bereaved to want to be by themselves and away from other people. This is generally a short-term behavior and will eventually correct itself. Social withdrawal can also include a loss of interest in anything going on in the outside world, so the survivor might stop watching the news or any television, as well as stop reading the newspaper.

Sleep disturbances – Very common after suffering a loss, these sleep disturbances might include difficulty falling asleep or waking often throughout the night and early morning hours. For normal grief, these disturbances generally correct themselves. If they do not, medical intervention might be needed. Persistence may indicate a more serious depressive disorder.

Treasuring objects that belonged to the deceased – Objects that once belonged to the deceased suddenly become treasure to the bereaved survivor. This is common and generally corrects itself with time.

Visiting places or carrying objects that remind the survivor of the deceased – This is the opposite of avoiding objects and/or places that remind the survivor of the deceased. With this behavior, for example, the survivor might carry around objects that belonged to the deceased, that the deceased gave them, or that remind them of the deceased in some way. This behavior is most likely from the fear of losing memories of the deceased.

Will all of these feelings, cognitions, physical sensations, and behaviors exhibit themselves in every person who is grieving a death? Probably not – but chances are the survivor will demonstrate one or several of them. It is important to remember that all of these characteristics are completely normal after a experiencing a loss. However, if any of them persist for an excessively long period of time (which varies, and is widely dependent upon the individual), it might indicate a more complicated grief.

Grief and Depression

Having reviewed the different ways in which grief can manifest itself, it might seem like many of the characteristics could also indicate depression. Let's take a look at the differences and the similarities between grief and depression.

Freud studied this issue back in the early 1900s and consequently wrote about it. He posited that depression, which he called "melancholia," is a pathological form of grief. He further noted that it is very much like normal grief but has a special characteristic of its own: the angry impulses felt toward the loved one are turned on oneself.

Gerald Klerman was a prominent depression researcher. Back in the late 1970s, he wrote about his belief that many depressions are brought on by a loss. The loss might have happened immediately prior to the depression, or it might have happened sometime earlier, but the depression was triggered by something that reminded the survivor of the death.

Today, we believe that grief looks very similar to depression, and in fact grief and depression might overlap, but they are not the same. With depression, as with a grief reaction, classic symptoms are present such as appetite disturbance, sleep disturbance, and intense sadness. However, with depression, there is also a loss of self-esteem that is not found with a grief reaction. Freud put it this way: when a person is experiencing grief, the world looks poor and empty; when a person experiences depression, the person themselves feels poor and empty. Likewise, modern cognitive therapists have suggested that the depressed have long-term negative evaluations of everything (themselves, the future, the world, etc.); in contrast, the grief experience is more short-lived and largely associated with a specific aspect of the loss.

The American Psychological Association's *Diagnostic and Statistical Manual*, 5th Edition, offers this distinction: "Symptoms associated with depression rather than grief are guilt about things other than actions taken or not taken by the survivors at the time of death, the survivor's thoughts of death other than the feeling that he or she would be better off dead or should have died with the deceased person, morbid preoccupation with worthlessness, marked psychomotor retardation, prolonged and marked functional impairment, and hallucinatory experiences (this does not include experiences of hearing the voice of or transiently seeing the image of the deceased person)."

To summarize: a survivor generally does not think less of himself or herself as the result of a death. If they do, and it lasts longer than a very brief time, it is probably an indication of clinical depression – and certainly some bereaved survivors do develop major depressive episodes following a death. (In fact, some believe that survivors may choose to direct anger against the self rather than the deceased in order to avoid facing ambivalent feelings toward the deceased: in these cases, depression arises as a defense against mourning.) If it happens that a major depressive episode develops during bereavement, this should be a considered a certain type of complicated mourning known as exaggerated grief, which will be touched on later in the course.

exam question...

3. Today, we believe that grief looks very similar to depression, and in fact grief and depression might overlap, but they are not the same. With depression, there is _____ that is not found with a grief reaction.

a. A loss of self-esteem
b. Appetite disturbance
c. Intense sadness
d. Sleep disturbance

It should be noted that researchers have observed that those who have a history of depression or some other mental health disorder might need professional attention and/or antidepressant medication if their depression persisted late in their bereavement. With the professional help and medication, they found improvement in sleep disorders and appetite disturbance as well as an improvement in mood and cognition. This might suggest a biological dimension to the depression. The depression, though, cannot be addressed through medications alone, and treatment should be included to focus on working through the depression.

Determinants of Grief

Grieving is a fluid process, and a person's response to the loss of a loved one is a complex reaction. The same person might even react in different ways to different deaths. These reactions are influenced by many different factors, called "determinants of grief." As suggested by Klicker (2007), these factors might include:

Age of the deceased – People tend to expect that everyone will follow the normal course of nature where the young survive and the old die. Thus, many feel that the death

of a child or young person is the most tragic death that can occur. However, some people mistakenly believe there should be less grief with a stillborn or a newborn, thinking they were here for too short a time for love and bonding to take place.

Let's break this down further, and look at several different situations:

The death of a parent
Many argue whether or not children are actually capable of mourning. Some experts say children cannot mourn until there is a complete identity formation, which generally occurs at the end of adolescence when a person is fully differentiated. However, others, like Worden (2009) argue that children can mourn as early as 3 years of age if there is an attachment. Regardless, children who lose a parent in childhood or adolescence may fail to adequately mourn the loss of the parent. Later in life, they might present with symptoms of depression or the inability to form close relationships during the adult years.

It has been suggested that a model of mourning is needed that fits children rather than using the adult model as a "one size fits all."

In the meantime, there are several things to keep in mind with children who have lost a parent or parents:

- Children do mourn, but the extent is determined by both the cognitive and emotional development of the child.
- The loss of a parent through death is traumatic but does not necessary lead to arrested development
- Children between the ages of 5-7 are particularly vulnerable. They are cognitive enough to understand some things, but have very little coping capacity.
- The work of mourning does not necessarily end in the same way for a child as it does for an adult. Mourning a childhood loss can be revived at many points in the adult life.

(Of course, adults also lose parents. However their cognitive abilities leave them better-equipped to mourn, understand, and cope with the loss than children).

The death of a child
An enduring type of loss that can cause complicated grief reactions is the death of a child. Along with grief, parents often feel guilt; there are generally five types of guilt that bereaved parents may experience:

- Cultural guilt – the death of a child could be seen as an insult to the social expectation of parents looking after and taking care of their children, and may lead to cultural guilt.
- Causal guilt – if the parent was responsible for the death of the child through some real or perceived negligence, they might experience causal guilt.
- Moral guilt – characterized by the parent's feeling that the death of the child was due to some moral violation in his or her present or earlier life experience.
- Survival guilt – when parents ask why they are still alive by their child had to die, as in a car accident or similar.
- Recovery guilt – the feeling of guilt when parents move through their grief and want to get on with their lives, believing it somehow dishonors the memory of the deceased child.

Some experts have found the divorce rate of parents to increase after the shared loss of a child; however, this is not conclusive. The difficulty in grieving the loss of a child might be increased if the parents are already divorced, though: divorced parents will be in close proximity to each other due to the loss, which can cause strong emotions and extreme behaviors. Control of the overall situation is often an issue with divorced parents: there may be struggles over the funeral and disposition arrangements, what to do with the child's belongings, and how to commemorate the child, among other things. It can also be hard if there are surviving siblings with divorced parents: these siblings often feel alienated, and/or as though they should choose sides. Dealing with these feelings does not allow them to grieve properly for their deceased sibling.

Surviving siblings often become the focus for unconscious actions by the parents. Immediately after the loss, it is common for parents to overlook surviving siblings: they are not given the care and attention they need because the parents are in a traumatic state, possibly even in shock, and are unable to provide it. In the longer term, parents tend to substitute for the lost child: that can involve anything from endowing surviving children with qualities of the deceased to giving subsequent children the same or a similar name as the deceased child. On the other hand, some families cope with their feelings about the death of a child by suppressing the facts regarding the loss – subsequent children may not know anything about their deceased older siblings.

It is sometimes assumed that children are simply too young to comprehend the loss or a sibling; others may feel that they need some sort of protection from the death. Particularly if no one will discuss the death with them, children are unsure of how to act. Without open and honest communication, they are forced to find their own answers, many of which may be incorrect: for example, they sometimes feel they should not play or be happy at all because people might get the impression that they did not care for or love their

deceased brother or sister. Without help understanding the situation, children may experience complicated grief later on.

Miscarriage and stillbirth
An estimated 1/5 to 1/3 of pregnancies end in a miscarriage; however, these losses are often socially negated: in other words, the parents and/or those around them act as if the loss did not happen. This can happen for a number of reasons. Sometimes the pregnancy is not public knowledge prior to the miscarriage, which can lead the parents to believe that they should not share their grief, either. Studies show that both men and women grieve with miscarriages; the longer the pregnancy, the more intense the grief tends to be. Given our society's emphasis on motherhood, mothers in particular may experience a sense of isolation, feeling embarrassment in addition to grief at having lost a baby, and even blaming themselves. These things can make grief more difficult to resolve.

