THE INITIATORY POTENTIAL OF GRIEVING
THE LOSS OF A LOVED ONE

by

ILKA LOUISE DE GAST

A clinical case study
submitted in partial fulfillment
of the requirements for the degree of

DOCTOR OF PSYCHOLOGY IN CLINICAL PSYCHOLOGY

INSTITUTE OF IMAGINAL STUDIES
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This clinical case study has been accepted for the faculty of the
Institute of Imaginal Studies by:

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______________________________
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Doctoral Project Committee Member
To my loved ones here and on the other side
Last night they came with news of death
not knowing what I would say.
I wanted to say,
"The green wind is running through the fields
making the grass lie flat."
I wanted to say,
"The apple blossom flakes like ash
covering the orchard wall."
I wanted to say,
"The fish float belly up in the slow stream,
stepping stones to the dead."
They asked if I would sleep that night,
I said I did not know.
For this loss I could not speak,
the tongue lay idle in a great darkness,
the heart was strangely open,
the moon had gone,
and it was then
when I said, "He is no longer here,"
that the night put its arms around me
and all the white stars turned bitter with grief.

—David Whyte
“News of Death”
(Reprinted with permission of Many Rivers Press.)
ABSTRACT
THE INITIATORY POTENTIAL OF GRIEVING
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by
Ilka Louise de Gast

In working therapeutically with clients who have experienced the death of a loved one, the conventional approach focuses on helping the bereaved work through painful feelings and emotions, and on restoring them to a functional state of being. This Clinical Case Study highlights other possibilities for working with clients which may provide opportunities for long-term personal growth, including greater self-awareness, changed priorities, a shift in worldview, and the deepening of capacities such as compassion and courage.

A review of the literature on bereavement consisted of biological, psychodynamic, cognitive/behavioral, sociocultural, and group perspectives, as well as imaginal approaches to bereavement. These sources provided context for the examination of the therapeutic process of six grief group participants who entered therapy after the deaths of their partner or spouse.

This writing examines the progression of their treatment. Issues that emerged included difficulties being able to function in everyday life, the wish not to continue living without their spouse, lack of trust in others and in the world around them, not knowing how to manage anger and other difficult emotions, and existential crisis. Interventions implemented were grief education, expressive arts, ritual, and visualization to work through painful emotions, strengthen coping skills, and explore existential issues.
After 15 months of group therapy the participants reported feeling less overwhelmed by grief, and were able to find joy in life once more and integrate their experience of loss in a way that was meaningful to them.

The learnings of this Clinical Case Study outline how the clients’ imaginal structures changed from those that include the Stoic Warrior and Victim structures to the Active Griever and Initiate structures. Key concepts and principles from the bereavement literature were used to interpret these structures.

Finally, by integrating theories on bereavement with interpretations of the clients’ imaginal structures, a comprehensive approach to bereavement is presented, including how to enhance the initiatory potential of grief. This approach encompasses, but is not limited to, the following factors: 1) accessing and actively expressing the pain of the grief; 2) receiving guidance from initiated elders; 3) grieving within a supportive community, within a ritual context, and utilizing expressive arts; 4) formulating a myth of the hereafter; and 5) nurturing the continuing bonds with the deceased.
ACKNOWLEDGEMENTS

I would like to express my appreciation to all the people who helped me with this Clinical Case Study. I wish to thank my husband, Joshua, for his emotional and practical support, and the invaluable conversations about the content and organization, as well as the editing of this work. I also wish to thank my wonderful community of fellow doctoral students, without whom this study would have surely taken many more years to complete.

Of course this study would have not been possible without my dear clients at Sutter, Visiting Nurse Association, and Hospice. I extend to them my heartfelt appreciation for their vulnerable and courageous work. My thanks also go to the many mentors in my personal grief process, as well those who enriched my professional and academic understanding of the process of bereavement including Richard Cuadra, Elisabeth Kübler-Ross, Malidoma Somé, Sobonfu Somé, Gail Bigelow, Aftab Omer and other faculty at the Institute of Imaginal Studies.

My gratitude goes to my family in the Netherlands for their support, and to my new Southern California family. I also thank my loved ones on the other side who taught me so much in both life and death, and finally thanks to my daughter, Sophia, who helped me experience the topic of bereavement from the perspective of new life and new hope.
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CHAPTER 1

INTRODUCTION

Clinical Topic

John Bowlby writes that the death of a loved one is generally considered to be one of the most difficult events in a person’s life.\(^1\) The pain of the loss, the struggle to adjust, the challenge to one’s sense of identity, and in some cases, the undermining of one’s basic assumptions about human existence, combine to represent some of the most devastating human experiences.\(^2\) It is usually assumed that at best these experiences will be tolerated and accepted, or at worst, they will forever embitter the bereaved.\(^3\) As this Clinical Case Study contends, however, inherent in the experience of the death of a loved one is the potential for something more: the possibility of a transformative change that can bring with it a new understanding and way of relating to life.

Death is typically feared in contemporary Western culture. Ernest Becker sums it up well when he states that “. . . of all things that move man, one of the principal ones is his terror of death.”\(^4\) As such, it is a topic that has been taboo and mostly ignored by those who have not had to deal with it personally. The result is that most people in Western, modernized cultures have not received adequate preparation for coping with the death of a loved one, or the grief that is a normal and natural response to loss. Research shows that if we do not process our grief after the loss of a loved one, we may prolong our suffering.\(^5\) We may somaticize our grief later on in our lives, become cynical and
bitter, or give up on life. Some individuals who are in extreme emotional pain even commit suicide.

Death and bereavement have become less taboo in recent years. There are many reasons for this. First, more images of natural disasters, wars, and other catastrophic events are encountered as a result of their reporting by the world media. Second, the Hospice movement that first began in London in 1967, and which seeded in America in 1974 has brought increasing attention and involvement in both the dying and bereavement process. Third, counseling for bereavement issues has become more accepted and destigmatized, led by the aging Baby Boomers.

The study of bereavement is important in society’s deepening understanding and treatment of loss. This topic is most relevant to the bereaved and practitioners who assist the bereaved. This Clinical Case Study goes beyond the conventional point of view which maintains that the grief process is for the purpose of the bereaved to recover sufficiently and function effectively after the loss of a partner. In particular, this Clinical Case Study explores how the loss of a partner through death has the potential of being an initiatory experience for the bereaved, which, in addition to helping the bereaved in very pragmatic and immediate ways, may also provide an unexpected opportunity for long-term growth and transformative change. David Whyte alludes to this potential in his poem entitled “The Well of Grief”:

Those who will not slip beneath
the still surface on the well of grief

turning downward through its black water
to the place we cannot breathe

will never know the source from which we drink,
the secret water, cold and clear,
nor find in the darkness glimmering
the small round coins
thrown by those who wished for something else.\textsuperscript{8}

The subject of this Clinical Case Study is a partner loss group which I facilitated
for 15 months. The main catalyst for selecting the grief group was my commitment to this
population resulting from my own experience of loss. The major area of clinical concern
for my clients was bereavement after the death of their spouses. Five participants in the
group had lost their spouses several months before joining; the sixth member had lost her
husband five years prior. Under my guidance, group members explored ways to work
through their grief and to make meaning of their experience. Working with ritual and the
expressive arts helped participants with their process and to begin to heal. Though at first,
members were devastated and did not believe they could endure the pain, by the end of
the group, each individual in their own unique manner, had opened up to life again in
new ways. Jean Houston speaks to this transformative process: “In times of suffering,
when you feel abandoned, perhaps even annihilated, there is occurring – at levels deeper
than your pain – the entry of the sacred, the possibility of redemption. Wounding opens
the doors of our sensibility to a larger reality, which is blocked to our habituated and
conditioned point of view.”\textsuperscript{9}

The new knowledge generated from this Clinical Case Study, particularly of the
initiatory potential inherent in the bereavement experience, may have broad applications
to other areas of psychological theory and practice related to other life transition issues.
Specifically, this knowledge may help aid, empower, or inform those experiencing
challenging life transitions such as divorce, end of employment, marriage, childbirth,
retirement, etc. Greater self-awareness, changed priorities, a shift in worldview, or the
deepening of capacities such as compassion, forgiveness, courage, and fierceness are all possibilities that may be realized by working through challenging life transitions.

This Clinical Case Study also illuminates working with the bereaved through the orientation of Imaginal Psychology. This orientation is concerned with care of the soul, which Thomas Moore characterizes in the following manner: “Tradition teaches that soul lies midway between understanding and unconsciousness, and that its instrument is neither the mind nor the body, but imagination. I understand therapy as nothing more than bringing imagination to areas that are devoid of it, which then must express themselves by becoming symptomatic.” 10 As the interface between the personal, cultural, and archetypal, Imaginal Psychology “helps to re-sacralize and re-enchant human experience after the traumatic secularization of the modern period.” 11

The bereavement group I facilitated presented me with an excellent professional challenge and an opportunity to use principles and practices from Imaginal Psychology. The six members of the group spanned a rich diversity of backgrounds, and shared a common commitment to participation in a group experience, where together, they hoped to work through their grief. I valued the group’s community building process, wherein each individual slowly but steadily developed a strong connection to the other members and the group as a whole. The conversations were vital and authentic, and the participants were open to the use of expressive arts and ritual, even though most were in their late seventies and had only recently come across these modalities. Most of the participants had traditional worldviews and three clients had little prior experience with therapy. However, the majority of group members were open to the initiatory potential of their
experience, and their difficult journeys of transformation were poignant and heart-warming to witness.

**Personal Story**

The primary reason for selecting the topic of bereavement for my Clinical Case Study is my own experience of loss. The following pages give an account of this experience. In just 18 months, from March 1994 to September 1995, three of the people I loved the most, my grandmother, my husband, and my mother, passed away. Four years before the first death, in 1989, I had moved to California from the Netherlands. I was 27 years old and happily living life, like the ancient mythological figure, Persephone, innocently picking flowers. When my husband became ill, the ground opened up, and I was abducted into the underworld. I am not exactly sure when I re-surfaced, but it was years later. The journey was an extremely difficult one, but also one that deeply enriched and changed my life in many ways.

My story begins in 1989, when I met James, my first husband; we married six months after meeting. We had a wonderful, carefree year together until he discovered that he was HIV positive. What followed was a time of great confusion and fear for both of us. My own HIV test was negative, which brought both tremendous relief and guilt. We spent the next months and four years trying everything to treat James’ health, from medication to diet changes, self-help seminars, meditation, and therapy. James made this entry in his journal:

So, here I am. I've gone from deadly fear to certain confusion. Am I fooling myself? Jumping at yet another hypothesis to absolve my fear? Is this denial with proof? In the past two years, my life has passed from me into the hands of scientists, hands that turn knobs that bring into focus an entire universe of microorganisms. My life has shrunk to one part per billion, my future, to one part per
ten billion. I exist in vitro, a petri dish on a lab shelf, a glass slide between the thumb and forefinger of some lab assistant who's thinking about what he'll have for dinner or the girl who delivers samples every Wednesday. I want my life back.14

Our focus during these years of turmoil was dealing with our predicament of James having AIDS and the possibility of his death, exploring what really mattered in life, and working through issues in our relationship. James spent a great deal of time processing other familial relationships, especially the one with his father, as well as imagining what might lie ahead after death.15

During that time, my grandmother became very ill and I traveled to see her in the Netherlands in March 1994. She had a number of complications that were related to old age, according to the doctors. My grandmother, Oma, was only 78 and had always said she would live until she was 104 years old, so this came as a big surprise to the whole family. Oma had a hard life and was a concentration camp survivor in Indonesia during the Japanese occupation. Even after the challenges and suffering she had endured, she was full of life, compassion, and humor. I was her first grandchild and adored her. My mother and I visited her every day for two weeks after which I had to get back to the US. As I left her hospital room for the last time, she called me her angel, and we both cried knowing that we would not see each other again.

While I was in the Netherlands, James had been staying on the East Coast with his family. I returned to him a week before he passed away in June 1994 in a rundown hospital in the Bronx. His local hospital in Connecticut would not admit him as his doctor was on vacation and the staff did not want to deal with his condition. However, James’ death was amazing to witness. Over the week he was in the hospital, he seemed to orchestrate his passing as if he were directing a play, with full confidence and even
humor. His instructions included specifics on the way he wanted to die and where he wanted to have his ashes scattered. He asked to see his family and friends sitting in the waiting room to say farewell and had words of wisdom for all.

On the day of his death, James seemed to get brighter and brighter as the day wore on, his face radiant and his eyes shining as if seeing into another world. He seemed to become less identified with the physical aspect of himself as he expanded into much more. He told me that he would try to keep in touch and described some of the profound things that he was experiencing and noticing on his journey. The last thing he said to his mother, brother, and me before slipping into sleep was “I love you.” Hours later, I was with him as he peacefully passed on.

My whole family was very supportive during James’ illness, but my mother’s help was especially invaluable, and she came to visit from the Netherlands several times to help take care of him. After James’ death, she traveled to the United States for his funeral, and in the following months, helped support me in my grief with her love and wisdom through many telephone calls.

Then only seven months after James’ death, and ten months after my grandmother passed on, the unthinkable happened . . . my mother was diagnosed with a brain tumor. I had just barely begun to breathe again after my experience with James when this new disaster struck. My brothers and I traveled back to the Netherlands from our respective foreign residences to be with our parents for our mother’s birthday in June. It was an emotional time that brought us all very close. I decided to stay in the Netherlands to take care of my mother after my brothers left because I just did not know what would happen with regard to my mother’s condition. I stayed with my mother and father for three
months. The months with them were ones that I will always treasure although they were also very hard as my mother’s health deteriorated rapidly. Her increasing discomfort as well as her weakened state and emotional struggle were hard to witness. This was particularly difficult as I was still grieving James.

Just as with James’ death, the last hours before my mother’s passing were deeply moving. My mother called us all to her room late at night and my father, brothers, and I were sitting around her bed when she asked each of our permission to leave. What followed was an incredibly sad farewell before our mother took her last breath. Then, as with James’ death, the pain of the grief was unbearable. This is how I described the moments after Mam’s death in my journal:

I do not have a clear memory of what happened next, I don't even know if I cried or not. All I can remember is that I felt terrible, exhausted, and empty. I had a horrendous headache and felt so nauseous that I was ready to throw up. I just had to crawl into my bed. . . . I had just lost my mother, the one who had brought me into this world. I felt as if I were some root vegetable that someone had ruthlessly and prematurely ripped up out of the soil, my roots severed before being capriciously tossed aside. I am left with no connection to the earth, no grounding, no guidance, abandoned and lifeless.19

Although James’ death was a deeply spiritual experience for me, and my mother’s more difficult death was intensely profound, my real suffering came with the realization that they were gone from this world and my life. The accumulation of the three deaths and the fact that they had occurred so close together was almost too much to bear. I literally did not know if I could survive the pain. One of the things that made it possible for me to continue was that all three of my loved ones fought so hard to live and, as such showed me how precious this life is. The bereavement group that I attended weekly for two years after their deaths was also very important, as was the expression of my grief
through writing and my continued relationships with the ones who had died through dreams and sensing their presence at times.

My life changed dramatically with the illnesses and deaths and the journey that this took me on. Professionally, I went from being an international business consultant to a graduate school student to pursue a career in psychology. Therapy and especially bereavement groups had been so important to me in my recovery that I wanted to be able to offer this to others in my situation. The experience of the deaths of my loved ones also changed me on a personal level. By processing both the ecstasy of the deep spiritual experience that was part of the deaths as well as the intense emotional pain that came afterwards, I eventually opened up to life in a different way. I lost the innocence that, like Persephone, I had begun the journey with, but gained a deeper wisdom and experience of life.

Within one year after my mother’s death I entered a training at Hospice and the Center for Attitudinal Healing. Several months later I was facilitating bereavement groups there. I learned through facilitating these groups and working with individual bereaved clients that there is the potential for some kind of positive transformation for bereaved individuals in general. It was this exploration that led me to the topic of this Clinical Case Study, bereavement and more specifically, the initiatory potential of grieving the loss of a loved one.

**Confidentiality and Ethical Concerns**

The confidentiality of my six clients is protected throughout this Clinical Case Study through the use of pseudonyms and the alteration of any specific, particular information, in order to prevent their potential identification.
I started the process of getting consent for using the six group participants in my Clinical Case Study by getting the consent of my supervisor. I spent time locating my clients, as it had been a year and a half since I had last seen them. I then called each client, told them about my Clinical Case Study and invited them to participate. It felt good to talk to them again, and I learned that many in the group had also kept in touch with each other.

They all said that they were happy, even honored, to be part of the Clinical Case Study because they had such good memories of the group, and it had helped them through a very difficult period in their lives. The only ambivalence I noticed was in “Sheila’s” (pseudonym) tone of voice during my initial phone conversation with her. She explained her ambivalence by saying that she could not imagine why I would want to include her as she did not regard her grieving process as an exemplary one. She was referring to the fact that it had taken her five years to allow herself to actively grieve by participating in a group.

