Addressing Grief in Acute and Community-Based Care Settings: A Research Update and Application to Practice

Society for Social Work Leadership in Health Care

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Goals and Objectives. Participants will be able:

1. To review models and concepts which give understanding to the experience of grief
2. To identify new developments and current trends in the field of grief study
3. To explain the latest research of the experience of grief and apply this to social work practice in acute and community-based settings
4. To identify cues for prolonged or complicated grief which can guide appropriate referral for more in-depth treatment
5. To apply the practice concepts of one model of grief intervention and apply this to cases from their own social work practice.
What is the first thing you think of when I say the word “Grief”? 
Loss?
Sadness?
Separation?
Anguish?
Change?
Ache?
Hurt?

Or, perhaps, more clinical terms, such as:

Stages?
Tasks?
Symptoms?
Complicated?
Pathological?
How does grief relate to your practice at your health facility?

Social Work in:
- Oncology?
- Cardiology?
- Surgery?
- Women’s Health?
- Infectious Disease?
- Transitional Care?
- Behavioral Health?
- Genetics?
- Neurology?
- Rehab?
- Transplant?
- Labor & Delivery?
- ER/Trauma?
- Renal Care?
- Burn Unit?
- Outpatient clinics?
- Primary Care?
- Home Health?
- Hospice?
- Palliative Care
What loss issues are experienced by patients and families at your facility?

Let’s discuss
How does your facility or social work service address these needs?
Let’s talk about Grief

Some essential concepts and terms:

- **Grief** - "a multi-faceted response to loss that includes psychological, behavioral and physical reactions combined with cognitive, emotional, behavioral, social, spiritual and somatic elements." Stroeb, M, Stroeb, W and Schut, H.

- **Bereavement** - an objective state of having lost someone or something. The term is generally used to describe the state of having suffered a loss due to death.

- **Mourning** - the process by which people adapt to loss; the public expression of grief, which is shaped by social and cultural expectations. It is how a person tries to incorporate the loss into life and keep living.
First, let’s review what “normal grief” looks like

- **Feelings**
- **Physical Sensations**
- **Cognitive**
- **Behavioral**
Feelings

- Sadness
- Anger
- Guilt and Self-Reproach
- Anxiety
- Loneliness

- Fatigue
- Helplessness
- Shock
- Yearning
- Emancipation
- Relief
- Numbness

Physical Sensations

- Hollowness in stomach
- Tightness in the chest
- Tightness in the throat
- Oversensitivity to noise
- Sense of depersonalization
- Breathlessness
- Weakness in the muscles
- Lack of energy
- Dry mouth
Cognitions

- Disbelief
- Confusion
- Preoccupation
- Sense of presence
- Hallucinations
Behaviors

- Sleep disturbances
- Appetite disturbances
- Absentminded behavior
- Social withdrawal
- Dreams of the deceased
- Avoiding reminders of the deceased
- Searching and calling out
- Sighing
- Restless hyperactivity
- Crying
- Visiting places or carrying objects that remind one of the deceased
- Treasuring objects that belonged to the deceased
Historical overview of grief: Models and Concepts
Early Grief Theorists: Psychodynamic Models

**Sigmund Freud** –
- Wrote ”Mourning and Melancholia” (1917)
- Freud established his view of griefwork, or decathexis, the process of letting go of attachments to the bereaved.

**John Bowlby** -
- attachment theory;
- biological need for security, even in animals
- similar to Freud seeing grief as an adaptive response to loss
Additional Psychodynamic models

Colin Murray Parkes –
- examined antecedent, concurrent and subsequent factors connected to the grief
- Parkes/Bowlby described ‘phases’ of grief - (shock/numbness - yearning/searching - disorganization/despair - reorganization)

Eric Lindemann –
- studied the Coconut Grove Night Club in Boston (1944) tragedy (500 people died in fire);
- found similar patterns of responses in bereaved;
- Described 3 steps that survivors experience
  - Accepting the loss as a definite fact
  - Adjusting to life without the deceased
  - Forming new relationships in the world
Stage Models