Generally, the same considerations hold true for stillbirths. In both scenarios, the most important factor in working through grief is for the parents to acknowledge that there was indeed a death.

Abortion
In today's society, abortion is generally viewed as a socially negated loss; indeed, to some, it is an unspeakable loss. For many reasons, the experience is usually something people would rather forget than come face to face with, but if the woman does not mourn the loss, she may experience the related grief in some subsequent situation.

A study analyzed data on 877,000 women, including 164,000 who had an abortion. The research found that those who had experienced an abortion had an 81% increased risk for mental health problems, were 34% more likely to experience depression, 110% more likely to abuse alcohol, 155% more likely to commit suicide, and 2020% more likely to use marijuana (Coleman, 2011).

One way to handle the grief that goes along with an abortion is for the pregnant woman to seek counseling prior to the abortion, to explore feelings associated with the pregnancy and the decision to terminate. Realistically, however, abortions often take place quickly, and the woman proceeds without any support from family and friends. Post-abortion counseling can be effective, too, but many women do not choose to seek it out.

Available support network – Research has shown that the more positive support a survivor has, the more positive their adjustment to a death will be. This positive support can come from family, friends, colleagues, school mates, or a counselor.

Concurrent stressors – People can experience a state of overload when several stressful events occur at or around the same time. Someone who experiences a death while going through another stressful event in their life such as divorce, losing a job, etc. may not react to the death of their loved one in the same way that they might normally.

Expectations of local, cultural, and religious groups – Although everyone responds differently to grief, part of our response is determined by what is expected of us by people in the different parts of our lives. This might include family, church, regional customs, cultural norms, etc. A part of a person's behavior is nurtured by important associations, and thus a person might display grief in a particular way because it seems "required."

Fulfillment of dreams – After the loss of a child, survivors often feel the child did not have a chance to fulfill their dreams or experience the wonders of life" in other words, the young person was cheated out of this opportunity. This can also be felt after the loss of an adult who was never able to accomplish the goals they had set for life: in this case, it is as though the opportunity passed them by.

Gender conditioning – Even though many people today try to avoid gender stereotypes, they are still prevalent. This is very apparent in our society's expectations of how a survivor should grieve a death. Men and boys are expected to be stronger than women and girls. Males, based what they are taught and what they see, often feel that they should be more angry than sad, while females are taught that only being sad and crying are both acceptable behaviors, even if they are also feeling angry.

Grief overload – This quite simply means that a person can experience too many losses in a short period of time. The losses might not all be death of people they care about, but could include divorce, a move, loss or death of a pet, loss or change of job, a theft or robbery, or something similar. This overload most often exhibits as an exaggerated reaction to the most recent loss – in this case, the death of a loved one.

Importance of the relationship – The relationship between the deceased and the survivor prior to the death will influence the survivor's response to the death. The intensity of the relationship prior to death will often increase or decrease the severity of the grief reaction. The closest relationships people have are not always with family members. Friends can have bonds that can make a death of one of the friends overwhelming to the surviving friend, just as with surviving family.

Manner of death – Although no one is ever completely prepared for the death of someone they love or care about, when the death is anticipated (such as in the case of chronic illness), the survivor has the opportunity to get some sense of closure. With sudden and violet deaths, there is no time to prepare or come to terms with the idea of losing the person before they are actually gone. Sometimes the ability to even understand what happened is impaired. Although adjusting to any death can be difficult, an unexpected violent death is likely to lead to a

complicated grief reaction. Any sudden death, especially if the person is young, can foster some vulnerability.

Normal coping behavior – In general, people behave in a similar way when confronted with different stressors. In other words, the behaviors a person exhibits when under stress are generally the same behaviors they will display when they experience the loss of a loved one or someone they are close with. Just because someone does not cry, for example, does not necessarily mean they are not grieving. It might just be that the person generally does not cry during a time of stress. It is important that those counseling that person are aware of their normal coping behaviors.

Number of previous losses and deaths – Grief can be cumulative, which means that a person could either gain strength from losses and handle each one better than the one before, or that the negative effect could build up and boil over during subsequent losses. Either way, this could factor into how a person handles a death.

Physical and mental health – Grief can contribute to both physical and mental ill health, so the state of health of the survivor at the time of the death of a loved one can be very important. If the survivor is already in ill health, they could potentially become worse. Of course, good health does not guarantee an easy experience for the survivor; nevertheless, it does give them another positive mechanism for defense.

Pre-death adjustment time – This is also known as anticipatory grief, which will be revisited later in the course. The time a person has to prepare for the death of a loved one can prove to be both positive and negative. Anticipating a death offers the opportunity to tell the dying individual things you want them to know, and also to say goodbye. This can be meaningful to both the dying person and to the survivor, and can potentially help relieve some of the grief following the actual death. However, it can also be difficult for survivors to watch their loved one slowly fade, with potential weight loss or gain, pain, mental confusion, etc. During this pre-death time, besides the pain from anticipating the person's death, the survivors are forced to think about what it will be like without their loved one, the pain they will experience at the time of death, and how their loved one is feeling.

Secondary losses – When a death occurs, it is considered a primary loss. Secondary losses are those losses that come as a result of the primary loss. They often involve the loss of a status: for example, if a woman loses her husband, she is no longer a wife. If a man loses his only sister, he is no longer a brother or sibling. The secondary loss could also involve something more concrete: for example, if the "breadwinner" of the family dies, the survivors may no longer be able to afford a certain lifestyle. They may have to move to a different house, go to a different school, cancel club memberships, etc. Secondary losses can also be more abstract, such as when a parent loses a child, the dreams they had for the child's future are also lost.

Unfinished business with the deceased – Loose ends in a relationship are quite common. We do not always tell people how we feel about them. Often, arguments or negative feelings in particular are not worked out in the moment, but are deferred to be dealt with later. If a person dies with feelings unshared, or with arguments or ill feelings not worked out, it can be very difficult for the survivor. This is why we often hear people express "I wish I had a little more time."

exam question...

4. "People can experience a state of overload when several stressful events occur at or around the same time. Someone who experiences a death while going through another stressful event in their life such as divorce, losing a job, etc. may not react to the death of their loved one in the same way that they might normally." Which determinant of grief does this describe?

a. Concurrent stressors
b. Grief overload
c. Normal coping behavior
d. Secondary losses

We spoke briefly about manner of death impacting the survivors' grief – let's return to this in more depth. The mode of death, also known as the mechanism of death, is the physiological derangement produced by the cause of death that results in death: in other words, exactly how the person died. How someone dies can always be a big determinant of grief. Although losing a loved one from a chronic illness or at an advanced age is not easy, these deaths are in some ways anticipated; by contrast, a more traumatic or unexpected death generally causes more complicated grief.

Death that occurs without warning, and may require special understanding and intervention, is a "sudden death." This can include accidental deaths, heart attacks, homicides, and suicides, among others. Sudden deaths generally leave survivors with a sense of unreality about the loss. It is not unusual for survivors to feel numb and to walk around in a daze. Survivors also might feel guilt, which is commonly expressed in "if only" statements; they may also feel a need to blame someone, a sense of helplessness, feelings of agitation, and a need to understand. Often medical and legal authorities are involved in sudden deaths as well, which can lead the survivors to feel further victimized.

Klicker (2007) described several modes of sudden – unexpected and traumatic – deaths:

Accidents – As the fourth leading cause of death in the United States of people between the ages of 15-24, accidental deaths are frequent, but always unexpected.

Motor vehicle accidents, which could happen to anyone at any time or any place a vehicle is used, are one of the most common causes of death by accident across the entire world. These accidents tend to be very traumatic and are a complete shock to family and friends. Families are often notified by police officers – or, as is happening

more and more with social media and the 24-hour news cycle, they might see the accident or the scene of the accident on television or another media outlet, without knowing that their family member is involved. In some cases, they might even recognize the car or some belongings and realize it is their loved one. In addition, motor vehicle accidents, as well as other types of accidents like workplace accidents, often involve court cases or inquiries. This forces the survivors to relive the accident over and over, prolonging the process of mourning.

AIDS – Acquired immunodeficiency syndrome, or AIDS, is a set of symptoms that occur during the final stage of human immunodeficiency virus infection (HIV). Once considered a disease limited to the homosexual community, AIDS can affect anyone: men, women, and children of all races and preferences. Today, instead of an immediate death sentence, AIDS has become more of a chronic disease: there are many new drugs and drug combinations that have allowed those with HIV infection and AIDS to live longer lives. However, despite its no longer necessarily causing a sudden death, like the others discussed here, AIDS still has the potential to trigger complicated grief.