We arranged for a time to meet as a group at Hospice in Emeryville. The only person who could not be there was “Jasmine” (pseudonym) as she had moved to Oregon. I met with the group in April 2006, in one of the conference rooms that we had occasionally used for our group sessions. It was wonderful to see each other again after all this time. I structured this meeting like the sessions we used to have, except for initiating the meeting by introducing the purpose of the group. The intention of this meeting was to provide an explanation of the Informed Consent forms for my Clinical Case Study and then to have the participants sign if they were willing. I reserved the signing for later in the meeting.
We joined hands and I read a poem by Pablo Neruda and one by Rashani Rea, after which I led the clients in a short meditation. Instead of dividing the hour and a half into short check-ins and a longer period of time to share, as would have been the case in a regular group session, I asked each participant to take as much time as they would like in sharing where they were now in their lives two years from when we last met as a group. Themes that emerged organically during the sharing were: Where are you now in relation to your grief? How was the group valuable to you? And how have you grown as a person?

Supervision

While facilitating the group sessions from January 2003 to April 2004, I received a two-hour group supervision session once a month for this period. My supervisor was a licensed clinical social worker (LCSW). I felt that I received excellent supervision in my work with this group. My supervisor was supportive of my ritualizing the therapy sessions with opening and closing rituals. The ritualizing helped create a safe space so that participants could access and express their strong emotion and feel deeply attended to. My supervisor also welcomed the utilizing of imaginal practices in the group therapy. She, herself, ritualized group supervision by asking us to sit in silence for a few minutes at the beginning of each session. There were between six and eight people in each supervision session, either at hospice as independent contractors, or as psychology interns. We would take turns presenting a case and receiving feedback from the group facilitator and other group members.
Framework of the Treatment

The specific context in which I worked with this bereavement group was as a paid independent contractor for Sutter, Visiting Nurse Association (VNA), and Hospice’s bereavement program in Emeryville, California. I had completed an internship with Sutter, VNA, and Hospice two years prior to beginning the group. In addition to facilitating the bereavement group for partner loss, I also facilitated a weekly grief group for teenagers, using expressive arts, at a local San Francisco Bay Area school.

The services provided by this agency include medical and mental health support for clients who had been diagnosed by their doctor as having less than six months to live, as well as services for families of these clients. Medical health support consisted of services offered by the medical director and visiting nurses, while mental health support included support from counselors, social workers, chaplains, and trained volunteers. The bereavement department provided support to families for their grief process prior to their family member’s death, as well as after the death of their loved one. There were five people on staff, as well as four psychology interns and five independent contractors such as myself who provided counseling and grief work.

I interviewed each of the six potential participants for the bereavement therapy group and received their consent for treatment with forms signed by each person. The initial information I was provided by Hospice regarding the clients’ stated reason for requesting treatment was that five clients were actively grieving the loss of their recently deceased spouses or partners, while the sixth was still grieving the loss of her spouse five years after his death. The presenting problem was that all six clients had significant challenges with respect to functioning in their everyday lives when they began grief
therapy. The challenges ranged from forgetting important appointments, such as meetings with doctors and attorneys, to not being able to get out of the house because of the inability to get out of bed or fear of breaking down in public. Other issues that emerged during the therapy were depression, severe loneliness, the wish not to continue living without their spouse, lack of trust in others and in the world around them, being consumed by, and not knowing what to do with their anger, and some presented a loss of faith in God and other existential issues.

The time period during which the treatment occurred was January 2003 to April 2004. I led weekly one-and-a-half hour group sessions for 15 months. The six group participants, whose treatment I describe in this Clinical Case Study, were the core members of an on-going group; they were together for approximately 15 months. “Wyatt” (pseudonym) and “Annie” (pseudonym) joined the group several months before Jasmine, “Harold” (pseudonym), “Ina” (pseudonym), and Sheila. Wyatt and Annie also left several months earlier. There were other group participants who came for several months at a time, a few stayed for around six to twelve months. The core group of six came consistently and missed only a few sessions. At any given time, there were four to nine people in the group.

Contact between myself and group participants outside the therapy sessions rarely occurred, but when it did happen, it took the form of telephone calls. On occasion I felt it necessary to check-in with clients after they had a particularly difficult time in the group. An example of this would be a situation with Sheila, described in the Progression of the Treatment chapter.
Adjunctive materials that were used in the group were educational hand-outs about grief, poems, guided visualizations, and candle lighting. Art supplies included 8.5 inches by 11 inches paper and crayons as well as writing paper and pens. The group participants themselves brought in photos of their deceased loved ones and other memorabilia.

**Client History**

The following section will present a brief developmental history for each of the six group participants. The history includes the participants’ gender, age, occupation, current living situation, highest education level achieved, assessment of their overall health, how long they were married to their spouse before their spouse’s death, and the reason for the death. Finally, there will be an overview of the clients’ prior therapy history as well as a diagnosis in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM - V) for their current condition.

Jasmine was born in Monaco in 1935 and was 68 when she participated in the grief group. She came to California with her American husband when she was 21 years old. She had completed high school in Monaco and, after marrying, became a homemaker. She was in good physical health. Jasmine and her husband had been married 49 years when her husband passed away due to lung cancer. Jasmine moved from Oakland, California to Portland, Oregon a few months after the end of the group, to be closer to her daughter.

Annie was born in 1923 and was 80 when she participated in the grief group. She lived in a retirement community in Oakland. Annie had a very difficult childhood growing up in foster homes and experienced extensive physical abuse between the ages
of three and five while in foster care. Her mother took Annie and her brother back to live with her when Annie was 16. As a young woman Annie had earned a masters degree, and then held administrative positions with a San Francisco Bay Area college. When she retired, she became involved with art and political activism. Annie was in the initial stages of glaucoma, but otherwise was in good physical health during the group. She had been married twice, before meeting her partner, “Jerry” (pseudonym), and had two children from her previous marriages. Annie and Jerry lived together on weekends for 14 years. Jerry died in a car accident. He had been under the influence of alcohol after drinking at his golf club, and drove into a tree on his way home.

Wyatt was born in 1946 and was 57 when he participated in the grief group. Wyatt had a bachelors degree, and was a sales representative and an artist. He was married to his wife for 13 years before she died of rectal cancer. They had a son from his wife’s previous marriage. Wyatt had a chronic condition of reduced blood platelets diagnosed after commencing the grief group. He found a new life partner while in the group. Wyatt and his new partner moved to Chico, California.

Ina was born in 1930 and was 73 when she participated in the grief group. Ina had a masters degree and worked in early childhood development, teaching parents at a Bay Area college. She was also the director of an infant nursery in Oakland. Ina was married to her husband for 49 years before he passed away due to complications after heart surgery. They had one son. Ina was Jewish and in good physical health. She lived in Oakland.

Harold was born in 1922. He was 81 when he participated in the grief group. Harold’s mother died when he was ten years old, one week after the birth of his younger
brother. In his words, he became “Mr. Mom” at that time and took care of his two younger brothers, while his father worked. Harold completed high school and then studied for two years at a technology institute. He worked in sales. He and his second wife were together for 30 years. She died of pancreatic cancer after having been in remission from breast cancer for many years. Harold was in excellent physical health during the group and lived in Oakland.

Sheila was born in 1924. She was 79 when she participated in the grief group, and unlike the rest of the participants, her loss happened quite a bit prior to her time in the group, approximately five years back. Sheila did not have a good relationship with her parents, who were divorced since she was three years old. Her mother sent Sheila to boarding school when she was nine years old so that her mother could do world travel. This was very traumatic for Sheila who felt abandoned by her mother. She stayed in boarding school until going to college. Sheila had a masters degree, but did not work outside the home after she married because her husband wanted her to stay at home and be a homemaker. She did work as a volunteer, however, including a volunteer job as docent for a Bay Area museum. Sheila and her husband were married for 49 years. Her husband died of heart failure in 1998. She herself was diagnosed with non-hodgkin lymphoma during her time in the group. Her cancer went into remission shortly after completing the group. Sheila lived in Oakland.

Three of the six group participants had experience with therapy prior to starting the grief group. Annie, who grew up in foster homes and had a number of issues, which she wanted to understand and work through, had been in nine years of weekly therapy in her early fifties. She shared during a group session that this earlier therapy had “saved”
her life. Wyatt had been in individual and group therapy with his wife to “help understand each other better” and work on their marriage. Ina had been in therapy in college because of her parents’ divorce, and then had been in three years of therapy as a result of a traumatic event at work. She later received marriage counseling with her husband, in order to work on their relationship.

The following section includes a diagnosis for each of the six group participants with a Global Assessment of Function (GAF) score for the beginning and end of their treatment. The diagnostic category for bereavement in the DSM - IV is: V62.82 Bereavement (Principal). All six clients were given this diagnosis, while four clients also received the diagnosis of Depressive Disorder NOS.

**DSM - IV diagnosis**

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<th>Jasmine</th>
<th>Sheila</th>
<th>Annie</th>
<th>Harold</th>
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<tr>
<td><strong>Axis III</strong></td>
<td>N/A</td>
<td>Non-Hodgkin’s Lymphoma</td>
<td>N/A</td>
<td>N/A</td>
<td>Reduced Lymphoma Platelet Disorder</td>
<td>N/A</td>
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<tr>
<td><strong>Axis IV</strong></td>
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<td><strong>Axis V</strong> Beg.</td>
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Progression of the Treatment

This section provides a general overview of the progression of the group therapy, beginning with a presentation of the initial reason for seeking treatment. Following this is an outline of the major themes and clinical issues that emerged through the course of treatment, as well as interventions used to work with these issues. Finally, a summary is provided of how the participants may have benefited from the therapy.

At the beginning of treatment, although they had accepted the reality of the deaths on an intellectual level, all six clients were experiencing some degree of emotional denial. In addition, all but one participant were fearful of processing their grief in case they would lose control of themselves and their lives. Ina said that she did not need anyone to help her with her grief and that she did not cry. Sheila and several other participants spent much of their group time talking about mundane details of their daily lives in order not to have to feel the pain of their grief. This denial-driven behavior of focusing on mundane details is distinct from other times during the group, when the participants would share details of their lives in order to get to know each other and develop trust.

Interventions used in the therapy to address this issue included reminding the group to stay with their feelings and share the story of their loss, rather than recounting the practical details of their lives. Educating the participants about the grief process was also significant. This included explaining how accessing and expressing feelings were important for the eventual integration of grief. Exploring family of origin material led to group discussions around the theme of stoicism, in which we explored how group
members were driven to act as if they did not need any help with their grief. This led to the awareness that stoicism was not serving the participants’ healing process.

Towards the middle of the treatment period, interventions included expressive arts projects to help participants explore the more complicated feelings around their loss. For example, the participants were asked to journal about problematic aspects of their relationship with their partners before the deaths. From the journaling came a sharing of painful stories about the relationships with their loved ones. Annie, in particular expressed her anger at her partner for the circumstances around his death, which she said mirrored facets of their relationship. Expressing the pain and anger in the group led to a breakthrough for Annie in which she could let go of some of her anger at her partner, after which she was able to trust the group participants and human beings, in general, for the first time. Shortly after this session, a confrontation between Ina and Sheila, with an intervention by the therapist, opened the way for Sheila to disclose what had occurred shortly after her husband’s death. This event had blocked her from actively grieving her husband for close to five years.

Toward the end of the therapy, the focus of interest in the group shifted to existential issues and making meaning of their loss. In order to respond to this change in focus, time was made in the therapy to explore both through journaling and discussion. Journaling and guided visualizations were utilized at the end of the treatment to explore the continuing relationship with deceased loved ones. Other themes that emerged included dating and new relationships, as well as the preparation for the end of therapy.

My overall sense is that the clients benefited from the therapy. They reported that by the end of the therapy they felt less overwhelmed by their grief, and although they still
missed their partners very much, they were able to enjoy life again. All six participants mentioned that they had changed as people, and had strengthened or developed capacities that they did not possess prior to the death of their spouse and attending the group. Annie said she had become much more trusting of people and more courageous as a leader. Sheila noted that she was less hard on herself, while Ina confided that she had let go of some of the perfectionism and emotional control that had been a big part of her life and had often caused her misery. Wyatt told the group that he had finally let go of some fear and had chosen to follow his bliss, his art. Jasmine had become more independent and courageous since the death of her husband, and found joy in places she had not expected. Harold had opened his heart again to a new companion in his life.

Learnings

The learnings gleaned through my work are based upon the interpretation of my clients’ and my own imaginal structures. Aftab Omer defines imaginal structures as: “assemblies of sensory, affective, and cognitive aspects of experience constellated into images [which] both mediate and constitute experience.” The primary imaginal structures evoked for the group participants during therapy include a reflection of their resistances to the therapy and their transference material toward me as their therapist, while my imaginal structures include a reflection of my own counter-transference material. The learnings chapter demonstrates how these imaginal structures relate to what happened in the therapy, and contains the key concepts and principles used to interpret these structures. In some instances several concepts and principles assist the interpretation of one imaginal structure.
Five aspects of the therapy emerged to describe what happened during the course of treatment. They include changes in the group participants’ 1) affect and grief process; 2) relationship to the group; 3) relationship to the therapist; 4) exploration of the continuing bond with the deceased; and 5) ability to make meaning of their experience. The primary imaginal structures evoked for the group participants in these five areas might be called the *Stoic Warrior*, *Victim*, and *Skeptic*. As therapy progressed, additional structures were activated. Among these were the *Active Griever*, the *Same Tribe* structure, and the *Initiate* structure.

These structures can be identified by how they manifested within the group dynamic. The Stoic Warrior structure, for example, is a way to describe the tendency to restrict the active expression of grief. It also describes the feeling of not needing anyone, whether it be the group or therapist, to help the participants with their grief. The Victim structure tended to blame others for their suffering, which had the effect of circumventing the participant’s own experience of grief. The Skeptic structure did not trust the grief process, fearful that letting go of their grief would end the connection with their spouse. The Skeptic was also reticent to explore or express their beliefs in a continued bond or ongoing relationship with the deceased, to avoid being judged as delusional. The emergence of the Active Griever structure made it possible for the participants to feel their pain and share their suffering with others. The Same Tribe structure let participants appreciate belonging to a group or community with which they identified, allowing them to feel safe to work through their grief. The Initiate structure enabled participants to change their perception and make meaning of their experience.
Also important to this analysis is the identification of my own imaginal structures. Among them are what might be called an *Incompetent* structure, an *Outcast* structure, and an *Ethical* structure. As therapy progressed, other more positive structures arose such as the Same Tribe structure, a *Generative* structure, and a *Wounded Healer* structure. The Incompetent structure created the perception of being ineffectual, and of being too young to work with this older group. The Outcast structure gave rise to feelings of being marginalized and of being rejected by the group. The Ethical structure was concerned with the ethics of unduly influencing the group, or forcing them to accept biases and beliefs that I brought into the therapy. The Same Tribe structure emerged when the participants expressed their gratitude and appreciation for the group and their shared sense of community. The Generative structure ushered in my own sense of gratitude for the group having the opportunity to receive the benefits of therapy, within the context of a supportive community, as I had. The Wounded Healer structure allowed for the realization that surviving my own grief gave the participants the hope that they could too.

To interpret the Stoic Warrior and Active Grieaver structures I used Sigmund Freud’s concept of *grief work*. This model of grief resolution assumes the significance of working through one’s grief by actively accessing and expressing the feelings of grief. Once the participants felt safe enough in the group and trusted the therapist and each other, they were able to get in touch with their feelings and engage fully in the grief process. The waning of the Stoic Warrior structure and the activation of the Active Grieaver structure allowed for the eventual integration of their grief.

The Stoic Warrior and Outcast structures were interpreted through the principle offered by Dana Cable, that the taboo of expressing emotions has led to many people in
Western culture grieving in private on their own. The Same Tribe structure that emerged later on in the therapy can be understood through Malidoma Somé’s principle that “a singular expression of grief is an incomplete expression of grief.” The participants started to appreciate the value of the group and belonging to this community to work through their grief, as the Same Tribe structure was evoked. A second principle, offered by Somé, that assisted the understanding of the Same Tribe structure says that it is important to grieve communally within a ritual context.

The Victim and Initiate structures can be interpreted through the concept of initiation as defined by Victor Turner, Robert Moore, Houston, Greg Mogenson, Tanya Wilkinson, and Malidoma Somé. The concept of initiation suggests that one can change their perception of the grief process, from one of meaningless suffering to the transformative possibilities inherent within the experience of loss. Wilkinson states that in contemporary culture, stoicism, blame and entitlement often reinforce the victim position, blocking the ability to make meaning out of a difficult situation. This principle helps further my understanding of the Victim and Initiate structures as well as the Stoic Warrior structure.