Elisabeth Kubler-Ross –

- Stages – the dying experience - Denial, Anger, Bargaining, Depression, Acceptance
- Stage model implies a certain passivity

Kubler-Ross later stated, however, that these stages were not meant to be viewed as ‘prescriptive’
Stage Models (cont’d)

Theresa Rando –

- Wrote Grief, Dying and Death (1984)
- Describes the grief process as including six individual but interacting processes
  - Recognize the loss
  - React to the separation – feel the pain of the loss
  - Recollect and re-experience the deceased and the relationship
  - Relinquish old attachments to the deceased
  - Readjust – adapt to the new world
  - Reinvest the ‘freed-up energy into a new life
Task Models

William Worden –

- Grief Counseling and Grief Therapy (1982)
- Posits 4 specific tasks to complete
  - 1. To accept the reality of the loss
  - 2. To process the pain of grief
  - 3. To adjust to a world without the deceased
  - 4. To find an enduring connection with the deceased in the midst of embarking on a new life
- The bereaved are seen as ‘active’ in the grief process rather than ‘passive’
Family Function Models

☞ Rudolph Moos – 1995

☞ Reminds us that grief does not occur in isolation

☞ The interaction patterns among individuals in the family may be more important than any ‘stages’ or ‘tasks’

☞ Attention to the changes in communication patterns within the family
More Recent Approaches – Dual Process Model

Stroebe and Schut, 1999

- Views coping with grief as a process of oscillating between a ‘Loss-oriented’ state and a ‘Restoration-oriented’ state
- **Loss – oriented** – more emotional work of grief
- **Restoration – oriented** – more task-focused grief work

- Includes concept of adaptive denial and distraction from the emotional work of grief
Continuing Bonds

Klass, Silverman and Nickman (1996)

- Rather than ‘letting go’ of the deceased, it is believed that a relationship bond continues with the deceased.
- Continuing the relationship with the deceased is part of a new narrative in the bereaved person’s life.
Meaning Making

Robert Neimeyer, 1998

“meaning reconstruction in response to a loss is the central process in grieving.”

This reconstruction includes the attempt to find or create new meaning in the life of the survivor, as well as in the death of the loved one.
Grieving Styles

Martin and Doka, 2000

- Contrasting patterns of grieving and mourning
- Patterns which are not related solely to gender, but to ‘style’ of mourning
  - Intuitive – emphasizing the experiencing and expression of emotion
  - Instrumental – focuses on practical matters and problem solving
- These contrasting styles are poles on a spectrum or continuum
- Related more to socialization and personality types than to gender
Recent shift in grief studies

More recently the focus has shifted from individual pathology to the type of loss, its context, and cultural factors contributing to one’s experience

- Disenfranchised Grief (Doka, 1989), Chronic Sorrow (Olshansky, 1962; Harris, 2010)
- No Closure (Bonanno, 2009; Becvar, 2001; Boss, 2006-2011)
- Grief & Bereavement in Contemporary Society (Neimeyer, Harris, Winokuer, & Thornton, 2011)

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**Disenfranchised Grief - Doka**

**Definition** - “the grief that persons experience when they incur a loss that is not or cannot be openly acknowledged, publicly mourned, or socially supported.” *

“… the term *disenfranchised* implies that some right or privilege was possessed in the first place….the original enfranchisement is conceived as having been both a right and a privilege uniformly granted to all members of a community or society.”**

- examples include stigmatized death (from AIDS or suicide); or deaths unrecognized by society (miscarriage, loved one from an affair);
- expression of grief is outside the cultural norm.


Ambiguous Loss - Boss

AL is a loss that remains unclear, can’t be fixed, and has no closure. It can be physical or psychological.