Unfortunately, there is still a perceived stigma surrounding death related to HIV and AIDS, and some consider these to be socially negated losses. Thus, there is often a lack of the social support that is needed after the death of a loved one. Survivors may feel they will be judged severely by others and rejected socially if the cause of death is known; likewise, people who are not properly educated about HIV and AIDS may avoid the survivor out of fear of contracting it themselves.

Disasters – An occurrence of severity and magnitude that normally results in death, injuries, property damage, and cannot be managed through the routine procedures and resources of the government. Disasters come in all different sizes and scopes: the extent of damage, loss of life and injury, and the degree of disruption to families and communities is different from disaster to disaster. Disasters might be natural or man-made events, and they might extend over a few moments or over a long period of time. Some disasters might include earthquakes, hurricanes, tornadoes, floods, tsunamis, volcanic eruptions, dam failures, explosions, mass shootings, fire, transportation crashes (i.e. major airline), structural collapses, etc.

Disasters with mass casualties often expose dead bodies to the public, causing psychological disturbances among survivors. This is known as the "horror factor" of disasters and is linked to mental health problems. Survivors could also have been exposed to the life-threatening situation themselves, and directly experienced the same disaster that caused the death of their loved one, possibly even witnessing the death. This terror experienced by the survivor is likely to generate psychological impairment as well.

Euthanasia – Euthanasia can be defined as the act or practice of allowing the death of a person suffering from a life-limiting condition. Generally considered a deliberate intervention by someone other than the person whose life is at stake, euthanasia is solely intended to end the life of a terminally ill person who is competent to make the decision to voluntarily request aid in dying. This is also known as voluntary active euthanasia.

Involuntary active euthanasia occurs when an intervention intended to kill a person is used, but the person it is used on is incapable of making a request to die, is an infant or young child, is mentally incompetent of making such a decision, or cannot offer an opinion in the matter because of impaired consciousness.

Passive euthanasia is forgoing or withdrawing medical treatment where there is no hope the patient will recover with the intent of causing death.

Physician-assisted suicide occurs when a physician provides medication or other means for a patient to use on themselves in an effort to end their own life. It is important to note that the physician does not administer the medication or anything else. The physician does not control the act, the patient does. There are currently six states that now legally allow physician-assisted death: Washington, Oregon, California, Montana, Colorado, and Vermont, as well as Washington, D.C. The verbiage in the law of Washington, Oregon, California, Colorado, Vermont, and Washington, D.C. is very specific to distinguish physician-assisted death from suicide, stating that "actions taken in accordance with [the Act] shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law." In addition to the states that have made physician-assisted death legal, there are several state legislatures that have previously or are currently discussing physician-assisted death.

Survivors, as with any death, will go through the mourning process. However, with physician-assisted death, there is a large amount of discussion about the death. There are several requirements in getting to the point of the assisted suicide, which involves many conversations about the terminal illness and the death itself. Knowing how much their loved one was suffering and that it was their decision to end the suffering when and where they wanted might help the survivors cope with the death.

Homicide – A homicide, or the killing of one human being by another, is possibly the most difficult unexpected death for survivors to cope with. Grief reactions may be intensified because of the violet nature of the death. Guilt, although a common grief response, may be amplified for survivors who feel they somehow failed to protect their murdered loved one. Another common grief response, anger, also tends to be intensified, and might be magnified to the point of rage. This could be felt toward the murderer, or eventually toward the criminal justice system, the police, an attorney, or someone else involved in a perceived injustice. Survivors might even consider retribution and revenge. Furthermore, media

coverage, which often sensationalizes the murder, will complicate grief for survivors. Some will resent the fact that anything, including their grief, is made public; if the overage is perceived as inaccurate, or slanderous toward the deceased, feelings intensify.

Sudden Infant Death Syndrome (SIDS) – Sometimes called crib death, SIDS is the unexpected and sudden death of a seemingly healthy infant between four months and one year of age. 7,000-10,000 babies die in this way each year in the United States alone. SIDS is a phenomenon that is not fully understood and the pathogenesis has not been firmly established. It is determined to be SIDS if no other cause of death can be found after thorough examination of the place of death, medical history of the infant, and a complete autopsy. It must be noted that suffocation, disease, neglect, and abuse do not cause SIDS.

Like other sudden and unexpected deaths, SIDS deaths cause unique grieving factors and are quite painful psychologically for the survivors. The parents are generally the ones who find the deceased infant: that memory alone, and those of any measures taken to revive the infant, are something they are unlikely to forget and will live with for the rest of their lives. In contrast, parents may feel overwhelming guilt or anger if the death occurred at the child's daycare or when the parents were not there: the feeling that the child would be alive had they been there taking care of them is hard for parents in this situation to get past.

Since there is an absence of definitive cause, this gives rise to considerable guilt and blame, and family and friends are left wondering how the child died. Explaining SIDS to other children – and even in some cases to adults – who do not understand the syndrome or have been given misinformation about the child's death causes the parents more grief they will need to eventually overcome. To add to that, there is generally a police investigation that can cause still more grief, and also make the parents feel as if they are suspected of abusing or neglecting the child.

Suicide – The deliberate act of killing oneself is commonly called a suicide. Grief after suicide is somewhat similar to, but also somewhat different from, grief after other unexpected deaths. While many of the same grief reactions occur, the experience is unique in that the survivors have to come to terms with an intentional and chosen death. This makes the grief process after suicide particularly challenging and agonizing for the survivors: reactions include shock, bewilderment, denial, guilt, powerlessness, obsessive review, blame, shame, anger, and fear. Survivors often ask questions like "Why did they do it? Why didn't I prevent it? How could he or she do this to me?"

In our society, there is also a stigma associated with suicide, which the survivors are left to handle after a family member takes this or her own life. The reactions of others can influence the survivors and their grief reactions: for example, if no one is talking to the survivors, or if everyone is acting as if nothing happened, this can be extremely isolating.

The family dynamics of suicide often contribute to grief, as well. For example, the surviving spouse of the deceased might all of a sudden remember every fight, big and small, thinking these disagreements led to the suicide – and fearing that others think so as well – which can lead to extreme guilt. And to top it off, if the couple had children, the spouse must help them through the tragedy at the same time.

In grieving losses other than suicide, parents may alienate other children as they focus on mourning the deceased child. However, parents who lose a child to suicide might suddenly become overprotective of their other children, due to their fears that the suicide was their fault, the surviving children are headed in the same directions and will also try to kill or hurt themselves, or that they might die in some other tragic way. The surviving children, who are dealing with their own grief, are also now smothered with attention or affection.

When children lose a sibling to suicide, they experience a variety of emotions in their response to the death. They might feel anger toward their sibling; they may also feel jealousy or resentment after witnessing the grief of their parents, thinking they must love the sibling more. As mentioned above, surviving children may end up smothered by grieving parents; conversely, if parents are grieving too much to take care of their surviving children's needs, there might also be a feeling of desertion.

A child who loses a parent to suicide often has very intense emotional responses to the death. Most often, they experience guilt and blame: maybe if they had been a "better" child, their parent would not have committed suicide.

Managing Grief: The Client

The Mourning Process

In 1984, J. William Worden published *Grief Counseling and Grief Therapy*, which referred to the Tasks of Mourning. For Worden (2009), "grief" refers to the personal experience of the loss, while "mourning" is a term to indicate the process that occurs after a loss. Combined with the "task" concept (consistent with Freud's grief work), the Tasks of Mourning imply that the mourner can do something about their grief, and needs to take action.

The Tasks of Mourning encompass four individual tasks, all of which the grieving person must address in order to adapt to their loss. Many find these tasks useful in understanding the bereavement process. While the definition of each task contains a suggested order, they do not need to be done in that order – and not every death a person experiences will apply to these tasks in the same way. Likewise, tasks can be revisited and worked through over and over again; different tasks can also be worked on at the same time. Finally, since mourning is a cognitive process and not just a state of being, there is effort required in addressing these tasks. Also described as "grief work," it involves the confrontation with and

the restructuring of thoughts about the deceased, the experience of the loss, and the changed world where the bereaved must now live.

Tasks of Mourning

Task I: To Accept the Reality of the Loss

Whenever someone dies, no matter if it is expected or very sudden, there is generally the sense that it did not really happen. The first task of grieving is to be able to face the reality that the loved one is dead: they are gone and they will not return.

As previously mentioned, many people who experience a loss call out for the deceased loved one. They might even sometimes "see" their loved one: for example, they might be out and about and mistake a stranger for their loved one. A big part of the acceptance of this reality is the understanding that a reunion with the loved one is not possible, at least not in this earthly life.

The survivor must accept the death both intellectually and emotionally. Far too often, much time and effort is expended on intellectual acceptance, and emotional acceptance is overlooked. The bereaved individual may be intellectually aware of the finality of the loss long before their emotions will fully allow them to accept that the information is true. It is easy to feel that the deceased loved on is simply away on a trip, or has gone to the hospital, and will be back soon. The reality hits hard when the survivor picks up the phone to share a story, only to remember that the loved one is not at the other end. It is not uncommon for belief and disbelief to alternate while one is grappling with this task.