As for my own imaginal structures, Carl Jung’s concept of the wounded healer and Houston’s concept of the sacred wound support the interpretation of my Incompetent structure and Wounded Healer structure. These concepts explain how the therapist’s own experience of loss can help them develop the capacities necessary to help others through their grief process. For this reason the principle that initiated or qualified elders are necessary to guide people through contemporary initiation ordeals, espoused by Louise Carus Madhi, Wilkinson, and Malidoma Somé, is also used. From my own
experience, I can say that my Incompetent structure became less dominant and my Wounded Healer structure was activated with the deeper understanding of how my own experience of loss, and my initiatory journey, qualified me to help others through their grief, no matter what our age difference, or how the participants’ process differed from my own.

Lastly, the participants’ Skeptic and my Ethical structures were interpreted through Bowlby’s concept of continuing relationships.\textsuperscript{28} I also used Jung’s principle that mourning is a process of creating a death myth or an image of life after death.\textsuperscript{29} Exploring the continued relationship with their loved ones, as well as creating a conception of life after death, may have helped the group participants be less skeptical by finding trust in the grief process, and eventually integrate their loss. My Ethical structure created discomfort and apprehension around exploring the ongoing relationship with the deceased. I did not want to unduly influence the group participants with my personal beliefs.

The participants’ Skeptic structure and my Ethical structure can simultaneously be interpreted by Sylvia Brinton Perera’s scapegoat complex.\textsuperscript{30} At times during the therapy, the participants resisted expressing or exploring the possibility of an ongoing relationship with their loved ones. The scapegoat complex can explain the participants’ fear of being judged for what they might have perceived as unconventional. Similarly, the scapegoat complex helps to interpret my Ethical structure. It explains that although I knew how important creating a conception of the afterlife was in my own grief process, I was afraid to bring this understanding to the group participants for fear of being judged by them.
Personal and Professional Challenge

Some of the personal and professional challenges I faced in my work with this group are reflected in the overview of the imaginal structures above. These included dealing with the participants’ Victim and Stoic Warrior structures and my Incompetent and Ethical structures. Other challenges consisted of my having enough empathy for specific participants, as well as my doubts around the benefits of disclosing details of my personal losses and how I had dealt with issues that emerged in my own grief process. Also a significant challenge was my wish not to unduly influence the participants with my beliefs and biases.

A particular sticky challenge I faced was the issue of self-disclosure. Early on, I asked myself whether it would be therapeutic for participants if I disclosed my own personal experience with the deaths of my loved ones. In the end I decided to share my experience, to help the participants develop trust in me by knowing that I personally shared their experience of loss and that they, too, could endure this suffering.

I was less certain of whether or not to disclose how I had dealt with my anger, because the method I had used was rather unconventional and sometimes seen as overly aggressive by those who do not understand it. Later in the treatment, I did share with the participants my experience of a training with Elisabeth Kübler-Ross and how we had worked to actively express our anger and rage by verbalizing our feelings and getting physical by hitting phone books with rubber tubing. This disclosure was a way of modeling to the participants just one method of processing this emotion.

A further challenge I faced was the issue of not wanting to unduly influence the group participants with my personal beliefs, biases and opinions. I encouraged discussion
and exploration around the participants’ ideas of an afterlife, and only occasionally, carefully disclosed my own, being mindful not to affect anyone else’s experience. Similarly, I was aware that my own grief process had been a transformative experience for me, which had led to many changes in who I was as a person and how I lived my life. As such, I wanted to hold the seed of the potential of initiation for the participants, without pushing them to explore the meaning of their experience of loss before they were ready.

My capacity of empathy was challenged by some group participants more than others. It was difficult to sit through mundane day to day details, and tirades of blame and complaints about doctors, family, and friends. Yet I understood the importance of allowing these particular participants the room to explore the full range of their grief reactions, before helping them find more direct ways of expressing their anger and pain. Finding the balance between helping them explore their experience and guiding them to new discoveries was one place where my doubts of competency emerged. I also dealt with the fear that I was not respected because I was much younger than the group participants. I did not want to overcompensate by being too directive, trusting that in time I would be perceived as a competent therapist.
CHAPTER 2

CLINICAL LITERATURE REVIEW

Introduction and Overview

D. W. Kissane, S. Bloch, and D. P. McKenzie state that bereavement is a complex, multidimensional process, influenced by biological, psychological, social, and cultural factors.\(^1\) As such it has been studied within a variety of disciplines and can be seen from a number of different perspectives. There have been many changes in the field of bereavement in recent years, which the literature in this Clinical Case Study will attempt to portray. This Clinical Case Study presents various perspectives on bereavement – biological, cognitive/behavioral, psychodynamic, sociocultural, and group – as well as imaginal approaches to bereavement. In order to distinguish the different perspectives, it will be necessary to briefly summarize each.

A biological perspective on bereavement holds that the experience of the loss of a loved one through death brings about physiological changes in the bereaved. This section includes a discussion of attachment and affect theory. From a cognitive/behavioral perspective, a loss through death changes one’s belief system and its related emotions and behaviors. Cognitive/behavioral therapy has as its goal the cognitive behavioral adaptation to the consequences of loss.\(^2\) A psychodynamic perspective assumes the importance of the emotional aspect of grieving and bringing unconscious or unacknowledged feelings to the surface of awareness.\(^3\) Also relevant is Freud’s concept of mourning as a decathexis, as well as his staged grief work model. Following this is a
presentation of Bowlby’s concept of continuing relationships and other grief theories that are being utilized in the field of bereavement.

A sociocultural perspective on bereavement recognizes the impact of ethnicity, race, religion, language, and worldview on a person’s experience of grief. Imaginal approaches to bereavement draw on a number of orientations and disciplines. With its intent to care for the soul, imaginal approaches consider the grief process a potentially transformative journey of soul. A group perspective on bereavement recognizes the significance of the role of community or group therapy to provide support for the bereaved.

Before expanding on the different perspectives of bereavement, an introduction to the differences between the concepts of normal and complicated grief will be presented. These differences will be further explored from the various psychological perspectives. J. William Worden suggests that grief refers to “the experience of one who has lost a loved one to death.” The term can also be applied to other losses. Drawing on the work of Erich Lindemann and Collin Murray Parkes, Worden writes that the manifestations of normal grief may include: 1) feelings such as sadness, anger, guilt, anxiety, loneliness, fatigue, helplessness, shock, yearning, relief, and numbness; 2) physical sensations, with some of the most commonly reported ones including a lack of energy, dry mouth, weakness in the muscles, oversensitivity to noise, tightness in the chest and/or throat, and breathlessness; 3) cognitions include disbelief, confusion, pre-occupation with the deceased, sense of presence of the deceased and hallucinations or some other kind of metaphysical phenomena; 4) behaviors such as sleep or appetite disturbance, crying, absentminded behavior, social withdrawal, dreams of the deceased, avoiding reminders
of the deceased, searching for the loved one, restless over-activity, and visiting places or carrying objects that remind the survivor of the deceased.\textsuperscript{5}

Complicated grief is also known as abnormal grief, unresolved grief, and pathological grief and is defined by M. Horowitz et al. as an intensification of grief that does not progress to resolution, but rather leads to problematic repetition and compromises healing.\textsuperscript{6} They write that, “. . . the intensification of grief to the level where the person is overwhelmed, resorts to maladaptive behavior, or remains interminably in the state of grief without progression of the mourning process toward completion. . . . It involves processes that do not move progressively toward assimilation or accommodation but, instead, led to stereotyped repetitions or extensive interruptions of healing.”\textsuperscript{7}

Worden writes that in order to comprehend why individuals experience grief differently from one another and what contributes to a complicated grief reaction it is necessary to understand how the mourning process is mediated by various factors.\textsuperscript{8} He lists the mediators of mourning as follows: 1) who the person was who died, examples include father, spouse, distant cousin; 2) nature of attachment such as having experienced conflicts with the deceased; 3) mode of death; 4) historical antecedents; 5) personality variables including age and gender, person’s coping style, attachment style, ego strength, beliefs and values; 6) social variables such as support availability, religious and ethnic factors; and 7) concurrent stresses.\textsuperscript{9}

Worden suggests that complicated grief reactions may be outlined under four headings: 1) chronic grief is a grief reaction that is “excessive in duration and never comes to a satisfactory conclusion”; 2) delayed grief is also called an inhibited, suppressed, or postponed grief reaction, which involves a past loss that was not mourned
sufficiently causing the excessive intensity of grief over a current loss; 3) exaggerated grief is a reaction which is “excessive and disabling” including clinical depression and anxiety disorders; and 4) masked grief, where “patients experience symptoms and behaviors that cause them difficulty, but they don’t recognize that they are related to the loss.”

The diagnostic category for bereavement in the DSM - IV is: V62.82 Bereavement (Principal). There is some discussion whether complicated grief should be considered a separate diagnostic category in the DSM - IV. H. Prigerson and S. Jacobs, who developed the Inventory of Complicated Grief, are among the main proponents of creating this “distinct clinical entity.”

A Biological Perspective on Bereavement

This section on the biological perspective on bereavement explores the impact of loss on human beings and the physiological makeup of grief. This includes an examination of Bowlby’s attachment theory, as well as Silvan Tomkins and Donald Nathanson’s affect theory. There is also an examination of the research that links the experience of loss to specific physiological changes in the bereaved and the deterioration of their health. Furthermore, this section addresses the need for psychological and psychiatric treatment, including medication, for normal or complicated grief.

The discussion of the biological perspective on bereavement starts with the work of Charles Darwin, who compares the similar ways in which sorrow is expressed by animals and human beings. Worden writes that in a like manner, Konrad Lorenz describes the behavior of the separation of a Greylag goose from its mate. Lorenz says that the observable characteristics appear to correspond greatly with human grief: “The
first response to the disappearance of the partner consists in the anxious attempt to find him again. The goose moves about restlessly by day and night, flying great distances and visiting places where the partner may be found, uttering all the time the penetrating trisyllabic long-distance call. The searching expeditions are extended farther and farther, and quite often the searcher himself gets lost, or succumbs to an accident.”  

Similarly, Bowlby summarizes the grief reactions of the goose, dog, jackdaw, orangutan, and chimpanzee in the following manner: “Members of lower species protest at the loss of a loved object and do all in their power to seek and recover it; hostility, externally directed, is frequent; withdrawal, rejection of a potential new object, apathy, and restlessness are the rule.”  Another example of grieving in the animal world is noted by George Engel, who describes the behavior of an ostrich who has lost her mate. The account, which is given in great detail, sounds typical of the kinds of reactions that can be found in the human survivor of the loss of a partner.

In order to understand the instinctual reaction to loss in human beings and animals, it is important to examine the nature of attachment. Bowlby’s attachment theory suggests that forming attachments with significant others comes from a need for security and safety in both young children and animals. Bowlby proposes that this attachment relationship precipitates the child’s ability to make affectional bonds later in his or her life. When the attachment figure is threatened or disappears, the instinctual response is one of immense anxiety, fierce emotional protest and even anger or aggressive behavior. If, as a result of this response “the bond is restored, the activities cease and the states of stress and distress are alleviated.” But if the danger is not removed, withdrawal, apathy, and despair will then ensue. Worden states that these primitive biological
processes are in effect in both animals and humans. However, he also believes that there are aspects of grieving specific only to human beings. These include a sense of depersonalization (i.e. nothing seems real), feelings of guilt, thoughts of disbelief, and behaviors such as the avoidance of reminders of the deceased because they are too painful. He also speculates that only humans dream of the deceased.

Affect theory, especially in the 1940’s, began to examine the emotional characteristics of grief. According to Nathanson, Tomkins is responsible for a revolution in our understanding of emotion. The innate affects, first described by Tomkins, which Nathanson calls internal scripts or organizers of affect, are depicted by Nathanson as a “group of hard-wired, pre-programmed, genetically transmitted mechanisms that exist in each of us and are responsible for the earliest form of emotional life.” When an affect has been triggered, it means that a stimulus has activated a mechanism which releases a “known pattern of biological events.” Nathanson names the biological part of emotion affect, while the rest he calls biography. Based on Tomkins work, Nathanson perceives the innate affects to include: 1) interest – excitement, 2) enjoyment – joy, 3) surprise – startle, 4) fear – terror, 5) distress – anguish, 6) anger – rage, 7) dismell, disgust, and 8) shame – humiliation. Nathanson writes that the affect particularly related to grief is distress – anguish. He continues on to say that any constant and unpleasant stimulus will activate distress and that this may include data from memory, perception, cognition or from a drive.

Michael Franz Basch integrates affect theory into modern psychotherapy. He suggests that the word feeling implies that an organism has become aware or conscious of an affect, which requires the presence of advanced brain components. The distinct
concept of an emotion, according to Basch, is the complex combination of an affect with the memory of a previous experience of the affect.\textsuperscript{30} Nathanson builds on this when he defines mood as the experience of affect in combination with unsolved problems from the past.\textsuperscript{31} He states that mood is a persistent state of emotion in which we can remain stuck for a period of time. Nathanson postulates that grief as a mood is made up of prolonged periods of distress triggered by the immediate experience and reliving of past personal loss.\textsuperscript{32}

Nathanson points out that before Tomkins’ contribution, researchers believed incorrectly that affect, behavior, and cognition represented three separate capacities (functions) of the human brain. Nathanson maintains that affect causes behaviors all over the body and influences (even controls) the thinking made possible by the most advanced component of the brain, the neocortex. He even goes as far as to say that affect is itself a form of thinking, “the action thinking of the old (reptilian) brain.” \textsuperscript{33}

There are a number of studies in the literature that indicate a possible relationship between bereavement and health issues and even mortality.\textsuperscript{34} Assessing the research conducted on the health consequences of bereavement, Worden notes that after the death of a spouse, symptoms such as dizziness, headaches, trembling, heart palpitations, and a variety of gastrointestinal symptoms may increase.\textsuperscript{35} Engel proposes that the psychological trauma of losing a loved one is on par with the physiological trauma of being severely wounded, and compares the process of mourning to the process of physiological healing.\textsuperscript{36} Engel warns that intensive grief, however, can cause serious illness or even death.\textsuperscript{37}
Parkes writes that in addition to causing psychological issues such as anxiety and depression, insomnia, etc., the loss of a loved one can also aggravate medical conditions such as rheumatism and asthma. He researched the heightened risk of death experienced by the bereaved and provides evidence for the metaphor of the broken heart. Parkes documents a major increase in the death rates of widowers during the six months after the death of a spouse, and that a high proportion of these deaths were caused by heart disease. Wolfgang Stroebe and Margaret Stroebe, in examining studies of conjugal bereavement and mortality, conclude that the risk of mortality increases for the bereaved, with widowers showing a higher risk than widows.

Hall and Irwin in their research on physiological functioning in bereavement come to the conclusion that the experience of bereavement impacts the immune and neuroendocrine systems. Jerome Frederick, a researcher for Dodge Chemical Company, developed a hypothesis which elucidates how this takes place. He explains that the stress response to grief triggers a series of physiological events on the pituitary-adrenal axis that depresses the individual’s immune system and thereby eventually leads to disease development.

Worden mentions a number of studies, such as Lindemann’s and Parkes’, pointing to the possibility that unresolved grief may be the underlying cause for particular psychological conditions seen at mental health clinics. He cites Aaron Lazare who estimates 10 to 15 percent of the patients at a Massachusetts mental health clinic, while S. Zisook and R. A. DeVaul estimate 17 percent of patients entering a psychiatric outpatient facility in California had conditions related to unresolved grief.
A discussion about whether or not complicated grief should be categorized as a medical problem is outlined by the Center for Advancement of Health. Categorizing grief as a medical problem could increase the availability of interventions for those who need such services. However, it raises the concern that harm may be caused through administering treatment when it is not needed, or through the provision of ineffective or incorrect treatment.

According to Worden, the emerging consensus on using medication to treat grief is that it should be used sparingly, especially in the management of normal grief. T. P. Hackett, maintains that the intention should be to provide relief from anxiety or insomnia rather than providing relief from transitory depressive symptoms. It is not considered beneficial to provide antidepressant medications unless clinical depression is diagnosed, as antidepressant medications have not been demonstrated to relieve normal grief symptoms.