Examples: dementia, adoption, autism, divorce, family cut-offs (e.g., GLBT); war or disasters where loved ones disappear with no body to bury: the Holocaust, MIA soldiers, genocide, terrorism (9/11), earthquakes (Haiti, Japan), tsunamis (Japan, South Asia), hurricane/floods (Gulf Coast after Katrina), political kidnappings, and forced disappearances (Kosovo, Nepal, East Timor, Africa-ICRC, and sadly, many more.)
And, from an historical overview of how grief is understood, let us now turn to a Research Update on the subject.
“An Empirical Examination of the Stage Theory of Grief”

Study Context

- The stage theory of grief remains a widely accepted model of bereavement adjustment still taught in most health professional programs, and espoused in diverse contexts.
- However, the stage theory of grief has previously not been tested empirically.

“An Empirical Examination of the Stage Theory of Grief”

The Yale Bereavement Study

Study’s Objective

- To examine the relative magnitudes and patterns of change over time post-loss of 5 grief indicators for consistency with the stage theory of grief
“An Empirical Examination of the Stage Theory of Grief”

Study Design, Setting and Participants

- Longitudinal, interview-based cohort study
- Funded by NIMH, NCI and others
- Sample gathered from community-dwelling bereaved individuals living in Connecticut
- Studied 233 participants from January, 2000 to January, 2003 who had lost family members (most often a spouse) due to natural, non-traumatic deaths
“An Empirical Examination of the Stage Theory of Grief”

Main Outcome Measures

- Five rater-administered items assessing:
  - Disbelief
  - Yearning
  - Anger
  - Depression
  - Acceptance

of the death from 1 to 24 months post-loss
Its Findings

- Contrary to stage theory, ‘Disbelief’ (Kubler-Ross’ “Denial”) was not the initial, dominant grief indicator.

- ‘Acceptance’ was the most frequently endorsed item and ‘Yearning’ was the dominant negative grief indicator from 1 to 24 months.
Additional Findings

- ‘Disbelief’ decreased from an initial high at one month post-loss
- ‘Yearning’ peaked at four months post-loss
- ‘Anger’ peaked at five months post-loss
- ‘Depression’ peaked at six months post-loss
- ‘Acceptance’ increased steadily throughout the study observation period ending at 24 months post-loss
The 5 grief indicators achieved their respective maximum values in the sequence (disbelief, yearning, anger, depression, and acceptance) predicted by the stage theory of grief.

These data indicate that in the circumstance of natural death, the normal response involves primarily acceptance and yearning for the deceased.

Regardless of how the data are analyzed, all of the negative grief indicators are in decline by approximately 6 months post-loss.
A graph of rescaled results
Conclusions and application to practice

- The findings reflect how the average person psychologically processes a typical death of a close family member.
- The normal response involves primarily acceptance and yearning for the deceased. Evidently, acceptance, even in the initial month post-loss, is the norm in the case of natural deaths.
- Yearning, not depression, is the most common response to natural death.
- Preparation for the death was associated with better psychological adjustment to the loss.
Conclusions and application to practice

- Chronically elevated levels of **yearning** are cause for concern.

- The negative grief indicators all peak within 6 months, individuals who experience any of the indicators (**disbelief, yearning, anger, depression**) beyond 6 months post-loss, then, deviate from the normal response to the loss.

- Findings, then, support the duration criterion of 6 months post-loss for diagnosing complicated grief disorder. The persistence of these negative grief indicators beyond 6 months is therefore likely to reflect a more difficult than average adjustment.
Study author Holly Prigerson, associate professor of psychiatry at Harvard Medical School and director of the Dana-Farber Cancer Institute’s Center for Psycho-Oncology and Palliative Care Research, says,

"This would suggest that people who have extreme levels of depression, anger or yearning beyond six months would be those who might benefit from a better mental health evaluation and possible referral for treatment."
What do these findings suggest about Grief and Grieving?