Addressing the first task of mourning and accepting the reality of death is not something that happens overnight: it takes time. Traditional rituals, such as the funeral, might help the bereaved survivors move toward acceptance. Those not present at the burial may need alternate ways to validate the reality of the death of their loved one, such as talking to a doctor or police officer, or viewing the death report or other related documents, among other things.

The opposite of accepting the reality of loss is denial: refusing to believe the loved one is dead. This distorted thinking may seem to soften the intensity of the loss, but it is very rarely satisfactory. Denial can happen at several levels and can take various forms. However, it most often involves either the facts of the loss, the meaning of the loss, or the irreversibility of the loss (Dorpat, 1973).

Denying the facts of the loss can vary in degree from a small distortion to a complete delusion. At the most extreme level of delusion, the survivor actually keeps the body, as they are in such denial that they cannot physically let go. More commonly, the survivor tends to go through "mummification," or retaining the deceased's possessions, ready for use when he or she returns. This is not unusual in the short term, but would be considered denial if it goes on for years.

Denying the meaning of the loss is an attempt to make it less significant than it actually is. This is not uncommon after a traumatic loss. The survivor might say something like, "We weren't close," or immediately get rid of the deceased's personal items and clothing. This is the opposite of mummification: it minimizes the loss, while allowing the survivors to avoid anything that would bring them face to face with its reality.

Denying the irreversibility of the loss involves a refusal to believe the loved one is not coming back, no matter what the survivor says or does. For example, someone who loses a child might walk around saying aloud to themselves, "I do not want you dead. You are not dead," despite all evidence to the contrary.

There are several other types of denial, including "selective forgetting" and a chronic hope for reunion. These things are generally normal shortly after the death, but become denial if they go on for an extended period.

Task II: To Process the Pain of Grief

Not everyone experiencing bereavement feels emotional pain in the same way, or experiences it to the same levels. Likewise, the pain may be influenced by a number of factors, known as "determinants of grief," as discussed earlier. Nevertheless, it is next to impossible to lose someone close without experiencing some emotional pain. It is necessary to acknowledge and work through the pain associated with loss, otherwise it can manifest itself through physical symptoms or some form of abnormal behavior. It is necessary to go through the pain of grief in order to get the grief work done.

Besides the sadness and dysphoria that we tend to think of with the pain of grief, there are other affects associated with loss that need to be processed as well. Other common feelings that survivors might experience anxiety, anger, guilt, depression, and loneliness. The newly-bereaved are often unprepared to deal with the force and nature of the emotions that follow the death of a loved one. In addition, there might be a subtle interplay between society and the survivor that makes this task more difficult: society may be uncomfortable with the survivor's feelings, and therefore may give the indirect message that they don't need to grieve and/or they are only feeling sorry for themselves. Comments like "He wouldn't want you to feel this way," or "You can always have more children," are frequently distributed by others in an attempt to help, but these comments only reinforce the mourner's own defenses: they may decide that they shouldn't feel the way they do, or that they simply do not need to grieve, leading to the denial of their need to process the pain.

The opposite of the second task of mourning is to not feel. People try to achieve this in a number of ways, the most obvious being cutting off their feelings and denying that the pain exists. Some survivors attempt to avoid all painful thoughts by using thought-stopping procedures to avoid thinking of the deceased and/or the death.

Others insist on thinking only good thoughts of the deceased, eliminating any unpleasant memories. Avoiding reminders of the dead and using alcohol or drugs are additional tactics. Some even try to find a "geographic cure," meaning they travel from place to place in search of relief from what they are feeling.

One of the main emphases of grief counseling is to help survivors through the second task. If the survivor does process the pain of grief, they may very well carry the grief with them throughout the rest of their lives. If the second task of mourning is not addressed properly, therapy may be needed later on: even if survivors are temporarily successful at avoiding the pain of grief, eventually most of them break down, generally displaying some form of depression. At this point, going back and working through the pain the survivor has been avoiding is often a more complex and difficult experience than dealing with it at the time of the death of their loved one. The struggle can be intensified by a less supportive social system than would have been available at the time of the death.

Note: research on attachment styles suggests that there are some individuals who do not experience much, if any pain, after a death. This might be because they have not let themselves become attached to anyone.

Task III: To Adjust to a World without the Deceased

There is a need to relearn what the world is like after the death of a loved one, and as part of this process, there are three areas of adjustment that must be addressed: external adjustments, internal adjustments, and spiritual adjustments. The external adjustments are how the death affects one's everyday functioning in the world. The internal adjustments are how the death affects one's sense of self. The spiritual adjustments are how the death affects one's beliefs, values, and assumptions about the world.

External adjustments: Adjusting to life in a world without the deceased means different things to different people, usually depending on what the relationship was with the deceased and the different roles the deceased played in the survivor's everyday life. The realization of what life will be like without the deceased often begins to occur around three to four months after the death, as the survivor begins to come to terms with living alone, raising children alone, facing an empty house, managing finances alone, and/or other big and important jobs that the deceased loved one might have done or helped with. Usually the survivor is not even aware, until this point, of all the roles played by the deceased loved one.

Many survivors actually resent the need to develop new skills and take on new roles that were previously their partner's. However, after a time, they may come to like the new skill they were forced to develop. This coping strategy – redefining the loss in such a way that it can actually benefit the survivor, thereby making sense of it – is often part of the successful completion of the third task. The death of a loved one can shatter the survivor's sense of purpose in life, so it is import to discover and create new meaning.

Internal adjustments: Besides adjusting to losing their loved one and the roles they played, the survivor must also adjust their own sense of self. This does not just mean acknowledging the loss of a title, like wife, mother, etc.; more fundamentally, death affects the survivor's self-definition, self-esteem, and sense of self-efficacy.

If the survivor defines themselves mostly or solely by their relationship with the deceased loved one, establishing a new self-definition may be difficult. They have to come to terms with the loss of the relationship and start defining themselves independent of it.

Some people's self-esteem is dependent on the relationship they have with their loved one (this is known as "secure attachment"). In this type of attachment, the survivor might suffer real damage to his or her self-esteem with the death of the loved one. This can be especially true if the deceased loved one was making up for some of the survivor's developmental deficits. For example, if the survivor never truly felt they belonged or that they were loved prior to their relationship with the deceased loved one, they may feel that way again after the death.

Grief can also affect a person's sense of self-efficacy, or the degree to which they feel that they have some control over what happens to them. This can lead to a situation where the survivor perceives themselves as helpless, inadequate, or incapable – for example, attempts to take over the roles of the deceased loved one may fail – and this can lead to progressively lowered self-esteem. Even should positive change take place, the survivor may attribute it to chance or fate, not to their own strengths or abilities.

In all three of these arenas, the task for the survivor is to think about things like who they are now, and how that person is different from the one in the relationship with the deceased loved one. Given some time, negative images generally turn to positive images, and survivors are able to carry on with their tasks of mourning and learn new ways of living in and dealing with their new self.

Spiritual adjustments: The final area of adjustment is the survivor's sense of the world. Beliefs are often influenced by families, peers, education, religion, and life experiences. The death of a loved one can challenge the survivor's fundamental life values and philosophies, shaking the foundation of the survivor's assumptions. Experts have identified three basic assumptions that are often challenged by the death of a loved one: the world is a benevolent place, the world makes sense, and the survivor is worthy. Challenges to these assumptions are particularly likely to occur when there are sudden and untimely deaths. (Note that not all deaths challenge the survivor's beliefs; rather, some deaths fit expectations and validate assumptions. For example, the death of an elderly person after a long and fruitful life, while sad, seems fitting.)

While it is normal for the survivor to feel they have lost their direction in life, they also work to find it again, searching for meaning in the loss to in order to rebuild assumptions and understand their new world.

Most survivors successfully complete task three: they take over the roles of their deceased loved one, developing skills they never knew they had, and move forward with a renewed sense of self and the world. However, some fail to adapt to the loss, falling victim to their own sense of helplessness. They may not develop the skills they need to cope, or they may withdraw from the world to avoid the challenges they face in this new environment without their deceased loved one.

Task IV: To Find an Enduring Connection with the Deceased in the Midst of Embarking on a New Life

The survivor should not be asked to give up their relationship with the deceased loved one, but to find an appropriate place for the deceased in their emotional life while still living their own effective and productive life. It may help to identify ways to memorialize and remember their deceased loved one, retaining an enduring connection while setting sail on a new life of their own.

For many survivors, the fourth task of mourning is the most difficult one to complete, and they get stuck at this point in the grieving process. It is difficult to put into words what the opposite of task four might be, but perhaps the best way to describe it would be to "not live." In other words, the survivor's life has stopped with the death of their loved one and has not resumed: they continue to hold onto the past attachment in a way that prevents them from forming new attachments. For example, maybe the survivor found the loss so painful that they now feel they should never love again, in order to avoid future pain.

exam question...