John D. Preston, John H. O’Neal, and Mary C. Talaga state that uncomplicated bereavement does not typically require psychological or psychiatric treatment, but if grief disintegrates into a clinical depression, psychotherapy, psychotropic medication, or both, become necessary. Preston, O’Neal, and Talaga estimate that between 15 to 20 percent of grieving individuals develop a clinical depression after experiencing a major loss. Worden is aligned with Preston, O’Neal, and Talaga’s position that those suffering from complicated grief may require grief therapy, but he suggests that some people experiencing uncomplicated grief may also benefit from the extra help or support offered through professional counseling. According to Preston, O’Neal, and Talaga, antidepressant medication is available for the following symptoms of clinical depression;
agitation, early morning awakening, serious weight loss, and anhedonia (loss of the ability to experience pleasure). The remaining symptoms of clinical depression include erosion of self-esteem, suicidal ideation or attempts, and a marked impairment of social, interpersonal, academic, or occupational functioning.

In summary, the biological perspective on bereavement is built upon Bowlby’s attachment theory and Nathanson and Tomkins’ affect theory to explain the physiological anatomy of grief. Research then demonstrates a link between an individual’s experience of bereavement to specific health issues, including how grief is shown to impact the immune and neuroendocrine systems. Several authors articulate the need for psychological and psychiatric treatment in addition to medication for complicated grief only, while others maintain that psychological work may also be beneficial for those experiencing normal grief (without medication).

A Cognitive/Behavioral Perspective on Bereavement

This section on the cognitive/behavioral perspective on bereavement explores the work of theorists who maintain that a loss through death changes one’s belief system and its related emotions and behaviors. It also examines how to assess the individual’s grief process, and how to provide a distinction between healthy and unhealthy reactions to loss before strategies are employed to assist clients with their process. Developments within the cognitive/behavioral perspective that have taken place in more recent years, especially as they pertain to bereavement, are also discussed.

According to Therese Rando, the tendency of therapists has, traditionally, been to emphasize emotions as central to the grieving process. She states that this tendency has led them to neglect its cognitive aspects. Rando posits that without appropriate
cognitive change, the mourning process cannot have a healthy outcome, regardless of how much emotional processing has been done. Presenting the cognitive perspective on bereavement, A. Beck states that this approach focuses on the relationship between the mourner’s emotions and behaviors and their cognitive evaluations about themselves, the world, and the future.

V. L. Gluhosky elucidates the cognitive/behavioral position further by stating that experiencing the death of a loved one deconstructs the existing views that a person has about life. He states that this necessitates a difficult and painful internal process of cognitively reorganizing an individual’s belief system, thoughts, and feelings.

Rando postulates that there are two sets of cognitive processes associated with bereavement. The first set pertains to the person’s learning of the reality of his or her loss and its implications. The second set depends on the accomplishment of the first and relates to living post-loss. Rando states that the second set of cognitive processes includes: “revision of the assumptive world, the necessity for adopting new ways of being in the external world, and the formation of a new identity incorporating the changes demanded by . . . the loss of the loved one.”

In discussing complicated grief, Ruth Malkinson states that the cognitive approach describes it as distorted thinking, where an extreme emotional reaction is influenced by the negative cognitive assessment of self, the world, and the future. She gives the example of a bereaved person interpreting the death of a loved one as an intended rejection or as evidence of being worthless. Beck referred to these maladaptive cognitive processes used during stressful life events as cognitive distortions, while Albert Ellis named them irrational beliefs.
According to Ellis’ model, (rational-emotive behavior therapy – REBT), the reactions to the death of a loved one are related to a specific set of beliefs or cognitions that are either functional or dysfunctional (adaptive or maladaptive). With loss through death, negative emotional reactions such as sadness can be perceived as relating to functional or adaptive cognitions. Malkinson gives the following example, “Life has changed forever, and it’s sad and painful.” Complicated grief, on the other hand, is regarded as the persistence over time of negative emotions relating to dysfunctional or maladaptive cognitions, which may led to depression or anxiety. Examples of this would be “Life is not worth living without my loved one,” or “I’ll never again be happy because he (or she) died. It’s unfair.”

Grief, within the cognitive/behavioral conceptual framework, as suggested by Malkinson, is considered to be a process that is a normal reaction to a very stressful event. This process helps the bereaved person synthesize his or her disrupted belief system into a form of healthy acceptance and adapt to the reality without his or her loved one. Whereas this perspective holds that grief involves intense emotions such as sadness, frustration and pain, it aims to minimize extreme reactions such as self-defeating feelings of depression, horror, and despair.

Malkinson believes that applying the cognitive/behavioral perspective to a bereaved person’s experience allows for an assessment of the individual’s grief process and enables a distinction between healthy and unhealthy reactions to loss. It then offers cognitive, emotional, and behavioral strategies for facilitating a more sound course of bereavement if necessary. Cognitive/behavioral treatment interventions used to assist clients to cope with loss and adapt their relationship with the living and the deceased
include: guided imagery, thought-stopping, exposure intervention, cognitive restructuring, breathing exercises, and skills acquisition.\textsuperscript{71}

In recent years, a number of developments have taken place within the cognitive behavioral perspective on bereavement according to Laura Matthews and Samuel Marwit.\textsuperscript{72} They draw attention to M. Stroebe and H. Schut’s \textit{Dual-Process Model} (DPM), which they say expands traditional emotional models of bereavement coping, beyond the emotion-based, single coping strategy.\textsuperscript{73} The DPM offers an analysis of cognitive processing and coping strategies.\textsuperscript{74} This model focuses on two phases of the mourning process and suggests that the bereaved alternate between the two. The first phase, also known as the loss-oriented coping strategy, is the concentration on the cognitive and emotional processes entailed in mourning. The second phase, also identified as the restoration-oriented coping strategy, is the focus on reorganizing life without the deceased.\textsuperscript{75} The alternating between these two phases may look like an oscillation between engaging versus avoiding intensive grief work. According to M. Stroebe and W. Stroebe this oscillation may partially account for the variation in the mourning behavior of different cultures.\textsuperscript{76}

Malkinson states that a substantial focus of recent cognitive therapy has changed from helping the bereaved adapt to a new reality without the deceased toward assisting them to “reconstruct new meanings.”\textsuperscript{77} Robert A. Neimeyer writes from this perspective that diverges from the more rationalistic cognitive theories, differentiating distorted or dysfunctional beliefs and reactions from “normative patterns” of grieving.\textsuperscript{78} This changed perspective resonates with a constructivist or narrative approach to psychotherapy. The principal assumption here is that the main work of the grief process
is to endeavor to restore meaning. Neimeyer contends that reorganization after loss is influenced by factors pertaining to the personal, familial, and cultural and that these factors are often marginalized in an attempt to standardize models.

To summarize the cognitive/behavioral perspective on bereavement, authors writing from this orientation maintain that without the appropriate cognitive change, the bereavement process cannot have a healthy outcome, regardless of how much emotional processing has been done. This section gives an overview of how this conceptual framework differentiates between normal and complicated grief and how each is treated. Normal grief is considered as a normal reaction to a very stressful event. In contrast, Malkinson and others maintain that complicated grief consists of distorted thinking. Beck refers to this distorted thinking as cognitive distortions, while Ellis names them irrational beliefs. A discussion is also offered addressing the developments in cognitive/behavioral therapy that have taken place in recent years, including Stroebe and Schut’s Dual Process Model and Neimeyer’s assumption that the main work of the grief process is to restore meaning in addition to the more traditional cognitive/behavioral goal of helping the bereaved adapt to a new reality without the deceased.

**A Psychodynamic Perspective on Bereavement**

This section begins with an examination of the differences between normal and complicated grief from a psychodynamic perspective. This approach to grieving assumes the significance of the emotions and bringing unconscious feelings to the surface of awareness. Following this differentiation between normal and complicated grief will be a presentation of various theoretical approaches to the mechanism of grief and grief resolution, including Freud’s concepts of decathexis and identification, and Bowlby’s
theory of attachment and separation. Bowlby’s concept of continuing relationships, as well as the development of this concept by Dennis Klass, Phyllis Silverman, and Steven Nickman will also be discussed. Finally, this section provides an introduction to the literature that describes the course of grief as stages, phases, components, or tasks.

The first part of this psychodynamic perspective on bereavement will address and expand on the differences between normal and complicated grief as first discussed in the introduction of the Literature Review chapter. Historically speaking, differentiating normal grief from complicated grief has been a challenging task. It really was not until early this century that the differentiation began to take shape as exhibited in the published writings of Freud and K. Abraham. Their approach was a descriptive one in which they attributed certain characteristics to normal grief and other characteristics to pathological grief. However, in subsequent research it has been found that some of the characteristics they suggested to be pathological are actually part of normal grief, such as periods of emotional pain, and anger after a loss, which Freud and Abraham believed to be indicative of a pathological grief reaction.

Moving beyond the dualistic compartmentalization of characteristics, Worden writes that complicated grief is related to the duration and intensity of grief reactions rather than the presence or absence of such characteristics. Similarly, Horowitz, et al. describe a continuum of grief related reactions and state that complicated grief or pathology is related to the intensity or the length of the duration of such a reaction:

“Today we find there is more of a continuous relationship between normal and abnormal grief reactions . . . and that pathology is more related to the intensity of a reaction or the
duration of a reaction rather than to the simple presence or absence of a specific symptom or behavior.” 84

In addition to opening the debate on normal and complicated grief, Freud was also influential in distinguishing grief from clinical depression. 85 He first noted in 1917 that with grief, self-esteem remains relatively intact and that grief only becomes clinical depression when there is a marked erosion of self-esteem.

Matthews and Marwit contend that the primary theoretical model of grief resolution that has prevailed for the majority of the twentieth century also stems from Freud’s early work. 86 According to Matthews and Marwit this model holds that the primary work of grieving is a decathexis, or a letting go of emotional attachment to the deceased. 87 In Freud’s own words, he describes the mourning process as a decathexis, “the withdrawal of the libido from the object, and a displacement of it on to a new one.” 88 In addition he states that, “mourning has quite a specific psychical task to perform: its function is to detach the survivor’s memories and hopes from the dead.” 89

Freud uses the term cathexis to define the initial process of connecting with the other person, while he calls the outcome of the cathexis, identification, which is the marked sense that this significant other is part of one’s identity or ego. 90 Drawing on Freud, Alicia Skinner Cook and Daniel Dworkin write that the process of eventual psychological separation from the deceased takes place as the memories and emotions linked to the deceased are re-evaluated and intensified, hypercathexis, until they have become so real and firmly fixed internally that they give the bereaved a feeling of permanent connection to the deceased and thereby some security. 91 Freud states that it is
at this point that the bereaved is able to accept the ending of the physical connection with the deceased and detach their hopes and memories from them.92

According to John Baker, the object relations theory of Melanie Klein places less emphasis on the detachment of the emotional ties to the deceased during mourning, and more emphasis on preserving and repairing the internal object relationship in the bereaved individual’s character.93 Klein perceives mourning as a process of reparation in which the destructive fantasies stimulated by the loss are contained, and the individual’s inner world is rebuilt.94 Klein goes on to say that bereaved individuals fear that they have lost not just this loved one, but also their internalized loved ones. However, this may result in positive changes, such as a strengthening of the individual’s relation to his inner objects.95 Klein writes: “Through the work of mourning [the bereaved individual] is reinstating all his loved internal objects which he feels he has lost. Every advance in the process of mourning results in a deepening of the individual’s relation to his inner objects, in the happiness of regaining them when they were felt to be lost.” 96

Skinner Cook and Dworkin illustrate how the object relations point of view expressed by V. D. Volkan expands upon Freud’s theory.97 They write that Volkan agrees with Freud that identification is a healthy coping mechanism by which elements or qualities of the lost object are integrated into the bereaved person’s existing personality or identity. Volkan proposes that this mechanism can enrich the ego after mourning is concluded.98 Volkan also speaks of the possibility of a reaction called introjection as an unhealthy result of mourning.99 This occurs when the lost object is not assimilated, but becomes an addition to the personality of the bereaved. Drawing on Volkan’s work,
Skinner Cook and Dworkin explain that this is problematic because it does not allow for the proper internalization of the lost object and completion of the mourning process.\textsuperscript{100}

Terry Martin discusses Bowlby’s break with traditional psychoanalytic views of mourning to include a rejection of the concepts of psychic energy and drive and a new conceptualization of affectional bonds.\textsuperscript{101} Bowlby refutes Freud’s idea that identification is primary to the forming of emotional ties and the mechanism of grief.\textsuperscript{102} Instead, he uses attachment theory to explain how emotional ties are created and how the grief process is similar to separation anxiety felt by infants when their mothers leave. He suggests that when an individual loses someone or something to which they are emotionally attached, childlike feelings of intense anxiety and fear are triggered, and attempts are made to regain the affectional bond and a sense of safety within the environment.\textsuperscript{103}

Skinner Cook and Dworkin are of the opinion that instead of being mutually exclusive, Freud’s and Bowlby’s concepts are both useful to create a more comprehensive context for bereavement. They characterize Freud’s concept of identification as an \textit{intrapsychic} or internal perspective, and Bowlby’s interactional factors of attachment and separation as an adjustment to the external environment, and that, ultimately, the process of grief encompasses both.\textsuperscript{104}

Bowlby challenges Freud on a second issue. Bowlby’s concept of continuing relationships (or the bereaved individual’s continuing sense of the dead person’s presence) as a feature of healthy mourning offers an alternative viewpoint to Freud’s theory that the purpose of the mourning process is the severing of bonds between the bereaved and the deceased.\textsuperscript{105} Although later in Freud’s career, after the deaths of his
mother, daughter, and grandson, it appears from correspondence that he changes his earlier theory, that in his personal experience with grief he feels the need for some sense of felt continuity with his deceased family members.106

Bowlby values the persistence of emotional attachment to the deceased, pointing to evidence that correlates secure attachment to the growth of self-reliance.107 In contrast to Freud, Bowlby believes that the continued relationship with loved ones may in fact help the bereaved individual’s process of recovery and eventual independence, rather than impede it. Bowlby writes: “It seems likely that for many widows and widowers it is precisely because they are willing for their feelings of attachment to the dead spouse to persist that their sense of identity is preserved and they become able to reorganize their lives along lines they find meaningful.” 108

According to Bowlby there are both appropriate and inappropriate locations for the bereaved to sense the dead person’s presence.109 During the daytime a loved one may be experienced as a companion who accompanies the bereaved everywhere. They may be sensed in specific locations including a favorite room, chair, the garden or grave site. However, Bowlby regards it a possible sign of pathology when the bereaved sense the dead person in mislocations, or inappropriate locations such as in another person or animal, especially if it is more than a “transitory” experience.110

Bowlby maintains that the understanding of the differences between healthy and pathological mourning is obscured by Freud’s concept of identification. He explains that the concept of identification, instead of being limited to instances where the deceased person is located within the bereaved, is extended to cover every case in which a continuation of the dead person’s presence is sensed, irrespective of location.111 Bowlby
says that this does not allow for the differentiation between appropriate or inappropriate locations. Addressing the significance of the acceptance of the continuing relationship concept to the literature on grief, Bowlby says: “Failure to recognize that a continuing sense of the dead person’s presence, either as a constant companion or in some specific and appropriate location, is a common feature of healthy mourning [that] has led to much confused theorizing.”

Klass, Silverman, and Nickman question whether Bowlby espouses the importance of the “indefinite” continuing relationship between the bereaved and their loved one, or whether he proposes that an eventual severance of this relationship is required as Freud suggests. They contend that inherent in Bowlby’s earlier model of successful mourning, which he does not amend in his later work, is the eventual breaking of ties with the deceased in preparation for the making of a new relationship. Klass, Silverman, and Nickman seem to regard this as a fundamental contradiction in his theory. They write that remaining connected to the deceased appears to facilitate the ability to cope with the loss and the accompanying changes. Klass, Silverman, and Nickman cite clinical reports that show how the resolution of grief involves these continuing bonds and how this can be a healthy part of the survivors ongoing life.

Examples of continuing bonds cited in the clinical reports edited by Klass, Silverman, and Nickman include: 1) dreaming of the deceased, 2) talking to the deceased, 3) believing the deceased is watching the bereaved, 4) keeping items that belonged to the deceased, 5) visiting the grave, and 6) frequently thinking of the deceased. On the whole, the experiences of continuing bonds in their reports are labeled as inner representations, or mental constructs, of the deceased. They draw on V. Tahka’s theory
of inner representation called *remembrance formation* to explain their understanding of
the concept of continuing bonds.\textsuperscript{118} Remembrance formation is a third form of inner
representation, that complements the other two forms, identification and introjection.\textsuperscript{119}
Tahka describes remembrance formation as a distinct form of internalization, whereby
the representation of the loved one is built and integrated into a remembrance of how the
person was experienced in life.\textsuperscript{120} Once this remembrance has been established, it can
later be called back to mind and dismissed at will. This remembering is experienced as a
fully differentiated object representation, without any illusion of its separate and
autonomous existence.