- Maybe Kubler-Ross was right – there are stages or phases to normal grief.
- Maybe there are internal processes which must occur in sequence for a person to heal from their grief.
- Maybe we can be better at identifying those who need further assessment of their grief.
Another study from the data obtained in the Yale Bereavement Study –

“Prolonged Grief Disorder: Psychometric Validation of Criteria Proposed for DSM-V and ICD-11”

“Prolonged Grief Disorder: Psychometric Validation of Criteria Proposed for DSM-V and ICD-11”

The goal of this study was to determine the psychometric validity of criteria for Prolonged Grief Disorder (PGD) to enhance the detection of and potential treatment of bereaved individuals at heightened risk of persistent distress and dysfunction.
Why this study was done - study context

- Many studies identify a subset of 10 – 15% of the bereaved for whom grief is both intense and chronic, persisting at disruptive level for many months or years. This population could be said to be experiencing Prolonged Grief Disorder (PGD).
- PGD is not currently recognized as a mental disorder although it meets the requirements for one given in the DSM-IV.
- Before PGD can be recognized as a mental disorder (and included in the DSM-V) bereavement and mental health experts need to agree on standardized criteria for PGD.
- Recently, a panel of experts agreed on a consensus list of symptoms for PGD.
- In this study, researchers undertook a field trial to develop and evaluate algorithms for diagnosing PGD based on these symptoms.
Study Methods

- A total of 291 bereaved respondents were interviewed three times, grouped as 0-6, 6-12, and 12-24 month post-loss.
- Researchers used ‘item response theory’ (IRT) to derive the most informative PGD symptoms from structured interviews.
- These interviews contained questions about the consensus list of grief symptoms.
- Researchers then used “combinatoric” analysis to identify the most sensitive and specific algorithm for the diagnosis of PGD.
What does Grief look like when it goes bad?

Criteria for ‘Prolonged Grief Disorder’

Proposed for DSM-V and ICD-11

A. **Event**: Bereavement (loss of a significant other)

B. **Separation distress**: The bereaved person experiences yearning (e.g., craving, pining, or longing for the deceased; physical or emotional suffering as a result of the desired, but unfulfilled, reunion with the deceased) daily or to a disabling degree
C. Cognitive, emotional, and behavioral symptoms: The bereaved person must have five (or more) of the following symptoms experienced daily or to a disabling degree:

- Confusion about one’s role in life or diminished sense of self (i.e., feeling that a part of oneself has died)
- Difficulty accepting the loss
- Avoidance of reminders of the reality of the loss
- Inability to trust others since the loss
C. Cognitive, emotional, and behavioral symptoms (cont’d)

- Bitterness or anger related to the loss
- Difficulty moving on with life (e.g., making new friends, pursuing interests)
- Numbness (absence of emotion) since the loss
- Feeling that life is unfulfilling, empty, or meaningless since the loss
- Feeling stunned, dazed or shocked by the loss
D. **Timing:** Diagnosis should not be made until at least six months have elapsed since the death.

E. **Impairment:** The disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning (e.g., domestic responsibilities).

F. **Relation to other mental disorders:** The disturbance is not better accounted for by major depressive disorder, generalized anxiety disorder, or posttraumatic stress disorder.
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doi:10.1371/journal.pmed.1000121.t003
Additional findings

The researchers show that individuals given a diagnosis of Prolonged Grief Disorder 6-12 months after a death have a higher subsequent risk of mental health and functional impairment than people not diagnosed with PGD.

What causes complicated or prolonged grief?

Predictors of Prolonged Grief Disorder

- Early parental death or divorce in childhood
- Loss of a first-degree relative
- Sudden, unanticipated or violent death of a loved one
- High levels of dependency on partner who has died
- Attachment insecurity


How does prolonged grief impact the bereaved?

Impact of Prolonged or Complicated Grief

- Broad range of functional impairments
- Health risks such as sleep disruption, substance abuse, compromised immune function, hypertension, heart failure, cancer and suicide
- Higher use of medical services, more frequent hospitalizations

These negative outcomes emerge even when levels of depression and anxiety are taken into account

Recent study of “broken heart syndrome” – found heart attack risk 21 times higher in the recently bereaved.