5. J. William Worden's Tasks of Mourning encompass four individual tasks, all of which the grieving person must address in order to adapt to their loss. "To Adjust to a World without the Deceased" is considered _____.

a. Task I
b. Task II
c. Task III
d. Task IV

Anticipatory Grief

Unlike survivor grief, which occurs after the death of a loved one, anticipatory grief refers to grieving that occurs prior to the actual death. Many deaths occur with some warning; it is during this period, while the loved one is in the process of dying, that the survivor begins the mourning process and begins to experience grief reactions. The Tasks of Mourning as defined by Worden, in this case, may begin while the loved one is still around.

The first task, accepting the reality of the loss, is probably the one that can be best facilitated during this anticipatory period: especially if the loved one is visibly failing, the survivor is likely to accept that the death is inevitable.

The second task, processing the pain and grief, might be more difficult during the pre-death period of anticipation. Many feelings are likely to arise during this time; for many, anxiety in particular increases.

Task three, accommodating oneself to a world without the deceased, might lead to some "role rehearsal" among the survivors. While some might view speaking of life without the loved one before they are gone as unacceptable behavior, insensitive, or in bad taste, in all actuality, this is normal. It may play an important role in overall coping with the eventual death.

(Task four is not really applicable to anticipatory grief; it can only be accomplished after the death of the loved one.)

The person dying may also experience anticipatory grief, although in a different way. The anticipation of loss can be overwhelming, and often the dying person will just turn his or her head toward a wall in order to try to cope with the impact of everything that is happening.

There is some evidence that those who are able to experience anticipatory grief handle the death better than those who do not have any warning, and are only able to begin grieving after the death. It is important, however, to note that this evidence is not conclusive.

exam question...

6. Unlike survivor grief, which occurs after the death of a loved one, _____ refers to grieving that occurs prior to the actual death.

a. Absentmindedness
b. Anticipatory grief
c. Denial
d. Predictive grief

The Purpose of the Funeral: Facilitating Grief through Ritual

The American Board of Funeral Service Education describes the purpose of a funeral as the following:

- Provides an opportunity to receive and express love
- Shows respect to the deceased's family and friends
- Provides opportunity to express grief
- Provides a face-to-face confrontation with death which confirms its reality
- Allows emotional support through sharing
- Meets the needs theologically, psychologically, and socially, of those who mourn
- Provides an opportunity for farewell through ritual
- Provides a dramatic representation of the fact that a life has been lived by reflecting upon memories of the deceased

- Helps establish emotional stability through a social support network
- Establishes a socially acceptable climate for mourning

While some people may criticize funerals and dismiss them as not being worth all the money they cost, it's obvious that the funeral service can be an important tool in the healthy resolution of grief. Beck (2000) suggests that, if a funeral is done well:

- It provides acting-out ceremonies that give expression feelings too deep to be put into words. For this purpose, the funeral is the best resource, as well as the most economical. It is generally understood and possesses the resources for meeting the varied social, emotional, and spiritual needs of the bereaved. It helps people wisely manage the crisis of death.
- It provides the framework for group support. It allows people to come together, communicate, visit, and relate to each other. It allows people to express love and concern and makes them feel comfortable doing what otherwise would be difficult and uncomfortable.
- It encourages the expression of feelings. The process is a feeling-oriented activity. Feelings are very important and need to be recognized, as well as expressed.
- It provides values to live by. The value of life in the presence of death is confirmed by the funeral. It shows respect for the dead, of course, but also for the living. Every funeral challenges those who attend to a new and better life.

Worden (2009) discussed facilitating grief through the funeral service in the context of his Tasks of Mourning, suggesting that, among other things, it can help make real the fact of the loss. The funeral service and everything it involves can be a major benefit in helping the survivors work through the first task of grief.

For example, whether the casket is open or closed is often a regional, cultural, religious, or personal preference. However, there is a solid advantage to allowing loved ones to see the body of the deceased: it helps to reinforce the reality and finality of the death. While this viewing can occur at the hospital or other place of death, it may be most comfortable for survivors at the funeral home. Even if the family chooses cremation, it is still possible to have an open casket and/or have the body present at the funeral service to help the family grieve. Afterward, it is often possible for the family to witness the cremation, which may also help facilitate grief.

Klicker (2007) took this even farther: when a violent death occurs, the traumatic nature of the death can cause physical disfigurement to the body. In these cases, families often chose a funeral service that does not involve a viewing of their deceased loved one, feeling it might be easier on everyone, or even more appropriate. But, he argues, this is most likely a mistake: the survivors of tragic deaths are generally the ones who most need to view the body of their loved one. With a lingering illness, the survivors are able to see the person as they are dying, and know that they were dying, and did die. However, sudden and unexpected deaths do not allow for this. Seeing is believing: it begins to make the experience real if the family is able to view the body of their loved one, however unexpected or traumatic the death. If not, they might take a longer time coming to terms with the reality of the death.

Worden (2009) also suggested that the funeral service can give people the important opportunity to express thoughts and feelings about the deceased. Of course, it is possible to over-idealize and over-eulogize a person, and ideally this should be avoided. The best situation is one where people are able to express both the things they are going to miss about their deceased loved one, as well as the things they are not going to miss. Although this may seem inappropriate at times, Worden assures us that it is not only okay, it helps forward the grief process by.

Finally, Worden (2009) explained that the funeral service can be a reflection of the deceased loved one's life, showcasing things that were important to the deceased. The service can help draw a social support network to the bereaved family soon after the death, which has the potential to be extremely helpful in facilitating grief.

exam question...

7. Among the purposes of a funeral described by _____ are "Provides a face-to-face confrontation with death which confirms its reality," "Meets the needs theologically, psychologically, and socially, of those who mourn," and "Shows respect to the deceased's family and friends."

a. J. William Worden
b. R. L. Klicker
c. The American Board of Funeral Service Education
d. The American Psychiatric Association

Handling Grief on Holidays and Special Occasions

Grief is hard enough on its own. It gets even harder to handle when "firsts" roll around. These "firsts" can be holidays, rich in tradition and fond memories of the loved one, which are now of necessity very different occasions. Whereas before, a person looked forward to holidays, they might now dread or avoid them: the emotions associated with the holidays for someone after a death might include sadness, emptiness, and loneliness. "Firsts" can also be special occasions which the bereaved must now experience without their loved one, like anniversaries and weddings.

Even having arrived at the "end of mourning" – that point where the emotional pain of death no longer negatively affects the bereaved's life, "firsts" can still be challenging.

De Vries and Zonnebelt-Smeenge (2001) offer suggestions about how to prepare for the emotional impact of holidays and special occasions:

- Even without the death of a loved one, each holiday is a bit different than the last one: time always brings change. The first holiday after the death of the loved one, survivors are forced to face a very definite and traumatic change, and it may help to remember there is no reason they have to celebrate the holidays exactly the same way they did before. With that in mind, survivors should give themselves the gift of time, and lower the expectations and pressures they put on themselves to "keep everything the same." The holiday itself is only twenty-four hours: make a plan for that day. For some people, the traditions involved in celebrating the holidays may be a comforting coping strategy. For others they are not, and they prefer to take a break from the holiday this time around, making a commitment to themselves to re-address it next year. For still others, it may feel most natural to spend the day dealing directly with their emotions as they face the hard reality of the death of the loved one. Either way, keep it simple. Make a choice for this year, and leave next year until next year.
- As mentioned, some survivors may find participating in traditions and celebrations comforting. That said, they should not try to keep themselves so busy that they avoid their feelings or distract themselves from the reality of the death of their loved one. Likewise, some people may expect or want them to deny or avoid the pain they are feeling, and others may try to influence them to put their grief out of their mind in order to enjoy the holidays. Although everyone most likely means well, they probably have little awareness of what grief is like. Only the survivors can decide what is okay for them, and they should be true to themselves. Feelings are natural: it is okay to cry and look sad. The more they face the pain of loss directly, the more quickly they will be able to overcome it and move on to a full resolution of their grief.