John Archer draws on Bowlby and identifies two aspects of Bowlby’s attachment
theory as being particularly relevant to bereavement: 1) the process of relationship
formation and loss, and 2) working with individual differences in attachment style.\textsuperscript{121}
Bowlby’s theory of attachment asserts that during the course of healthy development,
attachment behavior leads to the development of affectional bonds and attachments,
initially between child and parent, and later between adult and adult.\textsuperscript{122} Thus, types of
attachment styles generally originate from early parental attachments and separations.
Based on Bowlby’s and D. Winnicott’s work, Worden explains that when healthy
attachments are broken, it leads to feelings of grief.\textsuperscript{123} In contrast, when less healthy
attachments are broken, it leads to feelings of anger and guilt. Bowlby disagrees with
Freud that the bereaved individual’s anger directed at the deceased loved one is indicative
of pathological mourning.\textsuperscript{124}

In describing the correlation between attachment styles and complicated grief,
Bowlby elucidates that many of those who respond to a major loss with disordered
mourning are individuals who throughout their lives have tended to form complicated affectional relationships with certain special features.\textsuperscript{125} Included are individuals whose attachments are insecure, anxious and ambivalent.\textsuperscript{126} Bowlby suggests that an inhibited or delayed grief response is common in people with avoidant attachment styles.\textsuperscript{127} This particular attachment style may be the result of a childhood in which the expression of feelings was discouraged and thus perceived as unsafe. Chronic grief, Bowlby proposes, is related to ambivalent attachment styles. The ambivalent attachment style may have been caused by early experiences of discontinuities or frequent rejection by parents. Following Bowlby, Andrew Clark writes that inhibited or delayed grief is associated to factors that block the expression of grief and acceptance of loss, while chronic grief is related to factors that inhibit the process of psychological reinstatement of the lost other.\textsuperscript{128} Although Bowlby corresponds specific attachment styles to grieving responses, he also suggests that other variables, including social and psychological circumstances, are likely to influence the individual’s style of grieving.\textsuperscript{129}

The idea of the bereavement process as being some kind of staged grief work, based on Freud’s early work, has dominated the field of bereavement.\textsuperscript{130} Grief work is defined by Archer to be the mechanism through which an individual moves from grief to a post-grief state, referred to as recovery, readjustment, or resolution.\textsuperscript{131} M. Stroebe maintains that from the perspective of grief work theory, it is necessary to gain awareness of the reality of the loss in order to avoid complications in the grief process.\textsuperscript{132} The grief work or stage model hypothesis also claims that it is important for bereaved individuals to work through their grief in order to come to terms with it.\textsuperscript{133} Sandra Bloom posits that repression (banishing a memory from conscious awareness by which thoughts and
experiences end up in the unconscious) and dissociation or denial (the temporary but drastic modification of one's character or sense of personal identity to avoid emotional distress) are core defenses against overwhelming affect. She suggests that working through overwhelming affect is an important aspect of grief and trauma work and that unintegrated experience can lead to a variety of physical and emotional complications.\(^{134}\)

There is a wealth of literature that describes the course of grief as stages, phases, components, or tasks. Neimeyer notes that there is an assumption in traditional literature that there exists a series of phases of reconciliation.\(^{135}\) The phases start with the death of a loved one and proceed through different emotional reactions, until eventually the bereaved individual completes some form of adjustment or recovery.\(^{136}\) These phases indicate an emotional transition as well as distinct psychological stages and states.

Worden reminds us that there are overlaps between the various stages and phases and that they are seldom distinct or linear.\(^{137}\) Neimeyer writes that, in fact, there is a lack of empirical evidence for the presence of a universal sequence of stages and psychological states.\(^{138}\) One of the most influential grief theories, nevertheless, is the one proposed by Kübler-Ross.\(^{139}\) Kübler-Ross has had a major influence on contemporary understanding of the dying process and bereavement. Her model of the five stages of dying (denial, anger, bargaining, depression, and acceptance) can also be applied to the process of bereavement.\(^{140}\) Worden writes that there is a tendency to take Kübler-Ross’s stages too literally, or to assume that they happen sequentially.\(^{141}\) Kübler-Ross herself has cautioned people against this inclination.\(^{142}\) However, the influence of Kübler-Ross’s model of loss can be appreciated by its prevalence in international medical school
curricula on death and dying.\textsuperscript{143} It is often the primary resource for working with death and loss that is cited by faculty members.\textsuperscript{144}

Other grief models include those offered by Lindemann who divides mourning into the stages of shock-belief, acute mourning, and resolution.\textsuperscript{145} Parkes and Bowlby present four phases of mourning as numbness, yearning, disorganization and despair, and reorganized behavior.\textsuperscript{146} Worden offers an alternate model of grief represented by the four main tasks of mourning which include accepting the reality of the loss, working through the pain of the grief, adjusting to an environment in which the deceased is missing, and emotionally relocating the deceased and moving on with life.\textsuperscript{147}

In summary, the psychodynamic perspective on bereavement presented in this section begins with an exploration of the differences between normal and pathological grief based on Freud and Abraham’s writing and continues in Bowlby and Worden’s work. The primary theoretical model of grief resolution that has prevailed for much of the twentieth century stems from Freud’s work and holds that mourning is a decathexis, a severing or letting go of emotional attachment to the deceased. Challenging Freud’s model is Bowlby’s theory of the significance of a continuing relationship between the bereaved and the deceased. Klass, Silverman, and Nickman emphasize that continuing bonds are beneficial to the bereaved if maintained indefinitely. Also relevant is Bowlby’s examination of life-long attachment styles and their influence on an individual’s bereavement process. Finally, there is significant development of theories that define the course of grief as stages, phases, components, or tasks. Originally based on Freud’s staged grief work, models of the grief process most notably include those by Lindemann, Parkes, Bowlby, Kübler-Ross, and Worden.
A Sociocultural Perspective on Bereavement

This section on the sociocultural perspective on bereavement examines the significance of culture on an individual’s grief process. It compares and contrasts several Western and indigenous cultures, and explores how a culture’s particular approach to emotion, illness, and life in general, as well as their death myth or conception of what happens after death, influence the physical and emotional process after death. This section also examines cultural beliefs regarding continuing relationships with the deceased and an afterlife.

Richard R. Ellis maintains that an individual’s view of bereavement is based on cultural background and personal worldview. He describes culture to include ethnicity, race, religion, language, and worldview as the product of heritage and life experiences. D. W. Sue and D. Sue include several additional components in their description of worldview and culture. They state that worldview relates to cultural background as it reflects ethnicity and race, as well as social class and gender. Kenneth J. Doka agrees with Ellis, plus Sue and Sue in stretching the concept of culture to encompass spirituality and age. The significance of the concept of culture, according to Doka, is that it provides a way of making meaning of death, loss, and grief.

In a review of modern attitudes of death and bereavement, A. Friedman concludes that “there is nothing natural about the way a people experience... sex or death... both are products of culture: mediated, made and symbolic.” Stephen Schwartzberg and Richard Halgin posit that labeling a client’s grieving style as abnormal because it does not look like the cultural norm may be doing a significant
disservice to the person. They give the example of the response of periods of crying following the loss of a loved one, which is generally deemed appropriate. Yet, crying either too much or too little is considered an inappropriate or pathological response.

D. P. Irish states that for centuries the dominant culture in Europe and North America has primarily been male, Caucasian, and Christian. Scott Eberle suggests that although there exist many variations of this dominant culture’s worldview, one of the basic assumptions is that people are born into this world as an act of God, and if they serve Him by marrying, procreating, and working for their faith community, they “will be granted a place of respect, both on earth and in heaven.” Tom Pinkson, addressing the dominant Western culture’s death myth, writes that death as the Grim Reaper is sometimes seen as the enemy coming to get you. He continues to say that this death myth leaves little room for notions of soul, spirit, or the transcendent.

Joseph Campbell names these cultural beliefs and assumptions about life and death the inherited *group mythology*, which serves as a semiconscious foundation for each individual’s life story. Aligned with Campbell, Eberle notes that this group mythology is challenged by many outside factors. Eberle maintains that in these modern times the many competing worldviews introduced through books, internet, and the media cause individuals to increasingly question and reject their inherited worldview. As a result of these outside challenges, Campbell proposes that the search for meaning and purpose has become an individual, personal life journey, no longer residing in the group mythology.

However, the influence of ideology on bereavement practices in Western society remains strong. Irish writes that medical and religious institutions as well as
mental health professionals operating in the dominant culture have historically been influenced by Western death and bereavement ideology. P. C. Rosenblatt contends that contemporary Western medicine “wages war” on death through prescription cocktails, transplants, and machines. Eberle concurs with this contention when he says that the interventionist approach to medical care reached a new extreme in the early 1960’s with the introduction of cardiopulmonary resuscitation (CPR). He states that this is when people in the Western world “lost the art of dying” and the focus became keeping the client alive at all costs. But when the war on death is lost and someone dies, religious institutions are there to formulate rituals and promulgate their beliefs about death. Irish suggests that they, in turn, have created powerful cultural norms for the physical and emotional process after death. He states that religious institutions have “set cultural standards for disposition of the body after death, and the expected behavioral and emotional responses of the bereaved.”

Addressing current Western attitudes towards funeral rituals, Friedman suggests they were shaped by the experience of World War One. He attributes the “modernist vacuous” funeral rituals to society’s constant confrontation with death during World War One. Cable asserts that it is important for Western society to re-examine the significance of death rituals. Cable encourages the return of meaningful rituals to facilitate the grief process for those individuals who have experienced loss.

Critics of the grief work approach to bereavement have increasingly drawn attention to what they see as its limitations. For example, George Bonanno and Stacey Kaltman suggest that bereavement is not about working through grief, but instead is an
individual’s own way of “living post-loss.” In the adaptation to loss it is not a matter of incorrectly working through grief that creates pathology. Rather, they say that this post-loss life depends on a number of contextual factors such as cultural difference, age and gender, circumstances and significance of the loss, or social support.

With regard to today’s industrialized American and West European cultures, Cable writes that we live in a culture of fast food, cell phones, and high-speed modems, where everything is expected to function at top efficiency, and control and predictability are valued above anything else. R. J. Kastenbaum adds that mourning is not considered as serving any useful purpose, but rather as getting in the way of busy lives and society’s progress. Most employers allow the bereaved three days off work following a death, which indicates that the individuals are expected to get back to normal or to have completed their grief process within the week. Cable notes that our society does not see grief as normal or necessary and that the bereaved are encouraged to hold back their emotions and stay strong. She maintains that the taboo of expressing emotions publicly has led to many people grieving in private on their own.

In contrast to the taboo of expressing emotions in much of the Western world, the people of the Dagara Village of West Africa’s Burkina Faso perceive emotions and tears to be sacred. Malidoma Somé suggests that emotions are “the most vital cord that connects people to each other.” Furthermore, the Dagara believe grief to be “food for the psyche” and hold that just as the body needs food, the psyche needs grief in order to maintain its health. Based on this belief, one of the most elaborate rituals in Dagara culture is a three day funeral ritual. In conveying his people’s notion of the importance of communal grief, Somé writes that grieving while alone is an incomplete
expression of grief. He goes as far as to say that grieving alone can be detrimental to the bereaved and to the people around them. He says, “People who know not the power of shedding their tears together are like a time bomb, dangerous to themselves and to the world around them.” Somé maintains that communal grief has the power to send the deceased home to the world of the ancestors and to heal the pain of the bereaved.

Cable reminds us that North America and Europe are blended societies made up of many diverse racial, ethnic and religious groups. Many of these cultural groups have continued their own customs and identity around death and bereavement. Outside of the dominant culture, perspectives on bereavement vary greatly. For instance, Bonanno and Kaltman comment that a continued bond with the deceased is common in most Asian, African, and Hispanic cultures. They give the example of Chinese ancestor worship, in which intricate ceremonies are dedicated to honoring the continued relationship with deceased loved ones. D. W. Augsburger expands on the importance of funeral rites in ancestor worship when he states that they are believed to: help facilitate the passage of the deceased to the other world, announce the impending arrival to the appropriate authorities of the underworld, strengthen the family unit, and protect the living from the dead. Bonanno and Kaltman also postulate that historical analysis indicates that the idea of a continued bond with deceased relatives was once prevalent in the earlier history of Western European societies.

The belief in life after death prevails in many indigenous cultures, and although it is a widely held belief in contemporary American society, it is not generally acknowledged as a mainstream belief. A Harris poll in 2003 reported that 84 percent of the American population believed in life after death. The possibility of contact
with the deceased, also known as after-death communication (ADC) is also not generally thought of as a mainstream belief, although according to Bill Guggenheim and Judy Guggenheim, 20 percent of the American population is reported to have had one or more ADC experiences.193

To summarize, the section on the sociocultural perspective on bereavement explores the influence of culture on an individual’s experience of death and loss. Several authors describe contemporary Western culture’s approach to mourning and how it is not considered as serving any useful purpose, but rather as getting in the way of society’s progress. Cable discusses the taboo of expressing emotions and how this has led to many people in the West grieving in private. In contrast, Malidoma Somé notes how emotion and the communal expression of grief are valued in West Africa’s Burkina Faso, and that in fact grieving alone is considered an incomplete expression of grief. The last part of this section depicts several culture’s beliefs on continued bonds with the deceased, life after death, and after-death communication.

**Imaginal Approaches to Bereavement**

This section on the imaginal approaches to bereavement begins with a brief history of Imaginal Psychology and a definition of the imaginal. It then examines Western culture’s lost understanding of soul, particularly the *ancestral dimension* of the soul, which Mogensen describes as the connection with the collectivity of the dead, and how this impacts the individual’s experience of grief.194 This section also explores the meaning and potential of initiation, citing a number of theorists and psychologists who have contributed to the general discussion of initiation, as well as the initiatory journey that is specific to the experience of grief. Also discussed are various imaginal practices
such as ritual and the expressive arts. Finally, this section concludes with an examination of an ancient Greek myth that represents the journey of initiation, the story of Persephone and Demeter.

Omer points out that the ancient Greek philosopher Aristotle spoke of the imagination of soul. It is also interesting to note that Freud used the term seele (German for soul). The word seele, however, was mistranslated into English as ego, self, psyche, or mind. Rooted in the tradition of Aristotle and other philosophical traditions that focus on the language of images, Mogenson maintains that the imaginal school of psychology draws heavily from the writings of Jung and Henry Corbin who place the imaginal core of experience at the center of their work. While primarily associated with the psychodynamic tradition, Jung may also be considered one of the fathers of Imaginal Psychology. He brought psychology the concept of the collective unconscious, which can be defined as an “omnipresent, unchanging” substrate of the psyche. Jung is also well-known for his belief that “image is psyche.” Mogenson interprets this to mean that the psyche (or soul) manifests itself in images. Similarly, Omer asserts that image is the language of the soul.

Corbin is largely credited as having coined the term imaginal. He calls it the mundus imaginalis: “a world that is ontologically as real as the world of the senses and that of the intellect.” He postulates that the imaginal realm is situated between the corporal and spiritual state and that it is connected to the imagination. Noel Cobb maintains that image is not just some object out there, and is not the same as a picture, but that it is a world alive and embodied. He contends that it is neither inside us, nor outside us, but somewhere in between.
According to Omer, Imaginal Psychology is concerned with care of the soul.\textsuperscript{207} This orientation to psychology draws on spiritual traditions, expressive arts, somatic practices, deep ecology, mythology, indigenous wisdom, and social critique as a way of interfacing between the personal, cultural, and archetypal.\textsuperscript{208} Thomas Moore writes that care of the soul:

\ldots isn’t about curing, fixing, changing, adjusting, or making healthy, and it isn’t about some idea of perfection or even improvement. It doesn’t look to the future for an ideal, trouble-free existence. Rather, it remains patiently in the present, close to life as it presents itself day by day, and yet at the same time mindful of religion and spirituality.\textsuperscript{209}

It quickly becomes clear how Imaginal Psychology reaches beyond the traditional purview of psychology. Indeed, Jung believed that life continues after death in an imaginal form, in the world of images.\textsuperscript{210} Along similar lines, Mogenson believed that soul continues after death, that the deceased live on and continue to “individuate their images through our imaginations.”\textsuperscript{211} Mogenson writes, “Countless millions crowd the depths of the psyche waiting for the imagination to give them wings.”\textsuperscript{212} The psychology of the mourning process is, therefore, a function of the bereaved as well as a function of the deceased.\textsuperscript{213} Mogenson articulates this principle in the following paragraph:

From the imaginal point of view, the end of life is not the end of soul. The images continue. Deep inside the grief of the bereaved, the dead are at work, making themselves into religion and culture, imagining themselves into soul. Though the graveside would seem to be the place where we let go of the dead, it is also the place where we greet them again as angels. By returning to us in our dreams and fantasies, the dead assert their lasting value. Despite the fact that they are gone, they continue to be the assumptions, which underpin our lives.\textsuperscript{214}

Mogenson laments the demythologizing of death by science in modern secular society.\textsuperscript{215} Drawing on Jung’s work, he writes that the desolation of the bereaved is not
only the result of the loss of a loved one, but also of a bankrupt culture in which the loss occurs. He goes on to say that even before experiencing the loss of a loved one, particularly at this time in modernity, the bereaved is already “bereft of supernatural containers” as well as religious and spiritual themes that could provide the bereaved with support and comfort and provide the deceased with peace in the afterlife. Addressing the dilemma of the bereaved in these modern times, Mogenson asks: “How can the living let go of the dead if there is no one in the hereafter to receive them? And how can the bereaved reassure themselves that their loved ones are all right at a time in history when inner voices have become synonymous with a psychiatric diagnosis?”