Additional cues for identifying complicated or prolonged grief in a patient

- Cannot speak of the deceased without **intense and fresh grief** (years after the loss).
- Minor events **trigger** intense grief reaction
- **Themes of loss** in clinical interview
- **Uwilling to move material possessions** of deceased
- Or, conversely, wanting to **toss everything out** right after the death

Complicated or Prolonged Grief Cues

- **Physical symptoms** like deceased
- **Radical changes** in person’s lifestyle following the death
- Long history of **sub-clinical depression**
- Compulsion to **imitate the dead person**
- **Self-destructive impulses**
- **Unaccountable sadness** occurring at a certain time each year
- A **phobia** about illness or about death
- **Continued avoidance** of reminders of deceased
A Sampling of Bereavement Needs in the Medical Population from the Literature
The Seriously Mentally Ill*

A study found that nearly a third of the psychiatric outpatients who were surveyed were currently experiencing intense grief that had already lasted an average of ten years. *

**Conclusion:** the same situational factors that are predictive of more prolonged, severe grief in the general population affect as well those with serious mental illness.

**Recommendation:** “Because the majority of individuals with serious mental illness are middle aged and have aging parents, it seems imperative that service programs begin to offer practical planning for bereavement as an essential service.”

Seventy percent of family of terminally ill patients served in acute care setting made the following recommendations:

- That social workers be present when the doctor breaks bad news;
- That additional support be provided in how to talk to doctors;
- That social workers be involved from the point of admission of the patient; and
- That a primary social worker remain with the family throughout the hospital stay

Elevated Rates of Prolonged Grief Disorder in African Americans*

Sample of African Americans from the Yale Bereavement Study and the Coping with Cancer Study. This study found:

- The prevalence of Prolonged Grief Disorder (PGD) in the sample of African Americans was 21% (14 of 66), significantly higher than among Whites from the study 12% (55 of 471).
- Experiencing a loved one’s death as sudden or unexpected was also significantly associated with PGD over and above the effects of race/ethnicity.
- Highlights the need to adopt culturally sensitive methods of assessment and care for PGD prevention.

What interventions have been found in the research to actually assist the bereaved?

**Challenges in measuring this:**

- Little data on the numbers of people receiving normal intervention after death of loved one
- Interventions are not standardized – volunteer caring, bereavement support, grief counseling, grief therapy
- No agreed-upon definition of complicated/ prolonged grief yet
- No one model of individual treatment has been studied or universally accepted
Research on Bereavement Interventions

- More data on the nature of grief than on treatment
- Lack of empirical evidence on which to base interventions
- A recent meta-analysis of grief counseling shows little evidence that grief interventions (group or individual) are effective or even necessary for normal grief (Jordan and Neimeyer, 2003)
  - Most people have the resilience and available support to help them adapt to their loss, with or without counseling

However, evidence does suggest that for high-risk mourners (the 10-15% of bereaved), interventions appear to be more effective.

Examples of evidence-based programs include the following:

- **Family Bereavement Program** – a group support program for parentally bereaved children (Sandler, 2003)
- **Family Focused Grief Therapy** – for use in palliative care (Kissane, 2006)
- Support groups for those bereaved through loss from AIDS (Goodkin et al, 1999)
- **Individual intervention** for complicated grief (Shear, Frank, Houch & Reynolds, 2005)
What does this evidence suggest?

Most mourners probably do not need formal or professional intervention after the death of a loved one (resilience may be the norm rather than the exception for most people after most losses)

In contrast, evidence shows that for a certain subset of mourners – those with:
- A history of insecure attachments, abuse, trauma, or excessive loss
- Who have endured certain types of death circumstances (sudden or violent)
- For whom good social support is missing …

Have a significantly higher probability of developing complicated or prolonged grief response
How might these findings apply to my work?