De Vries and Zonnebelt-Smeenge (2001) also address things to keep in mind as survivors face the logistics surrounding "firsts":

- It is important that survivors take care of themselves physically: remember to eat, drink, exercise, and rest. Holidays can be physically draining anyway, but if is the first after the death of a loved one, it might be especially draining. Failing to take care of their physical self will only add to the fatigue and frustration survivors may already feel.
- Especially for the first year, the survivor might want to focus on surviving each holiday – just getting through them – and that is okay. Holidays come every year. Survivors can skip them once (or twice) with the confidence that as they move through their grief, they will have more energy to deal with the holidays the next time they come around.
- Death tends to put things into perspective for many people. Since the death of their loved one, many routines the survivor generally worried about or looked forward to may now mean almost nothing at all. With that in mind, all the attention given to particular activities during the holidays and other festivities might seem somewhat ridiculous. This is completely normal and understandable during the grieving process. Survivors should accept the feelings, while reassuring themselves that they will be able to enjoy these things again at some point.
- Baby steps. It may help survivors to remember that a healthy way to approach many issues is that a "something" attitude may be better than an "all-or-nothing" attitude. This just means that, even if they choose not to do nothing, they do not have to do everything, either. They can do something, even if it is something small: for example, they could try picking one traditional activity from this holiday or special occasion that also might have some special meaning for them, and focus on it. Although doing so might include some pain, it is the pain of change; going through it helps survivors begin to accept the absence their celebration.
- Survivors should talk with others about the reality of the death of their loved one, and the fact that their life, including how they celebrate holidays and special occasions, is now different.
- Similarly, survivors can look back at how they celebrated a particular holiday in the past, and their role in that celebration. How might it be different now, without their loved one? How might they want to handle the balance between their traditional ways of celebrating and the potential differences? Others who have been involved in the holiday traditions may also want to give input as to what was, and still is, important to them. The goal is to incorporate the traditions, but accommodate to allow for the newness of the situation.
- If they choose to accept an invitation to someone's home for the holidays, survivors should give themselves some leeway: when they decide to accept the invitation, they should let the host know that they will try to participate but might have to excuse themselves at some point during the event. (For this reason, it is strongly suggested that survivors do not host an event themselves during the first year after the death of their loved one. If they are a guest, they can leave if things become difficult, or they can cancel at the last minute without greatly impacting everyone else's holiday. However, if they host the event themselves, it is much more difficult to escape or cancel without ruining the holidays for others.) They might also consider having a backup plan in case they change their mind about attending the event: something else they can do that is comfortable for them and helps them feel safe.

De Vries and Zonnebelt-Smeenge (2001) further propose the following activities to help the survivors separate their

own sense of self from that of their deceased loved one during holidays and special occasions:

- Survivors should remind themselves that, while they have wonderful memories of their deceased loved one that are associated with past holidays and other special occasions, they also enjoyed those holidays and special occasions for other reasons as well. They can use these reasons as a jumping-off point for building a renewed view of the holiday or special occasion as something they enjoy for themselves.
- Pursuant to the previous point, survivors can make lists of things they like about each holiday or special occasion – including things they may have enjoyed prior to the relationship they had with their deceased loved one. Identifying these things could create avenues for rekindled pleasure: they can choose to make those things more important in the holiday or special occasion in their life as it is now.
- In addition to identifying aspects of holidays and special occasions that were enjoyable in a way unrelated to their deceased loved one, survivors may consider incorporating one or a few of the traditional activities that they enjoyed doing with their loved one or as a family.
- Survivors should make a plan for incorporating the things that they want to include in their celebration of the holiday or special occasion going forward. They can develop specific strategies for when they will do it, how they will do it, and with whom they will do it. There is a strong advantage in thinking ahead, giving themselves and others who also grieve the deceased time to prepare.
- In addition to the usual holidays and special occasions, survivors now have a new one to include: the anniversary of the death of their loved one. This is not just a new day to remember, but a difficult one at that. Do they – and how do they – want to remember and honor their relationship with their loved one on the date of his or her death? Some people choose to light a candle, reread special cards or love letters, or look at pictures. Whatever they decide to do, the anniversary of the death during the first several years will undoubtedly be an occasion for some painful emotions; however, it can also provide an excellent opportunity to work toward healing the pain.

De Vries and Zonnebelt-Smeenge (2001) also put forth thoughts about respectfully storing memories in the past so that survivors can move on in the present:

- Survivors should not be afraid to talk about their deceased loved one. It can help them express how important he or she was to them (and still is). Talking about the person who died also helps survivors accept the reality of the death, in addition to giving them a forum to express some of the emotions associated with the death and memories of the loved one. Survivors might also tell their loved one's favorite story, toast them, write a poem to/about them, play their favorite song, or try making their favorite food.
- Survivors can write a letter to their loved one that has died, recalling several memories they have of holidays and special occasions and how their loved one played an important part. It might even be a good idea to go to the cemetery (or whatever memorial is available for their loved one) and read the letter aloud.
- Survivors can go through cards, letters, pictures, and other personal memorabilia associated with their relationship with the loved one that has passed away. In addition to reliving the occasions and remembering their loved one as they go through these memories, survivors may wish to make a picture book, video, or slide presentation of the holidays and special occasions. They can find a way to incorporate this memory book or presentation during future holiday celebrations to remember their loved one.
- In addition to the above, survivors can request that their friends and family write down special memories they have of the loved one that has died. These memories can be added to the collection discussed previously, or kept in a separate keepsake book to go back to and look at as needed.

When the survivors are ready to do so, DeVries and Zonnebelt-Smeedge (2001) offer ideas as to how they can begin to invest in a new phase of life:

- Survivors should take time to purposefully recognize how their deceased love one influenced who they are today, and determine what they learned from their relationship with their deceased loved one. Those things are not lost now that the loved one is gone. Each survivor is a different person from who they would have been without that relationship with their loved one, and they carry that uniqueness with them into the future.
- Survivors can write a list of goals, desires, and hopes that they have for their life from this point on, especially as they apply to the holidays and other special occasions in their life. Deciding on these goals, and how to make them part of their new life, can enhance their present and their future.
- Survivors should try to consciously choose to live their new life to the fullest – to embrace this new volume of their life. This makes it easier to recognize the new gifts and blessings they will encounter as they move along life's journey.
- Finally, survivors should remember that having a resurgence of grief prior to a particular holiday or special occasion is absolutely normal, even if the death of the loved one was several years prior. Everyone is different, and a timetable cannot be placed on grief. However, the intensity and frequency

of grief should diminish over the first few years, and if this has not happened, the survivor may be holding on to some things that are preventing them from moving on with life: for example, the survivor might have been in shock, or avoided dealing with their grief earlier in the process. If their loved one died more than three years ago, and their grief is still sharp and painful, survivors should think seriously about receiving grief counseling. Though holidays and special days can eventually become filled with joy once again, some people do need additional help in reaching that point. This is not a weakness: seeking additional help is a sign of courage, and will likely be of benefit.

Grief Counseling

Most survivors are able to cope with the normal grief reactions and address the four Tasks of Mourning on their own after losing a loved one. However, some people experience higher than normal levels of distress, which can often lead to a poor outcome of the grieving process.

Historically, grieving has been facilitated via religious organizations, family, funeral rituals, and other social networks. However, times change – today, some survivors who struggle with the tasks of mourning seek professional counseling for help with their thoughts, feelings, and behaviors. Others do not specifically seek out counseling, but do accept it if offered. Grief counseling is seen as a valid supplement to the more traditional facilitations as previously mentioned, and can help bring an effective resolution to the loss.

Worden (2009) suggested a distinction between grief counseling and grief therapy. *Grief counseling* is when survivors seek help facilitating uncomplicated, or normal, grief and are looking for a healthy adaptation to the tasks of mourning within a reasonable period of time. *Grief therapy* consists of specialized techniques used to help survivors with abnormal or complicated grief reactions (and will be discussed in more detail later in the course).

The general goals of grief counseling are to help the survivor adapt to the death of their loved one and adjust to a new reality without their loved one. Grief counseling also has specific goals that correspond to Worden's Tasks of Mourning:

- Increasing the reality of the loss
- Helping the counselee deal with both the emotional and behavior pain
- Helping the counselee overcome various impediments to readjust after the loss
- Helping the counselee find a way to maintain a bond with the deceased while feeling comfortable reinvesting in life.

Different types of counselors can help facilitate the goals of grief counseling. Trained doctors, nurses, psychologists, and social workers support people who have sustained a significant loss; this work can be done on an individual basis or in a group setting. Volunteer counselors who have been selected, trained, and supported by professionals are also an option; these counselors might be more specialized – for example, widows who have already gone through the grief process helping other widows, etc. Another possibility is a self-help group, where bereaved individuals offer other bereaved individuals support; this might be done with or without the support of professionals, and can be individualized or done in a group setting.

As funeral and death care professionals, it is important to recognize when someone might need some grief counseling, and be aware of what is available to them. Funeral professionals should have an idea of what is offered in their local community, and be able to refer bereaved individuals when needed.

It would be nice to have a set list of indicators that tell when someone might need grief counseling or be at-risk for difficult grieving. Experts have attempted to identify those individuals most likely to be at-risk and in need of grief counseling, but it is difficult to do with precision.