Mogenson elucidates T. S. Eliot’s views of Western culture’s lost understanding of the ancestral dimension of the soul, the connection to all who have preceded us, and how this loss impacts both man’s attitude to his own death and his experience of grieving the loss of a loved one. Eliot laments this lost connection to the dead, and suggests that this has spawned a “quiet desperation.” In the following poem, Eliot portrays modern man waking up after death, longing to engage with the ancestors, but instead only knowing how to call for empty “broken stone” heroes:

In death’s other Kingdom
Waking Alone
At the hour when we are
Trembling with tenderness
Lips that would kiss
Form prayers to broken stone.

Mogenson maintains that the connection with the collectivity of the dead (and the larger tradition of mourning) needs to be recreated in order for the bereaved to find access to the mourning process. Mogenson refers to the abyss of loss as an aspect of the collective unconscious that comprises all the losses and deaths that have gone
before. Jung proposes that in order to renew this connection, the bereaved must form a conception or myth of the hereafter. He promises that doing so will also help modern man inhabit their lives more fully, because knowing death is an integral part of living life.

The process of exploring these notions, and the personal and collective transformations that occur with new experiences and insights, brings to light another aspect of the imaginal approaches to bereavement, the potential of initiation. Much of the traditional and contemporary literature on grief assumes that the purpose of the grief process is for the bereaved to recover sufficiently to enable him or her to once again function effectively after the loss of a loved one. The imaginal approaches suggest that the grief process may also provide unexpected opportunity for growth and positive change. Mogenson speaks to this when he writes: “Though the troubled mourner may view the decease of a dear one as abandonment, punishment, betrayal or torture, the therapist must help him to view these throes of grief as necessary features of the initiatory ordeal we call the mourning process. Though therapy must facilitate whatever rites of initiation have been postponed from earlier life stages, the actual work of mourning is accomplished by the bereaved replying to the lives of the dead through an increased vitality in their own living.”

Victor Turner defines initiation as an individual and inner process of growth and *individuation*. Jung developed the concept of individuation, which is about how an individual grows towards wholeness, psychologically. Omer uses the concept imaginal structure in order to describe the changes that take place during the individuation process. He suggests that an individual’s imaginal structures or core beliefs change or
transmute during their inner process of growth, with some structures activated waning in strength, and others gaining more power. Omer holds that “during the individuation process, imaginal structures are transmuted into emergent and enhanced capacities as well as a transformed identity.” Capacities can be described as deeper human potentials or virtues, such as courage and compassion. During the individuation process of an initiatory experience, capacities emerge or are strengthened and identity is transformed.

Charles Whitfield offers a reminder that it is necessary to go through deep psychological and emotional work to achieve integration or healing and that bypassing these important stages of the process does not ultimately serve the individual. This is best illustrated by an individual who acts as if they have integrated an experience or talks about the spiritual learnings without having gone through the work. Whitfield uses the term spiritual bypass to describe the denial involved in unassimilated events or premature transcendence.

Robert Moore describes initiation as the process of dying and being reborn. He eloquently writes that: “Initiation really refers to something that is part and parcel of the universal spiritual journey, the pilgrimage of human life. Initiation is the process of dying and being reborn.” Moore suggests that four scholars share the credit for developing an understanding of the three-phase process of initiation. These authors are: Arnold van Gennep, Joseph Campbell, Mircea Eliade, and Turner. Drawing on the work of these scholars, Moore gives an overview of the three phases. He says phase one takes place when ordinary consciousness is challenged. He writes that an example of this is the experience of the death of a loved one. Van Gennep uses the term Separation to describe
this phase, while Campbell names it the Call. Eliade describes it as Profane Time I, and Turner calls it the Preliminal state. According to Moore, phase two occurs when ordinary consciousness is transcended. An example of this is the grief process. Van Gennep names this phase, Transition, and Campbell used the phrase, “descent into the zone of magnified power.” Eliade describes the second phase as Sacred Time, and Turner calls it, the Liminal Phase. Moore writes that the third phase of initiation occurs when ordinary consciousness is reconstituted. He uses the example of reintegration after a loss. Van Gennep calls this phase, Incorporation, whereas Campbell describes it as “the return with boon that restores the world.” Eliade names this final phase, Profane Time II, and Turner uses the term Post-liminal state.

Houston contributes to the discussion on initiation by introducing the concept of the sacred wound. This concept holds that a person’s wounding reveals a larger story and that transformation occurs in its discovery. Inherent in this story is a sacred myth. In this sacred myth the individual is called to shift and move in new directions, to look at what has been hidden to consciousness until the time of the wounding. The wounding can open up an individual to a larger reality, which may be blocked to their habituated and conditioned viewpoint. By allowing the engagement of the sacred wound, the person sacrifices the old story to the new one. The individual is thus taking the story from the personal to the mythic and unitive, which Houston presents as moving through the frames of “this is me” to a more expansive “I am.”

In discussing the social context of initiation, Anthony Stevens asserts that there is a psychological and social need to be initiated. He says that this is evident in patients undergoing analysis, within whom archetypal symbols of initiation seem to appear (in
dreams, for example) at critical periods in the life-cycle such as puberty, marriage, childbirth, divorce, or death of a loved one. Erich Neumann calls this phenomenon “the personal evocation of the archetype.” It suggests that every new stage of life requires the recognition, experience, and integration of the appropriate symbols of initiation. If Western culture does not provide these symbols in institutional form, then the Self is pushed to provide them in whatever way it can.

Discussing the need for initiation in Western culture, Madhi writes that “fulfillment of the deep need for initiation in our world today seems to have gone underground.” The way this is showing up in modern society, Madhi maintains, is that images and symbols of ancient rites of passage are often found in dreams and fantasies, as well as the unconscious acting out by people, no matter how old they are. The psyche (or soul) continues to offer initiatory direction and insight as inner guide, even if this direction creates situations that are not comfortable to one’s ego.

Holger Kalweit points out that many Asian peoples and tribal cultures realize the many opportunities presented by suffering and the death of the ego. Conversely, Western culture and medicine declares war on sickness, death, and even change itself, so that psychic and physical suffering have remained unacknowledged as a way of altering consciousness and as a means of self-healing and transformation. Madhi suggests that modern civilization as a whole has lost a social way to experience life-transitions through rites of passage and initiation. Neumann adds that these transitions in life were once considered numinous experiences, which were ritualized by the collectivity or community. In reference to these life transitions, he writes: “In modern man where collective rites no longer exist, and the problems relating to these transitions devolve
upon the individual, his responsibility and understanding are thereby so much
overburdened that psychic disorders are frequent [at life transitions]. All these stages in
life were formerly numinous points at which the collectivity intervened with its rites;
today they are points of psychic illness and anxiety for the individual, whose awareness
does not suffice to enable him to live his life.”

Madhi asks “where have all the elders gone”? She states that qualified adults
are necessary to guide Western culture’s young people through contemporary initiation
ordeal and transitions; elders who have themselves been initiated. The concept of the
initiated elder is similar to the wounded healer archetype as described by Jung. David
Sedgwick notes that Jung invokes the myth of Asklepios, the wounded healer, and that it
is the woundedness of the healer that creates the healing power. In Jung’s own words
he says “it is [the analyst’s] own hurt that gives him the measure of his power to heal.”
In one of his later works, Jung boldly states that “only the wounded physician heals.”

Malidoma Somé portrays the Dagara tribe in West Africa’s Burkina Faso as an
example of a culture that offers the “fulfillment of the deep need for initiation” and a
social way to experience life transitions through ritual and initiation. Ritual is essential
to Dagara culture and the three-day funeral ritual, led by the village elders, is one of its
most sophisticated rituals. In speaking to the significance of ritual, Somé writes that
entering into ritual is a response to the call of the soul.

E. C. Whitmont describes ritual as a container to hold overwhelming affect, and
characterizes its use in the following paragraph:

Any affect or emotion which in its raw and unaltered form is too intense to be
controlled by will alone may need its ritual. Without ritual, such energies may
inundate the ego and force it into acting out or into obsessive behavior. Ritual
brings about containment and acceptance, control of intensity, and dosage.
Ritual offers us an alternative to repression for dealing with potentially overpowering affect.\textsuperscript{261}

In discussing the importance of communal grief within a ritual context, Malidoma Somé suggests that communal grief can help both the bereaved and the deceased.\textsuperscript{262} He maintains that a communal expression of grief has the power to send the dead to the world of the ancestors and to heal the pain of the bereaved. In contrast, the absence of a supportive community to serve as a container, “radically” recognizing and acknowledging the person’s suffering, may prevent the end of an individual’s suffering and the completion of the initiation.\textsuperscript{263} Thus, Somé contends that community is vital to the closing of an initiatory ordeal: “In general, people can come to terms with their suffering only if there is a profound translation of their pain into larger meaning. This, he states, can happen only through the acknowledgement and recognition of the community, whereby suffering serves a greater recognizable good.” \textsuperscript{264}

In addition to ritual, using expressive art can be considered as another transformative practice.\textsuperscript{265} Several authors discuss the utility of the expressive arts in working with the bereaved. Shaun McNiff suggests that art can help the artist to come in touch with (and transform) their suffering.\textsuperscript{266} He adds that by working with images, the art process allows the soul to minister to itself.\textsuperscript{267} McNiff maintains that soul demonstrates a universal shamanic instinct, an instinctual process of caring for itself. McNiff describes how an artist can dialogue with his own art through an engagement of the many figures of imagination, and proposes that letting these inner figures speak is healing to the artist.\textsuperscript{268}

The theme of healing and transformation following an initiatory ordeal is present throughout the history of man. The ancient Greek story of Persephone and Demeter is a
good example. In this story Persephone is abducted into the Underworld by Hades. She is taken from the Upperworld, an innocent, unaware maiden and eventually resurfaces from her initiatory journey as the Queen of the Underworld. She continues her days living three months of the year in the Underworld, and the other nine months in the Upperworld with her mother, Demeter. In her analysis of the myth, Wilkinson describes the Upperworld as relating to the realm of the conscious, masculine, ego, and progress oriented, while the Underworld corresponds to the realm of the unconscious, feminine, vulnerable, and meaning oriented.

Wilkinson delineates two forms of initiation; intentional and unintentional. She says that initiations are typically assumed to be intentional rites of passage for which the initiate receives extensive preparation. This preparation provides the initiate with guidance for a “successful completion of the descent-and-return- cycle of initiation.” Wilkinson defines the initiation of Persephone as unintentional. This represents the plight of the bereaved who inadvertently experiences the loss of their loved one. Wilkinson goes on to say that in Western culture the initiate receives minimal or no guidance for completing their initiation. The predominant “heroic ideal” provides only stoicism or blame as responses to initiatory experience, and these according to Wilkinson do not cultivate a real return. In fact, they keep the individual frozen in the experience of victimization as the core of their identity.

Wilkinson proposes that the way in which Persephone progresses through her initiation by transforming her innocence into maturity can help provide a model to the initiate, guidance that is lacking in contemporary Western culture. Persephone evolves from the nameless maiden to the Queen of the Underworld. Her suffering is transformed
through her individuation. Persephone’s new identity is able to bridge the Upperworld and Underworld, symbolized by her eternal cycle of descent and return.\(^{274}\)

In summary, the imaginal approaches to bereavement posit how life continues after death in an imaginal form, and that the mourning process is a function of the bereaved as well as a function of the deceased. Jung and later Mogenson propose that in order to access the mourning process, the bereaved must renew their connection with the collectivity of the dead by formulating a conception or myth of the hereafter, something that has been mostly lost in contemporary Western culture. The imaginal approaches also focus on the initiatory potential of a major life transition, including the loss of a loved one, and how suffering can be re-imagined as a sacred wound that contains the potential for personal growth and the development of capacities such as courage and compassion. Several components necessary for a successful completion of an initiation are outlined, including the importance of communal grieving within a ritual context and the initiatory guidance of elders.

**A Group Perspective on Bereavement**

This section on the group perspective on bereavement discusses traditional means of familial and communal support for the bereaved in Western and indigenous cultures, and examines how these support systems have broken down in recent years. Following this is an exploration of the differences between individual and communal grieving, and how grief counseling or therapy groups provide a unique opportunity for the bereaved to grieve communally. Finally, this section identifies the challenging dynamics inherent in group work, and differentiates between self-help groups, counseling groups, and therapy groups.
Skinner Cook and Dworkin state that traditional modes of support for the bereaved have diminished in Western culture in recent years. They maintain that families and communities, which offered help in the past, are now usually less available to help the bereaved after a loss. They attribute this to the ease of mobility and transient lifestyles, which have over the years steadily eroded the cohesiveness of the extended family and community. Skinner Cook and Dworkin go on to say that as a result, grieving individuals often have no opportunity to share their grief with others on an ongoing basis. The authors believe that for some people a grief counseling or grief therapy group can provide this lost possibility to grieve and that social support and the normalization of the grief process offered through these groups are invaluable.

Similarly, Worden writes that grieving is a social phenomenon and people have the need to grieve together. He cites other studies that show social support can help alleviate the negative effects of stress, including the stress of the loss of a loved one. Worden suggests that one of the factors that creates complications in grief is in fact the absence of a social support network and that this absence may be due to geography or social isolation. According to Worden, one of the problems with social support is that it may be available around the time of the death and for the first few months thereafter, but may dwindle or disappear six months to a year later when friends and relatives expect the individual to get over their grief and get on with their lives. D. E. Sherkat and M. D. Reed contend that more significant than the availability of support is the bereaved individual’s perception of this support and their satisfaction with it. Sherkat and Reed are of the opinion that social integration, or the time spent with others
and the quality of this support, being able to confide in others, are two elements that create support satisfaction.

Sandra Bloom writes that human beings require other human beings to respond to their emotions and to help contain feelings that are overwhelming.²⁸² Malidoma Somé is aligned with this and says that an individual expression of grief is an incomplete expression of grief. He proposes that communal grieving is necessary for integration to happen.²⁸³ Somé contends that an individual’s suffering needs to be recognized by others. He maintains that it is community that provides the “radical and genuine recognition and acknowledgement” that is necessary for suffering to end.²⁸⁴ Thus, according to Somé, a community’s witnessing and support of an individual’s grief is necessary, and if this recognition and acknowledgement is absent then the suffering may not end, but indeed grow larger. However, Somé writes that it is not any type of community that will provide this powerful container for grief.²⁸⁵ He maintains that the type of community that can effectively support the bereaved is one which utilizes the practice of ritual. Ritual can simultaneously hold the intensity of emotion and offer the deep attention that is necessary for strong communal support.

It has been suggested by Skinner Cook and Dworkin that a therapeutic group setting can provide an alternative to the traditional form of communal or familial support for the bereaved.²⁸⁶ According to Skinner Cook and Dworkin, there are key distinctions between grief self-help, counseling and therapy groups.²⁸⁷ They go on to say that although these three types of groups have many characteristics in common, the main differentiating factors have to do with the style of group leadership and how the participants interact. The authors also point out that self-help and counseling groups
provide a supportive environment to the mourners while grief therapy groups offer guidance, direction, and even challenge the participants to help them through the grief process.  

In drawing a distinction between self-help and therapy groups, Skinner Cook and Dworkin point out the following differences (counseling groups fall somewhere in between these two groups): the purpose of a self-help group is mutual support, while the purpose of a grief therapy group is to provide support and professional help with complicated grief. Regular attendance and active participation are not required in a self-help group, but are required in a grief therapy group. Membership is open in a self-help group, while it has specific criteria in a therapy group. Self-help groups usually meet once a month, while therapy groups meet once a week. The duration of the group is open ended in a self-help group, but is often a fixed time limit in a therapy group. There is usually no cost for a self-help group, while there is a weekly cost for the therapy group. Self-help and counseling groups help participants with the sense of isolation, provide grief education, normalize and validate emotional reactions to loss, help the rebuilding of new relationships, and offer reassurance of the possibility of eventual resolution.