- **Hospice Bereavement Services**
  - Anticipatory grief
  - Post-death bereavement follow-up

- **Hospital Death Education and Intervention**
  - Do we identify those with factors for complicated or prolonged grief, and if so, what services do we provide?

- **Behavioral Health Services**
  - How well do we screen those with substance abuse and other disorders for their loss history?
Hospice Bereavement Services

Anticipatory Grief
- How effective are you at identifying risk factors for complicated bereavement at start of care?
- How do you amend the Plan of Care when these risk factors are identified?

Post-death bereavement follow-up
- At what time points in the year following patient’s death do you contact the bereaved?
- Could the ‘peak-points’ give guidance as to when would be best to contact and what to discuss when?
Hospital Death Education and Intervention

- Do we identify those patients with factors for complicated or prolonged grief, and if so, what services do we provide?
- Do we routinely include a grief or loss history in our assessments of patients who are referred for a psych consult?
- Is our material which we give to patients/families current in its content regarding what is being learned about grief and its course?
- Are you aware of resources in your community for treatment of complicated/prolonged grief for patient/family referral?
Behavioral Health Services

How well do we screen those with substance abuse and other disorders for their loss history?

Do our behavioral health services reflect a current understanding of complicated/prolonged grief, or do we treat patients only for depression, anxiety or PTSD?
Suggested applications to practice

- We need to be better at identifying those who are at higher risk for complicated grief.
- Both assessment and intervention must become more culturally sensitive.
  - “...most bereavement interventions have evolved to meet the needs of Caucasian, middle class, older female mourners” (Jordan, Neimeyer, 2007)
- Stay in touch with the research on grief and bereavement. This new evidence should affect how we meet the needs of those we serve.
What practice approaches do you employ with your patients?

- Behavior Modification
- Motivational Interviewing
- Problem Solving
- Cognitive Behavioral Therapy
- Advocacy
- Crisis Intervention
- Grief Counseling/Therapy
- Education
- Brief/Solution-Focused
- Family Treatment
- Case Management
So, grief intervention is not necessarily the only, nor even the most appropriate approach for our patients’ needs in all cases.
What would you say are the purpose of each of these approaches?

- Behavior Modification → Increasing specific behaviors
- Motivational Interviewing → Compliance and behavior change
- Problem Solving → Getting to desired end/resolution
- Education → Addressing pt’s knowledge deficit
- Cognitive Behav. Therapy → Modifying cognitive distortions
- Crisis Intervention → Regaining emotional homeostasis
- Brief/Solution-Focused Tx → Increasing exceptional states
- Case Management → Patient is linked to resources
- Grief Counseling → Pt. fully exp’ing/adapting to loss
- Family Treatment → Family system aligning and supporting patient’s treatment plan
Whatever your method or approach to grief support/counseling, some under-girding principles (not techniques or models) from the work of Alan Wolfelt, Ph.D. may help you in working with those in grief.

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**Companioning the Mourner:**

**Eleven Essential Principles**

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How are we socialized to approach grief as care providers?

The medical model looks at most troublesome ‘conditions’ in terms of something to be ‘fixed’, to be ‘treated’, like a disease.

Is grief something to be ‘cured’? - A collection of symptoms which needs to be treated medically? A pathological state that needs to be addressed on someone’s ‘treatment plan’?
A Different View

In contrast to the medical model of symptom removal, Wolfelt’s ‘Companioning’ approach would create a space for the symptom, giving permission, even encouragement for it to arise within the client.

Then, and only then, paradoxically, will this ‘condition’ begin to heal
How can we do this when we are focusing on treatment goals and outcomes, and expected by the medical team to “get the patient/family to feel better”?