That said, some characteristics specific to widows and widowers are:

- A high level of perceived non-supportiveness in the bereaved person's social network response during the crisis
- A moderate level of perceived non-supportiveness in social network response to the bereavement crisis occurring together with particularly "traumatic" circumstances of the death
- A previously highly ambivalent marital relationship with the deceased, traumatic circumstances of the death, and any unmet needs
- The presence of a concurrent life crisis

Indications that family members other than spouses might have difficulty grieving and need additional support include:

- More young children at home
- Lower social class
- Employment little, if any
- Anger high
- Pining high
- Self-reproach high
- Lacking current relationships

As death care professionals interact with the bereaved, they should be aware of these indicators, and also keep in mind that not everything is black and white. If the death care professionals has the slightest indication that an individual might be at-risk, it's likely best to mention what options are available in the community for support.

Grief Therapy

As we've discussed, grief therapy is different from grief counseling: the goal of grief counseling is to facilitate the tasks of mourning in the recently bereaved so that the mourner makes a better adaptation to the loss, whereas grief therapy has the goal of identifying and resolving the conflicts of separation that preclude the completion of mourning tasks in individuals whose grief is chronic, delayed, excessive, or masked as physical symptoms.

Abnormal grief reactions, or *complicated mourning*, is when the grief level has intensified so much that the survivor is overwhelmed and resorts to unhealthy behaviors, or remains in the state of grief without progression through the tasks of mourning. Experts have conducted extensive research in the attempt to define complicated grief and mourning in a way that can be measured. While nothing has been added to the *Diagnostic and Statistical Manual* to help identify persons with this condition, Worden (2009) highlighted an existing model that he has found helpful in his clinical work. It includes four main categories:

- Chronic grief reactions – A chronic or prolonged grief reaction is one that is excessive in duration and never comes to a satisfactory conclusion.
- Delayed grief reactions – sometimes called inhibited, suppressed, or postponed grief reactions, the survivor experiences symptoms of grief at a future date.
- Exaggerated grief reactions – the person experiencing the intensification of a normal grief reaction either feels overwhelmed or resorts to maladaptive behavior.
- Masked grief reactions – survivors experience symptoms and behaviors that cause them difficulty, but they do not recognize the fact that these symptoms or behaviors are related to the loss.

Grief therapy is considered most appropriate in situations that reflect one or more of these four categories.

There are several factors that lead to complicated mourning.

Relational factors – These factors define the type of relationship the bereaved individual had with the deceased, and the wounds that death opens up in it. A relationship with unexpressed hostility most commonly hinders mourning. In life, there was an inability to deal with a high level of ambivalence in the relationship; now that one person in the relationship is dead, the survivor has an excessive amount of anger and guilt that causes difficulty with adequately grieving. Another type of relationship that might hinder grief is a highly narcissistic one where the deceased represents an extension of the survivor. If the survivor were to admit to the loss, they would need to confront a loss of part of themselves. So instead, they deny the loss ever happened and fail to grieve. A third difficult relationship is a highly dependent one, as the survivor loses their source of dependency and feels abandoned. In some relationships, such as if the deceased was an abusive parent or partner, the survivor deals with increased grief because of what they wished for but never got and now can never have.

Circumstantial factors – Circumstances surrounding a loss are important predictors of the strength and the outcome of the grief reaction. Some circumstances that might prevent a survivor from grieving, or make it difficult to bring grief to a satisfactory conclusion, include uncertain losses where the death is not confirmed because the body is missing, or multiple losses as with natural disasters or accidents.

Historical factors – People who experienced abnormal grief reactions in the past are more likely to have an abnormal grief reaction with other deaths.

Personality factors – The bereaved individual's character and how it affects his or her ability to cope with emotional distress is also a factor. Some people are unable to tolerate extremes of emotional distress and withdraw in order to defend themselves against such strong feelings. This short-circuits the process and often triggers a complicated grief reaction. Additionally, as we generally try to live within our definition of ourselves, one's self-concept might also hinder grief. If a survivor views him or herself as the strong one in the family, they might feel they do not need to grieve, and eventually experience a complicated grief reaction.

Social factors – Grief is really a social process, and is best dealt with in a social setting where people can support and reinforce each other as they deal with the loss. Experts have pointed out three social conditions that may indicate complicated grief reactions.

1. The loss is socially unspeakable, as with a death by suicide. In these situations, there is a tendency for the family and friends to keep quiet about the circumstances surrounding the death. This can cause harm to the survivors, who may need to communicate with others to resolve their own grief.
2. The loss is socially negated: as we've seen, this is when the survivors and those around them act as if the loss did not happen. This might occur with an abortion, for example. Socially negated losses lead to what some call "disenfranchised grief," where the mourner's grief is not recognized by our society.
3. The absence of a social support network that consists of people who knew the deceased individual and can give support to the survivor or survivors.

It is not uncommon for people to move far away from friends and family members in today's society. A social support network might be absent because of geography, but could also be absent because of social isolation by the survivor or by the deceased before death.

exam question...

8. _____ consists of specialized techniques used to help survivors with abnormal or complicated grief reactions.
   a. Grief counseling
   b. Grief therapy
   c. The Task of Mourning
   d. None of the above

The End of Mourning

According to Worden (2009), mourning is finished when a person completes the four Tasks of Mourning. But how long will that take? There is really is no one answer.

After the death of a loved one, two years is not too much of a stretch – but there is also a sense in which mourning is never finished. Survivors should understand that mourning is a long-term process, and their end result will not be the same as how they were before grief. Survivors should also be aware that grieving is not a linear process: grief may reappear and need to be readdressed.

One indication that mourning is moving toward completion is when the survivor is able to think of their deceased loved one without feeling pain, and without physical manifestations of grief such as intense crying or tightness in the chest. There is always a sense of sadness when thinking of someone who was loved and lost, but it is a different kind of sadness; it lacks the painful quality it previously had.

Another indication of the end of mourning is when the survivor begins to regain an interest in life, feel hopeful again, experience gratification, and adapt to their new roles and the environment they now live in without their loved one. When their emotions can be reinvested into life and those who are living, the survivor is on their way to the completion of mourning.

Managing Grief: The Funeral Director

Expectations of the Profession

Funeral service professionals work with the bereaved during times of extreme emotional need, guiding people through arguably one of the toughest times in life. As professional caregivers, they enable families and communities to express their emotions, as well as help them to properly grieve. Clearly, funeral professionals have a difficult job: it seems only natural that the funeral professional experiences grief of his/her own.

This may happen for a number of reasons. For example, working with the bereaved day in and day out can often make funeral service professionals painfully aware of their own losses. This is especially hard if the loss the client family is dealing with is similar to a loss that the funeral professional experienced. Another way grief can get in the way is when the funeral professional fears losses, such as parents, children, partners, etc. Generally, people have a low-level awareness of these feared deaths; however, if the client family has a loss similar to the funeral professional's most feared losses, this may cause the funeral director grief. Finally, the funeral professional's own death awareness presents a special challenge. When a funeral professional serves a family, he or she is faced with the inevitability of death. This awareness is heightened and can cause more grief when the deceased is similar to the funeral professional's own age, sex, etc.

In order to help funeral professionals with their own grief, it is important that they face the losses they've experienced in their own lives, and make sure they have been adequately resolved. As we've seen, this is important for every loss, but particularly for the funeral professional, who is confronted with death each and every day. Experiencing grief is natural, but it must be done in a healthy way in order to continue helping families deal with their grief.

Stress and Compassion Fatigue

It has been suggested that professional caregivers such as funeral professionals often start out their careers with naïve enthusiasm. Their expectation of making a difference in people's lives might soon be overwhelmed by the sheer volume and urgency of need engulfing them on a daily basis.

Funeral homes operate on a constant, 24-hour rotation that never quits. Funeral directors must deal with economic, operational, and emotional stress on a daily basis. They must also deal with the demands of providing compassion to the bereaved. Wolfelt (2004) outlines the symptoms of what he refers to as "funeral director fatigue syndrome." This is generally known as "compassion fatigue," and is common among caregivers who focus solely on other people and forget to take care of themselves emotionally and sometimes even physically. This can lead to destructive behaviors. Common symptoms of compassion fatigue include:

- Exhaustion and loss of energy
- Irritability
- Impatience
- Cynicism
- Detachment
- Physical complaints
- Depression
- Isolation from others

While it is admirable to help bereaved families, and their need might seem to justify emotional sacrifices, ultimately funeral directors and other caregivers are not effectively helping others when they ignore what they themselves are experiencing on the inside. Wolfelt mentioned that emotional overload, circumstances surrounding death, and caring for the bereaved all will inevitably lead to

bouts of funeral director fatigue syndrome. However, there are ways to avoid or get rid of these symptoms. In short, although it is easy to get wrapped up in the workload, funeral professionals must carve out the time to adopt positive, healthy habits in their own lives. Some tips offered by funeral professionals and experts on how to avoid compassion fatigue include:

- Spend time with family and friends whenever free time is available
- Embrace technology such as smart phones that allow you to be away from the funeral home and still tend to work, be on call, etc.
- Take vacations, work out, find a hobby, or whatever it takes to forget about work and feel happy

In addition, death care professionals must develop a regular coping system and mourning mechanism to put each death they encounter on a daily basis into context. This is different for every death care professional, but is important. Experts suggest that death care professionals take a moment each and every day to grieve. Any delayed and unresolved grief will not stay swept under the rug and will cause a greater risk for burnout. It's a balancing act: death care professionals must be careful not to "care too much," but not to hold back, either. These professionals must instead recognize and accept that caring and hurting go hand in hand, especially when facing death and loss on a daily basis.

exam question...