Irvin Yalom discusses 11 primary factors that help group participants in group therapy. These include: instillation of hope, universality, information, altruism, cohesiveness, imitative behavior, catharsis, the corrective recapitulation of the primary family group, development of socializing techniques, interpersonal learning, and existential factors. Skinner Cook and Dworkin maintain that the first seven factors apply to self-help and counseling support groups and that grief therapy groups concentrate on four additional factors that set them apart from self-help and counseling groups and make
them into a forum for change: 1) the focus on family of origin recapitulation; 2) the consideration given to interpersonal learning; 3) the development of socialization techniques; and 4) the reflection on and working through existential issues.\textsuperscript{291}

Another important difference between the different types of grief groups is that self-help groups often draw on members of the group as leaders, while therapy groups use trained mental health professionals.\textsuperscript{292} Irvin D. Yalom and S. Vinogradov expand on the role of leader within a grief therapy group by describing the role they themselves took as grief group leaders.\textsuperscript{293} They said that what they did was to facilitate a natural process of self-exploration, by either standing back from what was going on in the group or acting as “gentle midwives” to themes and issues that arose spontaneously during the treatment period. Instead of staying with the emotional catharsis, they found themselves focusing on “growth, self-knowledge, and existential responsibility.”\textsuperscript{294} According to Yalom and Vinogradov, leadership within a therapy setting should include the following skills: 1) understanding group dynamics and using group interaction as an instrument for growth; 2) the capacity to monitor the process of each group participant and knowing what they need to move forward; 3) working with the clients’ resistance; 4) the ability to use crisis intervention techniques when required; 5) to discern when to take the lead or when to let the group participant lead; 6) challenging group members when their fear inhibits them from addressing important issues; 7) having the awareness of one’s own issues and how they may influence leadership decisions.\textsuperscript{295}

There are some significant distinctions between individual and group psychotherapy. Bessel van der Kolk, writing about trauma survivors, contends that in individual therapy there is an inherent inequality with the therapist as helper holding the
answers and the client as the one needing help. A group setting allows for more flexible roles, with mutual support and moments of passivity and activity. The sharing of feelings in groups of people who have undergone similar experiences allows for roles of both victim and helper. In this type of setting participants may start re-experiencing themselves as being useful to others which can foster a subjective feeling of control and meaning in their life.

Finally, it is interesting to address a dynamic that takes place in a group therapy setting. A fear may at times be present in group therapy where the collective morality is given more legitimacy than the individual’s own experience and perspective. Sylvia Brinton Perera relates this to the concept of the scapegoat complex. She identifies the scapegoat complex as a constellation of four distinct, but related aspects of identity: 1) the condemning, attacking accuser or judge, 2) the self-righteous accuser or false priest, 3) the burdened, alienated victim or wandering goat, and 4) the victim or holocausted goat. She proposes that these aspects of identity keep an individual bound to a collective perfectionist morality. When the rules of this collective morality are perceived to be transgressed, the transgressor is exiled. The scapegoat complex can explain the participants’ fear of being judged for what they perceive as unconventional beliefs or fear of being alienated by the group.

In summary, the section on the group perspective on bereavement begins by addressing the importance of communal support for those experiencing a loss and the way that traditional avenues of support for grieving individuals have declined in recent years due to the eroded cohesiveness of the extended family and community. Malidoma Somé concurs that an individual’s suffering needs to be supported and witnessed by
community and that this in fact is vital in order for the suffering to end. Skinner Cook, Dworkin, and Worden suggest that grief counseling or therapy groups offer this lost opportunity to grieve communally in contemporary Western culture. Finally, there are important differences between grief self-help, counseling, and therapy groups as explored by Yalom, Skinner Cook, and Dworkin.

**Conclusion**

In summary, the biological perspective on bereavement posits that the experience of the death of a loved one brings about physiological changes in the bereaved, linking the experience of bereavement to health issues, including how grief impacts the immune and neuro-endocrine systems. The cognitive/behavioral perspective holds that a loss through death changes the bereaved individual’s belief system and its related emotions and behaviors, and maintains that without the appropriate cognitive change the bereavement process is less likely to have a healthy outcome, regardless of how much emotional processing has been done. The psychodynamic perspective assumes the importance of the emotional aspect of grieving, and of bringing unconscious feelings to awareness. It utilizes the theoretical model of grief resolution that stems from Freud’s work, which holds that mourning is a decathexis, a severing or letting go of emotional attachment to the deceased.

The sociocultural perspective on bereavement addresses the influence of culture on an individual’s experience of death and loss, while imaginal approaches focus on the initiatory potential of the loss of a loved one, and how suffering can be re-imagined as a sacred wound. The group perspective on bereavement evaluates the importance of communal support for those experiencing loss. Authors writing from this orientation posit
that grief counseling/therapy groups offer an opportunity to grieve communally, especially necessary today with the widespread demise of community and the extended family in contemporary Western culture.

These six sections on bereavement compare and contrast in some interesting ways. While they all seek to address suffering, they have different ways of labeling pathology and the subsequent course of treatment. The biological and psychodynamic perspectives, for example, tend to label grief as either normal or pathological, and consequently their approach focuses on finding and fixing problems and restoring the bereaved to a state of normalcy. Jung broke away from this view and expanded the course of treatment to include the individuation process. Similarly, imaginal approaches aim not only to restore the bereaved to a functional state of being, but also to provide an opportunity for long-term personal growth.

Group theory is split depending on the influence of other orientations. Group practitioners and theorists who use imaginal approaches, for example, emphasize the initiatory potential of communal grieving, rather than using the group as a platform for solving clinical pathologies. The cognitive/behavioral perspective is also split. The more traditionalist theories focus on differentiating dysfunctional beliefs and reactions from normative patterns of grieving, while contemporary theorists aim to help the bereaved in adapting to a new post-loss reality and restoring meaning and purpose in their lives.

The psychodynamic perspective derived from Freud’s theory of the unconscious places central importance on the emotional aspect of grieving, and to bringing unconscious or unacknowledged feelings to the surface of awareness. Imaginal approaches work in a similar way, but also underscores the importance of dealing with
unconscious imagery (personal, cultural, and archetypal) as a primary means of connecting with soul and to understanding the soul’s journey.

While some forms of cognitive/behavioral and group theory acknowledge the unconscious, they deal with it less directly, especially in the context of grief therapy. Cognitive/behavioral practitioners typically do not consider it necessary to excavate unconscious material to initiate positive change. Change, they believe, is less dependent on metabolizing unresolved feelings or repressed memories, and more about working with bringing belief structures and behaviors into awareness, with the aim of freeing the bereaved from stuck and distorted patterns and allowing for more conscious choice.

Group theorists are divided into two camps, typically along the lines of psychotherapy and self-help/counseling groups. Practitioners within the former camp (particularly if they are of the psychodynamic or Imaginal Psychology orientation) are trained to work with unconscious material within a therapeutic context, while those in the latter camp are usually not trained mental health professionals, and therefore do not typically address issues related to the unconscious. Of sources mentioned in the six sections in this chapter, biological is the only one that explicitly does not acknowledge the unconscious.

The concept of continuing relationships between the bereaved and the deceased is a controversial one. There are differences among the various sources highlighted in the six sections of the Literature Review with respect to what exactly constitutes healthy bonds, and what could be labeled pathological. Since ideas about life after death influence one’s relationship to the deceased, there is also division among theorists and practitioners as to how to work with the issue of continuing relationships.
While the sociocultural perspective examines the many different worldviews and beliefs about the afterlife, including after-death communication and ancestor worship, not all theorists would agree that a continued relationship with the deceased is a natural or necessary part of the grieving process. The biological perspective does not typically acknowledge continuing bonds between the bereaved and deceased and will prescribe medication for “hallucinatory” tendencies. The psychodynamic perspective is split on the issue. In the traditional Freudian camp, continuing relationships are problematic or pathological, and practitioners work with the bereaved to sever emotional attachment. In contrast, Bowlby views persisting relationships, and sensing the presence of the deceased, not only as a natural and necessary part of the grief process, but also as a way to help satisfy the emotional needs of the bereaved and preserve their sense of identity. Klass, Silverman, and Nickman question Bowlby’s notion of continuing relationships and whether or not he believes these relationships can continue indefinitely. Klass, Silverman, and Nickman stress that the bonds between the bereaved and the deceased remain beneficial to the bereaved and may be nurtured indefinitely. Although several reports cited in their work address the bonds in terms of after-death communication, on the whole they are labeled as inner representations of the deceased.

Theorists from Imaginal Psychology, including Jung maintain that life does indeed continue after death in an imaginal form, in the world of images. Jung and Mogenson identify the mythological dimension of mourning. Mogenson maintains that the connection with the collectivity of the dead needs to be recreated in contemporary Western culture. Following Jung, he writes that the bereaved can achieve this by creating a conception or myth of the hereafter. This renewed connection with the collectivity of
the dead can help the bereaved nurture their relationships with the deceased and thereby more fully access, trust, and integrate the mourning process.
CHAPTER 3

PROGRESSION OF THE TREATMENT

The Beginning

I conducted an interview with each potential participant before they began the bereavement group. All had lost their spouses or partners several months before starting the group, except Sheila who had lost her husband five years earlier. The interview demonstrated all six clients having difficulty accepting the reality of their loss. Intellectually they knew it was real, while emotionally they wished it had all been a terrible dream.

Wyatt and Annie had been part of the group for four months and two months respectively, when Ina, Jasmine, Harold, and Sheila joined. For their first session, I met the group participants in the waiting area of the reception at Sutter, VNA, and Hospice and led them through to the office. The six clients and I took our seats in a circle around the wicker table. A cream colored candle was positioned in the center. The blinds were drawn giving a safe, enclosed feeling. The colorful art on the walls and plush pillows on the couch helped to make this a cheerful and inviting setting.

In the first meeting, the participants were softly talking to each other until I started the session by introducing myself and the structure of the group. As was customary with new clients, I then asked each of them to sign a confidentiality statement and I read them the group guidelines. When the business of the group was completed, I lit a candle, saying: “this candle is to remember and honor our loved ones,” after which I
invited the participants to close their eyes if they felt comfortable doing so. Everyone closed their eyes and seemed to settle into their chairs as I led them in a short guided meditation, directing them to focus on their breathing in order to help them center and relax. The poem that I read was entitled “The Lilies” by Ellen Brenneman. Jasmine, Ina and Harold reached for a tissue several times to dry their tears.

When all six group participants had opened their eyes, I explained the check-in process and asked the clients to introduce themselves and to mention what brought them to the group. I reminded them that they would have more time to share their stories later in the session, during which they could take turns to express anything related to their grief. The only directive I had for the check-in (and longer share) was that they not interrupt each other and allow enough time for the person speaking to be with their feelings in silence, if necessary. I modeled the check-in by briefly, describing my own losses and the way they had affected me and my life. I felt that disclosing my personal experience would help develop the trust necessary for creating a therapeutic alliance with the group participants.

Looking around the circle as the participants took turns speaking, I was aware of the following details: Jasmine was impeccably dressed in a pale blue outfit, conservative length skirt and matching blouse. Her jewelry was tasteful and understated. She seemed somewhat reserved, but had a kind and friendly manner. Her thick French accent was charming, and the story she shared of her husband’s death was very moving. She and Michael had a very loving relationship that started when she was 18 years old, and she had moved to the United States with him. She told the group that she had been very dependent on Michael, and that he took care of everything right to the end. In the months
before his health deteriorated, he sorted out finances and taxes in preparation for his
death. Incredibly, Michael wrote Jasmine a letter that he asked her to read after he died. It
was a beautiful letter that she said she would always treasure, a letter in which Michael
assured her that he would always be with her. The last months of his illness were very
hard and she and her daughter cared for him at their home. Jasmine’s intense sadness was
palpable as she told us her story.

Ina was dressed in matching pants and sweater in a style that was neat, but
colorfully informal. She came across as being capable and self-confident and was very
talkative in the initial check-in. I remember thinking that she would be a valuable
participant with a lot to contribute, but that I would have to be careful that she did not
dominate the group. At times I felt a little intimidated by her and imagined her thinking
that I was far too young and pretty to be facilitating this group. She told us of the death of
her husband Terrance with deep feeling, while also exercising the utmost composure. She
introduced her story by stating that this was a classic case of “the surgery was a success,
but the patient died.” Terrance tragically died after heart surgery that had concluded
without complications. Although she shared her experience with controlled emotion, her
tears gave away the deep sadness that she was experiencing, tears that she quietly dabbed
with her large white handkerchief.

Sheila seemed the most conservative of the six participants in both dress and
manner. She smiled politely throughout her check-in, but underneath her measured and
polished exterior she seemed to be in much emotional pain. Her first session was a torrent
of complaints about her present living situation, especially the noise of the remodel going
on next door, intermixed with a brief version of the death of her husband, Victor. Similar
to Ina’s husband, he died unexpectedly at the hospital just before he was scheduled to come home. Sheila deeply regretted that during the last month before her husband’s death she had to wear gloves to touch him because of the high risk of infection. She also had spent many hours scrubbing their house from top to bottom in preparation for his homecoming and very much wished that she could have spent those hours with Victor instead.

At 80 years old, Annie was one of the more senior people in the group, but was always dressed with a modern fashion sense and artistic flair. She was quiet and still, somewhat guarded, but seemed much more comfortable than she was in her initial session two months earlier. In her first session she had expressed how she lacked experience with groups and did not like them much because they made her nervous. There was a disarming honesty and directness about her. She was not afraid to reveal that her relationship with her partner, Jerry, had been an unconventional one, in which for 14 years they lived together at his house during the weekends and separately at their own places during the week. She loved him dearly but was very angry, both for how he had been drinking before crashing his car into a tree, and for how he had not left a will.

Wyatt had been part of the group the longest and appeared self-confident and talkative. He introduced himself and his story with depth and feeling to the new group members. My first impression of Wyatt was that he had good self-awareness and seemed interested in learning how to integrate the experience of his wife’s death. I was somewhat concerned, however, that his positive attitude and spiritual interest may have been a spiritual bypass to avoid fully experiencing his grief. Especially during his first months in
group, Wyatt frequently spoke about what he was learning in a rambling, intellectual manner, rather than sinking into his feelings.

Harold gave the impression of being a sensitive soul. He was quietly reserved and cried all the way through his check-in. He was grieving his second wife, Louise. His first wife, Mary-Beth, had died of alcohol poisoning. He admitted this current loss was a very different experience than the death of his first wife, one that was much more painful for him. He was still angry at Mary-Beth for not taking care of herself, implying that she brought on her own death. Louise was the love of his life. Her death, due to cancer, was almost more than he could bear. Harold was well dressed and looked as if he was in excellent health. He told the group he worked very hard at staying healthy by exercising daily at his club.

I remember noting during this first session that one of the first details each participant shared in their check-in was the length of the marriage or partnership with their loved one. There seemed to be a competitive element to this, as if the longer the marriage, the more genuine the grief. Coincidentally, Jasmine, Ina, and Sheila had all been married exactly 49 years. Harold had been married 30 years to Louise, Annie had been with her partner for 14 years, and Wyatt had been married for 13 years. In her check-in, Sheila emphasized the 49 years, while omitting the fact that she was beginning this group five years after the death of her husband. Conversely, while Annie was quite straightforward in describing the unconventional nature of her relationship with Jerry, she seemed to be nervously anticipating someone’s disapproval or a response that would label her grief as less legitimate. Those who seemed to disapprove hurriedly changed the topic of conversation. I deliberately brought it back by suggesting that the most important
thing to remember was the love we shared with our partners, no matter what form the relationship took or how it appeared from the outside. Annie looked visibly relieved when the conversation shifted from the type and length of the relationship to the love that each couple had shared.

There was one cultural issue of interest that involved Jasmine. She was the only non-American among the group participants. I acknowledged the differences she expressed regarding her upbringing in Monaco and would speak of my own Dutch cultural background. She seemed to appreciate knowing that she was not the only foreigner in the group. Similarly, Ina was the only Jewish participant and I encouraged her to share with the group the customs and rituals from the Jewish faith related to grieving the loss of a loved one.

A crisis issue occurred in the fourth month of treatment which required immediate attention. While sentiments of giving up on life or not wanting to continue living without their spouse was a topic that came up periodically in the group, I became aware that Sheila might actually be wrestling with some suicidal ideation. I took her aside at the end of this particular session to assess. I found, however, that she did not have a plan to commit suicide. I encouraged Sheila to talk to her medical doctor or psychiatrist about taking medication to help her through this period and reported the incident to my supervisor. My supervisor and I stayed in close communication with Sheila during this particular month, but did not need to take any further action.

**Treatment Planning**

The initial treatment plan stipulated a one and a half hour group therapy session, once a week for as long as the participants wished to attend. The primary orientations
used in working with these clients were depth and Imaginal Psychology. A cognitive/behavioral orientation was also applied to provide psycho-education regarding the grief process. Methods included conversation, expressive arts, guided meditation or visualization, and ritual. An opening and closing ritual for each session was offered to provide a safe therapeutic container for the participants.