Are we not, though, accustomed to seeing and addressing the problem and patient differently than other disciplines on our medical teams?
Treatment vs. Companioning

Treatments vs. Companioning
For Spiritual, Emotional, Existential Issues

Treatment Model
- Tries to return the mourner to a prior state of homeostatic balance ("old normal").
- Control or stop distressful symptoms; distress is bad.
- Follows a prescriptive model where counselor is perceived as expert.
- Pathology rooted in sustained relationship to dead person.
- Positions the griever in a passive role.
- Grieving person ranges from compliant to noncompliant.
- Quality of care judged by how well grief was "managed."
- Denial interferes with efficient integration of the loss and must be overcome.
- Establish control; create strategic plan of intervention.
- Provide satisfactory answers for all emotional, spiritual questions and dilemmas.

Companioning Model
- Emphasizes the transformative, life-changing experience of grief ("new normal").
- Observe, "watch out for," "bear witness" and see value in soul-based symptoms of grief.
- Bereaved person guides the journey; "teach me" is the foundational principle.
- Is a normal shift from relationship of presence to relationship of memory.
- Recognizes the need for mourner to actively mourn.
- Grieving person expresses the reality of being "torn apart" as best he can.
- Quality of care monitored by how well we allowed the griever to lead the journey.
- Denial helps sustain the integration of the loss from head to heart. It is matched with patience and compassion.
- Show up with curiosity; willingness to learn from the griever.
- Honor the mystery; facilitate the continuing "search for meaning;" no urgency to solve or satisfy the dilemma.
What is meant by ‘Companioning’?

“…companioning requires humility rather than expertise, and surrender rather than control…If you desire to support fellow human beings in grief, you must create a safe place for people to embrace their feelings of profound loss.

…This safe place is not a physical space but rather a cleaned-out, compassionate heart. It is the open heart and befriending of your helplessness that allow you to be truly present to another human being’s intimate pain.”
Wolfelt talks about the “creation of an empty but friendly space”

What do you think he means?

He also adds, “Those of us who companion mourners do indeed feel helpless. And there is good reason – because we are helpless.”

How can this be?

Another quote – “Helplessness is in opposition to expertise.” Techniques, he adds, are often mistakenly used to combat our sense of helplessness, to the patient’s detriment.
Tenet One

“Companioning is about being present to another person’s pain; it is not about taking away the pain”

- When does another’s suffering make you most uncomfortable?
- What does it mean to ‘sit with the pain’ of another and not try to ‘fix’ it?
- We may discover that we want to fix another’s pain because it is hurting us too much.
- When we rush in to take away a person’s pain do we also take away the opportunity for them to integrate the loss into their life?
- Jung – *Soul work* (downward into the dark, deep and unpleasant)
  - *Spirit work* (upward, ascending movement toward the light)
- Being truly present with another’s suffering is *Soul work*
Tenet Two

“Companioning is about going to the wilderness of the soul with another human being; it is not about thinking you are responsible for finding the way out.”

- “Suffering doesn’t mean something is wrong”
- Being comfortable with uncertainty, with companioning them into the ‘wilderness of soul’. Are you attached to outcomes?
- Or do we assist the bereaved in distracting himself to ‘keep busy’ with talk or to try to find one’s ‘old self’ again?
- It’s difficult to ‘trust the process’ when you don’t know where you’re going and it only leads you into more pain.
- How do you “stay present to what is, without thinking you need to change it or take it away?” You observe the soul & surrender
“Companioning is about honoring the spirit; it is not about focusing on the intellect.”

“To be torn apart and then become whole again, we need more than our intellect.”

Why do you suppose that we feel we have to understand and control everything?

When do we most find ourselves asking the patient questions?

What kind of dance are we creating?

What social work skills facilitate our ‘staying with the pain’ of another and not trying to just ‘think through’ the grief?

Does ‘soul’ and ‘spirit’-centered care require a different language from that of our traditional mental health care? Why?
Tenet Four

“Companioning is about listening with the heart; it is not about analyzing with the head.”