9. Which of the following is NOT a common symptom of compassion fatigue?
a. Cynicism
b. Hyperactivity
c. Irritability
d. Physical complaints

Burnout

There are several accepted definitions of burnout, alternately characterizing it as a syndrome, a condition, a loss, and a state. Here are some working definitions that exist according to Canine (1996):

- A debilitating psychological condition brought about by unrelieved work stress, which results in depleted energy reserves, lowered resistance to illness, increased dissatisfaction and pessimism, increased absenteeism and inefficiency at work.
- A progressive loss of idealism, energy, and purpose experienced by people in the helping professions as a result of the conditions of their work.
- A state of physical, emotional, and mental exhaustion caused by long-term involvement in situations that are emotionally demanding.

Research has demonstrated higher-than-normal stress levels among professionals such as funeral directors, palliative care unit nurses, and emergency workers. The potential for burnout increases as stress occurs constantly with little or no time to grieve one loss before moving on to the next one. Psychologist Dr. Ronald Barrett coined the term "bereavement burnout" for a situation that develops when there is such an accumulation of unresolved, compounded grief that an individual may simply grow numb.

Canine (2006) stated that "Burnout is rooted in an individual's desire for meaningfulness. We want our lives to be significant. And each of us determines what that meaning is – and isn't – that allows us to feel fulfilled….in harmony with ourselves." When thwarted from realizing their meaningful ideal selves, by internal or external circumstance, people no longer feel good and might begin to experience bouts of anxiety, depression, guilt, and disillusionment.

Burnout may be reflected in behavior changes that can affect coworkers and client care as well as personal relationships. The consequences of burnout may include loss of health and well-being as well as a decline in professional performance. The ongoing risk of decline in physical, social, and professional effectiveness requires an awareness of both burnout's symptoms and its stages, as well as ways to manage it.

Symptoms of Burnout

According to Canine (2006), some *symptoms of burnout* include:

- Exhaustion
- Despair
- Powerlessness
- Apathy
- Alienation
- Depression
- Loss of self-esteem
- Irritability
- Loss of energy
- Cynicism
- Poor concentration
- Nightmares
- Loss of creativity
- Negative attitudes

Stages of Burnout

The *stages of burnout*, as defined by Canine (2006), are marked by progressive "points" that have accompanying mental, emotional, and physical ramifications.

Stage 1 – This stage is characterized by the initial stimulation of a new job, and the enthusiasm and desire to succeed and prove oneself. It is a positive and possibly unrealistic time when the death care professional feels ready, willing, and able to do everything.

Stage 2 – This stage is reached when stress begins to build, and fatigue and job disappointment begin to set in. The death care professional might start to believe that the company which he or she is part of does not share the same level of commitment to the work and how important it is.

Stage 3 – This stage is also known as chronic exhaustion. It brings a higher intensity of emotion and possible physical symptoms. Anger, depression, proneness to accidents, and conscious or unconscious guilt might now come into the picture. The death care professional might become less communicative and begin to withdraw socially. Some choose addictive coping mechanisms such as caffeine, alcohol, nicotine, or other drugs – even if they used these things before, use might increase substantially during this stage.

Stage 4 – This stage is that of emergency or the crisis point. If nothing is done to help, the death care professional is at risk for opportunistic illness, and is also likely to demonstrate aversive behavior on the job. This might include coming in late, leaving early, taking longer breaks, becoming angry when demands are made, and treating clients impersonally. At the same time, the death care professional is experiencing feelings of failure and pessimism, and might obsess over his or her disappointments and loss of values that were held so highly in the first stage.

Stage 5 – This is the crossroads between help and hopelessness. It should be a goal of every death care professional and their managers to prevent this stage of burnout from happening. The erratic behavior that is typical of this stage can have a negative impact at work, at home, and even in leisure activities, and can lead to the death care professional either quitting or being fired from their job.

exam question...

10. According to Canine (2006), "Stress begins to build, and fatigue and job disappointment begin to set in. The death care professional might start to believe that the company which he or she is part of does not share the same level of commitment to the work and how important it is," describes _____ of burnout.

a. Stage 1
b. Stage 2
c. Stage 3
d. Stage 4

Managing Burnout

A study of funeral directors suffering symptoms of critical incident stress indicated that those in the reporting group with increased symptoms between the ages of 30-39 were the most likely to leave the funeral profession altogether. Although no cause-and-effect relationship can be drawn from the data, it should suggest to employers that if vulnerable groups can be identified, there should be programs or mechanisms or techniques in place to help them before burnout claims more of the death care professionals that are needed so much in our society.

On an individual level, managing burnout can be done by leading a well-balanced, harmonious life. The difficulty for death care professional, though, is that emotional, physical, and mental resources are often stretched beyond their normal limits. This is brought about by trauma, pain and suffering, serial losses, and compounded grief that these professional deal with on a regular basis.

In response, Canine (2006) created a model illustrating the management of burnout, which directs death care professionals to care for the whole person. His holistic approach identifies five major arenas of life that death care professionals must attend to in order to minimize their potential for burnout.

The core of this model is the spiritual center. This does not require a religious affiliation, a philosophy of life, a purpose in life, and/or a sense of a higher power all apply. Death care professionals should be cognizant of how to best exercise their spiritual muscles, whether that be through prayer, meditation, journal writing, communing with nature, self-examination and reflection, or practicing the tenets of a particular religious faith. In a wheel around the spiritual core, there are the other four arenas of life: mental, emotional, physical, and social.

The mental arena relates to self-image, self-esteem, and self-criticism. If the death care professional is feeling at risk of losing balance and tumbling into burnout, it might be a good idea for him or her to reaffirm how worthwhile they are. This can be done by going through thank you notes from families, looking at past accomplishments and achievements, and even simply reminiscing about how good it feels to help a family during their darkest time. In addition, it's worth listening carefully to what the inner critic is telling them – they may need to change by modifying their behavior, taking a sharper look at their idealized self, or both.

The caregiver's emotional life is also important: this arena addresses the good feelings that result when emotions are identified and expressed. Two strong emotions that death care professionals must deal with are anxiety and anger. It is very important to recognize these feelings, and to know that they are generally triggered by a lack of understanding or a lack of control. When a death care professional is faced with either of these emotions, it is critical that they ask themselves – or others who might be aware of the situation – to identify exactly what it is that they do not understand or cannot control. The goal is to grow better, not bitter.

The physical condition of the death care professional also plays a factor in managing and/or avoiding burnout. Physical well-being need not be present initially, but can be a goal to work toward: prior to beginning any kind of exercise routine for the first time, they should seek the advice of their physician. Once achieved, only about 20 minutes of exercise four times a week

is necessary to maintain this sense of physical health. The specific exercise the death care professional engages in is not important, as long as the heart rate reaches a level of aerobic activity (again, with the clearance of their physician). Along with regular exercise, death care professionals should stay away from drugs, alcohol, tobacco, and caffeine, and should maintain a careful level of fat and sodium intake in their diet, as well. Nutrition should incorporate recommended percentages of protein, carbohydrates, vitamins, minerals, and fibers to keep the death care professional well-balanced and healthy.

Finally, the social arena of life should also be considered. This includes the primary relationships in a caregiver's life like personal and professional ones, as well as the casual ones. Reaching out to others in a social way, such as via hobbies, sports, etc., allows an opportunity to build relationships that are rewarding and meaningful to the death care professional; individuals who sustain these relationships are less likely to experience burnout.

Conclusion

Death is difficult. It is difficult for the survivors, as well as for those professionals who work with the deceased and with the survivors. With proper knowledge of the grieving process, what is healthy, and what is not, funeral professionals can not only help the families they serve, but they can help themselves, as well.

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COURSE EVALUATION

We'd love your feedback!

Evaluations can be submitted by mail or email (contact information above).

Learner Name: _____

Course Name: _____

	Low				High	
Orientation was thorough and clear	1	2	3	4	5	
Course objectives were clearly stated	1	2	3	4	5	
Content was organized	1	2	3	4	5	
Content was what I expected	1	2	3	4	5	
Program met my needs	1	2	3	4	5	
Satisfied with my learning experience	1	2	3	4	5	
Satisfied with customer service, if applicable	1	2	3	4	5	n/a

What suggestions do you have to improve this program, if any?

_____

_____

What educational needs do you currently have?

_____

_____

What other courses or topics are of interest to you?

_____

_____