- This stuff is too mystical for me! ‘Heart’ is too vague a concept for me.
- Open-heartedness =
  - Humility
  - Unknowing
  - Unconditional love and acceptance
  - Readiness to receive
Tenet Five

“Companioning is about bearing witness to the struggles of others; it is not about judging or directing these struggles.”

- What does it mean to you to ‘bear witness’ to another’s struggle?
- “You have to do your own work first to acquaint yourself in depth with your soul-based emotions.” What does that mean to you?
- How have you found in your practice that your relationship with your own wounds relates to your capacity to accompany a patient/client into painful places?
- When do you notice your ‘natural compassion’ present with a patient, rather than your ego-based, expert, polished professional
Tenet Six

“Companioning is about walking alongside; it is not about leading.”

- Does companioning another risk you giving up being the ‘expert’?
- “The high-functioning companion has the gift of high levels of immediacy. The mourner’s needs are right there in the present moment…” What keeps us from being in the present moment with a patient or family member? Where are we often trying to get?
- If we spend all our time ‘walking alongside’ a patient or client, what are you afraid might happen?
Why, do you suppose, it is so hard to just ‘be present’ in the face of someone else’s pain and suffering?

- It puts us in touch with our own un-worked sources of suffering
- We are trained to be ‘helpers’ for others
- We go into sessions with the mandate (often from the medical team) of ‘getting them to feel better’ or resolving their impediments of grief
- We want to ‘do a good job’
- We have a need to make the session ‘productive’
- Other things?
Tenet Seven

“Companioning means discovering the gifts of sacred silence; it does not mean filling up every moment with words.”

- What does silence do to you when you are with another? Or alone?
- Why do you suppose the bereaved often turn to self-distraction as a coping mechanism for their grief?
- What thoughts do you observe yourself having when you look at another in silence. Try it for 3 minutes.
Tenet Eight

“Companioning is about being still; it is not about frantic movement forward.”

- What is the relationship between stillness and grief or death?
- “… stillness invites the head to settle gently into the heart.”
- “If you do not see that it is in hurting that we ultimately heal, you will greet stillness with anxiety and fear.”
- Do you find that you ever “keep yourself and the mourner busy with techniques intended to avoid the depth of a multitude of feelings?” What would be an alternative?
- What is the first thing you do when you get into your car? Or arrive home?
Tenet Nine

Companionship is about respecting disorder and confusion; it is not about imposing order and logic.”

- How comfortable are you with disorder and confusion? (I work here, don’t I?!) What does being out of control do to you?
- Have you ever worked with a patient/client who attempted to intellectualize with order and logic to overcome their grief? How can we assist such a client?
- What is it, do you think, about experiencing deep feelings that makes us feel ‘out of control’?
Tenet Ten

“Companioning is about learning from others; it is not about teaching them.”

- Can you remember the last time you were touched by what a patient/client share with you?
- “I believe that mourner can instinctively sense who can listen to their stories and who cannot.” What do you think makes the difference in this regard?
- In what ways does the U of Michigan Hospital environment contribute to/hinder you from taking the time to listen to your patients?
- “Honoring stories, both our own and others’, requires that we slow down, turn inward and create the sacred space to do so.”
Tenet Eleven

“Companioning is about curiosity; it is not about expertise.”

Ever heard the concept of ‘beginner’s mind’ or ‘know-nothing mind’? What do you think this has to do with our work with our patients?

“Paradoxically, you can only learn from the mourner by acknowledging you don’t know. It is out of your helplessness that you ultimately become helpful.” How does your training get in your way in working with others?

“In the beginner’s mind there are many possibilities; in the expert’s mind there are few.” (The myth of the expert)
Isn’t this strange, that the encouragement of a symptom promotes its healing?

Why is it that when we create a space for things ‘as they are’ (both within ourselves and our clients) even though ugly and painful, that it fosters the conditions necessary for transformation and healing?

Why do you suppose this is so?
“Grief heals when it is received by a caring other.”

Wendy Lustbader
It’s been wonderful to be with you all today. Thanks for coming!