The specific goals of the treatment plan were to: 1) rule out physical disease; 2) establish a therapeutic alliance/relationship with the group participants; 3) help them establish a relationship with each other; 4) address the recent deaths and revive memories of the deceased by sharing stories; 5) educate the participants about the grief process; 6) acknowledge difficulties in everyday functioning related to grief; 7) strengthen coping skills; 8) work through specific bereavement issues; 9) explore and work with ambivalent or unexpressed emotions such as anger, fear, guilt, and resentment; 10) use imaginal processes such as journaling, visual arts, and ritual to work with emotions that are too painful to express verbally; and 11) explore sources of strength and support, existential issues, spirituality, and death myth.

To achieve the goals identified in the treatment plan the following interventions were planned: 1) create an opening and closing ritual for each session in order to provide a safe container to help establish an alliance between myself and the group participants, and between each other, as well as a safe therapeutic container for the participants’ grief work; 2) encourage sharing stories about loved ones, including bringing photos and other memorabilia, in order to bring up memories and access feelings of grief, as well as to help the participants get to know each other and build trust; 3) use expressive art to help participants access and work through their feelings; 4) give homework of reaching out
and phoning someone else from the group; 5) use psycho-educational material, including Worden’s four tasks of grief to teach the participants about the grief process in order to normalize and encourage their process; 6) explore family of origin material; 7) discuss difficulty in everyday functioning, as well as explore and teach coping skills; 8) ask participants to journal about difficult, ambivalent emotions and issues in order to bring them forward and work them through; 9) focus on working with anger; 10) use discussion and journaling to explore sources of inner strength and support, existential issues, spirituality, and create a death myth; and 11) write a letter to and from the deceased, as well as use the guided boat visualization to explore and nurture the bond with loved ones.

The Therapy Journey

Beginning of the Therapy

The beginning of the therapy involved building trust between the group participants, and between the participants and myself. Providing structure and a safe, sacred therapeutic container in order to help build trust and promote active grieving was created by implementing an opening and closing ritual for each therapy session. The opening ritual consisted of lighting a candle to remember the clients’ loved ones, as well as a short guided meditation and the reading of a poem. The closing ritual concluded the session with a second guided meditation while the group participants joined hands and finally blew out the candle.

At the end of the first session I encouraged the participants to call and support each other during the week, and gave them a list of names and telephone numbers (all six clients asked to be part of the list). By as early as the second week, some of the clients had called each other and were starting to get to know each other outside of the
therapeutic setting. Jasmine, Ina, Harold, and Sheila started meeting for lunch after their second week in the group (the therapy group conveniently ended at around lunch time). They met consistently over the course of the 15 months they were in therapy together. Other group members who were not part of the core group of six featured in this Clinical Case Study, but who also participated in the group for a period of time, were also invited and joined for lunch. Two in particular continued to meet the core participants for lunch, even after they (the non-core participants) had stopped coming to group.

In the first few months of treatment, all six clients talked about having a range of overwhelming feelings regarding the death of their spouse and their present situation. They expressed how they were not accustomed to dealing with intense emotions including sadness, anxiety, anger, guilt and fear. Jasmine, Sheila, Ina, and Harold shared their reluctance to process their grief for fear of losing control. They said that if they allowed themselves to delve into their pain they may never stop crying. Annie expressed that she still felt this way even after two months in the group.

It was especially during these first months of therapy that the participants would move the conversation away from their grief to talk about the more practical details of their lives. Although this was sometimes necessary as a way to protect themselves from the pain, I would step in and gently guide the conversation back to their feelings if the avoidance continued for too long. Educating the participants about the grief process was another intervention employed. I used Worden’s tasks of grief to explain the importance of accessing and expressing their feelings for the eventual integration of their grief.3

An intervention implemented early in the therapy was to invite the participants to draw their grief, using colors to express themselves. This seemed to help them access
their feelings more easily. In the debrief following the art process, I did not interpret the work for the participants, but encouraged them to make their own meaning and share with the group to the degree they felt comfortable. Several participants were surprised by the sea of black and dark colors that appeared on the page, and how the colors reflected the intensity of their grief.

In one of these early sessions I also asked the participants to come prepared to share the story of their lives with their partner, bringing any memorabilia they wished to share, including photos of their loved ones, letters, and symbolic objects. They were posed several questions to guide them in this process. The questions included: how they met; the kind of relationship they had, including good aspects and challenges; the circumstances of the death; and the moment of death, if they were with them or not and were they able to say good-bye. In addition to helping the participants access their emotions, this process encouraged the participants to engage with each other and recognize the commonality of their experience, which also helped build trust. The stories were all special in their own way. Sheila, for example, described meeting her husband as “finding her equal,” “two misfits who belonged together,” and added that he was the only one who protected her, when her parents could or would not. Jasmine shared the romantic story of meeting her husband. He was an army officer who swept her off her feet in Monaco and brought her back to California when she was only 18. The sacrifice and suffering involved in the care giving of Jasmine, Harold, and Wyatt’s partners in their last months of life and the moment of death were incredibly moving, as were the stories of the tragic sudden deaths of Ina, Annie, and Sheila’s partners. The life and
vitality in the eyes of these beautiful men and women in the photos passed around the room brought tears to our eyes.

A few sessions later as the participants became more comfortable exploring and expressing their feelings with one another, several group participants explained how they felt incapacitated at times due to feeling desperately sad, hopeless, and lonely. Two specific interventions were implemented to address this. One was more education about the grief process in order to normalize their experience, and the second intervention entailed exploring and teaching coping skills. Jasmine, Annie, and Ina complained of having bouts of memory loss, as well as a lack of concentration and clarity of mind to perform simple daily tasks such as taking out the garbage or making an appointment with the doctor or accountant. Jasmine in particular admitted to feeling confused and helpless. Her husband had been the one to do all their finances and household maintenance, and when he passed away she barely knew how to write a check or change a light bulb. When she told us how she had almost fallen off a ladder trying to change a light bulb the day before group, Harold, being the protective man he was, reprimanded her for trying to do this on her own. He offered his help with any future chores that were hard to do by herself. Ina also suggested a handyman service that she used herself. I acknowledged Jasmine for having the courage to develop these skills without her husband, and encouraged her to not feel ashamed if she needed to ask for help. I encouraged all the group participants to ask each other for help or reach out to friends and family for support.

Ina seemed very practical and expected a lot from herself. She shared with the group that since Terrance’s death her motto had been to always say “yes” in response to
friends and colleagues inviting her out. Although most of the other participants applauded Ina’s positive attitude in the midst of her pain, it also created some tension and discomfort. Jasmine and Annie responded that they could not say “yes” all the time, while Sheila stated defensively that she always said “no.” When I asked how this felt to the group, Sheila, Jasmine, and Annie said they felt Ina was too strong in her opinion that saying “yes” was the only right way. At this point I intervened and underscored the importance of following your heart, or protecting yourself according to what you feel is right, as opposed to how others want you to behave. When Ina admitted that the topic of her husband rarely came up in these visits, I suggested that while it is wonderful that friends and family offer help and attention, the fear of deep emotion may motivate some people to distract the bereaved from their grief, for the sake of their own comfort.

Jasmine spoke up at this time and agreed that some of her friends were very uncomfortable with her grief. One acquaintance and his wife had criticized her, three months after her husband’s death, telling Jasmine that she was stuck in a place of self-pity. The other group participants expressed their anger at how insensitive these people were, and brought up other hurtful things that had been said to them. Wyatt, for example, had been told that he was still young and could find another wife, or that he was lucky he had not lost a child. Sheila’s friends had tried to comfort her by reminding her that she and her husband had a good long life together, and that he was not in pain anymore. Wyatt said he knew these people generally meant well, but realized they just did not understand grief.

At this place in the therapy, I used the intervention of exploring family of origin material. While discussing their childhood, Sheila, Ina, Annie, and Harold all realized...
that their families had endured lengthy phases of instability and trauma, and that as children they were expected to keep their worries to themselves and stay “strong.” While exploring these memories, Ina commented that she did not want to be seen as feeling sorry for herself, because she had learned early in life that it would not serve her. She disclosed that this was probably related to the fact that she was the one to take care of her mother and brother, having an abusive and dysfunctional father. However, she noted that she was now starting to realize the importance of allowing herself to come apart, to go through the pain of her grief instead of acting as if everything was under control.

Although Ina’s motto of always saying yes seemed rigid in one extreme, Sheila’s was rigid in another. Her response to invitations since Victor’s passing five years ago was to almost always decline. She added that there was not much that gave her joy these days. Jasmine and Annie resonated with Sheila’s inconsolable sorrow, and I explained how losing the ability to experience pleasure, called anhedonia, is a symptom of grief. Wyatt added that he felt some joy in his life again, but was reticent to show this to others in case they thought he was “over his grief.” He also felt some guilt when he noticed himself having fun, a feeling that everyone else seemed to understand.

In the first several months of therapy, Sheila expressed herself in a somewhat negative manner that at times was difficult to witness. Her life seemed to be a string of complaints and tragedies. It took all the compassion I had to remain present, and to help her find a way through her negativity and the recounting of mundane daily details. I noticed that some of the other group members seemed to fidget a lot when it was Sheila’s turn to talk. At first everyone was polite to Sheila and did not confront her, being sensitive to the fact that she still felt this way five years after the death of her husband.
They could tell she was still suffering like the rest of them. One day when Sheila did not attend group, however, several participants raised questions about her. Some speculated that one of the reasons she was still actively grieving was that she did not have the support of a grief therapy group after her husband’s death. Acknowledging this seemed to give everyone a renewed appreciation for the group and helped them to let go of some previous misgivings.

Despite a growing willingness to express their feelings of loss, it was not until later in the therapy that they could disclose feelings of anger directed at their spouses. Similarly, it was hard to bring up problems they had in their relationships while their partners were living. I explained how the idealization of a loved one after their death is a normal aspect of the grief process, but that anger, guilt, or other unexpressed emotions can complicate the bereavement process if not dealt with. Now that the group participants were beginning to trust one another, opportunities would soon emerge that would allow for the processing of these difficult feelings.

Middle of the Therapy

Towards the middle of the life of the group, the participants began to be more forthcoming with difficult emotions. The intervention implemented to work with these emotions was to ask the group participants to do some journaling in order to gain more awareness of the issues they were working with. I asked them to focus on the more complicated feelings around what they remembered about their relationships, including anger, guilt, or resentment. After ten minutes of writing, the participants shared with the group.
Jasmine realized that she had guilt for not being more patient with Michael in his last months. She described herself as having been “bitchie.” Ina and Wyatt also experienced guilt concerning problems they had in their relationships for which they felt responsible. Ina admitted that she and her husband both brought a lot of baggage into their relationship, which at times had got the better of them. Despite this, however, they stayed together for 49 years and were still “in love at the end.” Wyatt admitted to his regret that he could not be a better listener in his relationship and always had to try and fix things. Sheila admitted sheepishly that she and her husband were “a pair of misfits” who came together from difficult childhood backgrounds, but had a very good “love” life. The disclosure of these feelings and issues appeared to give Ina, Annie, and Sheila the courage to start expressing their anger at their spouses for dying. Harold was the only person who said that he did not share these feelings. He said that he had used up all his anger after the death of his first wife because of how she had “killed herself with her alcoholism.”

It was at this point in the therapy that I implemented the intervention of working directly with the participants’ anger using journaling and discussion. Although most of the participants were fully engaged in the exploration of their anger, Annie seemed to be most invested in this process as she was working with more anger than the rest of the group. She explained that she was furious because of the circumstances around Jerry’s death. He had been under the influence of alcohol when he had crashed his car into a tree. He also did not leave a will and made no financial arrangements for her. Although they had spent the past 14 years together on weekends, they were not married and so Annie was not even able to stay in the house they had shared all those years. She was very upset
that his ashes had been interned in a plot next to his first wife’s, which felt as if her role in his life was irrelevant. Annie blamed his second wife who had “taken him to the cleaners” and who, according to Annie, was the reason for Jerry’s ambivalence regarding his relationships and financial affairs. (Ironically, he had been a professor of business by profession.)

Annie shook with rage and pain as she told the group how unfair all this was and how she did not find out about his death until five days after the accident. After staying at the house for a few days, she was asked to leave by a public administrator. Annie was not permitted to take any of Jerry’s personal effects. The house that she loved was then robbed three times and she could not do anything to protect it. She said that she was so angry that she had no love for Jerry at this point. It took several sessions of working with her anger in the group through journaling, verbally recounting her story, and voicing her anger before she could feel her love for Jerry, as well as her deep sadness about his death and how the subsequent events unfolded.

An additional issue uncovered during the course of treatment was Annie’s general lack of trust in people, which may have stemmed from her abusive childhood. It wasn’t until seven months into the therapy that she expressed how she had never trusted people, even after many years of therapy. She described herself as being a very private and defensive person. In this particular session, however, Annie said she felt for the first time in her life that she could trust people. When I asked her to share with the group how she came to this new place of trust, she beamed and declared that it was “a breakthrough [for her] to realize that we are all the same underneath.” Having witnessed the other participants in their grief, and having seen that they were all in pain, that they all had
intimate stories and emotions, it was as though she had recognized the humanity of everyone in the room. This created a social bond that she had not experienced before. Trusting the group participants in this way enabled Annie to be open to the idea of trusting others outside the group. A few moments later she added, regretfully, that it had taken her all of 80 years to learn this.

It is interesting to note that in a session shortly after Annie’s breakthrough, Ina confronted Sheila on why it seemed that Sheila was in the same place as the rest of the group with regard to her grief and why she was not “further along.” This was an issue that had been brought up only when Sheila was absent in the group. Up to this point, no-one had the courage to ask Sheila directly or express their feelings about it. In this particular session, Ina told Sheila that it scared her that Sheila was still in such a place of overwhelm because she, herself, did not wish to be in this same place of deep grief five years from now. Sheila responded with a defensive attitude, almost not wanting to engage Ina on this topic. It looked as if she was not going to offer any explanation and the other participants seemed to be getting increasingly agitated.

As it was now five months into Sheila’s treatment, and I knew some level of trust had been established, I intervened and encouraged Sheila to tell us how she was affected by this interaction with Ina and if she wanted to say anything in reply. Sheila then disclosed what had happened to her two months after the death of her husband. She had been in grief therapy for six weeks when the therapist passed away unexpectedly. He died of heart failure, which was exactly the cause of her husband’s death. Sheila said she stopped crying for her husband the day she heard about her therapist’s death. She added that she did not fully understand why she had stopped grieving. I offered her the
explanation that her therapist’s death had traumatized her so much that she stopped actively grieving her husband. It was only now, five years later and with the help of this group, that she could allow herself to go back into her grief.

Sharing this experience with the group, and the feedback she received as a result, was a turning point for Sheila, who up to this moment had been very negative about her life in general. She now saw how she judged herself harshly for not being in a different place in her grief. She then admitted to how greatly relieved she was when I told her that I did not consider it abnormal for her to have put her grief on hold after experiencing this second, traumatic loss so soon after Victor’s death. Sheila cried in a new way that day, revealing a vulnerable part of herself that we had not seen before. It was the first time that she consciously allowed her feelings to surface, to let us in to witness the deep sadness of her grief.

Having participants at different places in their grief was helpful according to some of the clients. Ina, in particular said that she appreciated Wyatt and how he approached his grief. It was true that Wyatt had been in the group longer and was in a more hopeful place emotionally. He also often articulated what some of the others were feeling or just becoming aware of for themselves. Ina made a point of saying how greatly she valued what he shared with the group. Wyatt once commented that after a partner dies it feels as if you remain half of a couple, incomplete. This led to a discussion about how their identities had changed since the death of their partners. Ina, Jasmine, Sheila, and Harold said that for many months they had no idea who they were without their spouses. Jasmine and Sheila voiced that they had not only lost their spouse, but felt as if they had lost themselves, too. I employed the intervention of disclosing my personal experience and
added that when my husband died, I felt as if my identity had shattered. Many participants seemed to resonate with this image of being shattered, saying that it was only now in the therapy that they felt their self-confidence re-emerging and a renewed sense of who they were without their spouses.

Interestingly, although Wyatt was respected for having been in the group the longest, his musings also frustrated some participants. Sometimes Wyatt became instructional and was overly positive about what he was learning about himself, before the others were able to appreciate their own learnings. I would remind the group that everyone was in their own place in their process, and that no-one was expected to be anywhere else. Furthermore, although Wyatt did have good awareness of the learnings inherent in his process, he occasionally shared thoughts and concepts that seemed like a spiritual bypass. At these times I would intervene and remind Wyatt to speak from his feelings.

Annie brought up the issue of elderly grief, specifically how an elderly person’s expression of grief is sometimes misunderstood as senility. Being in her early 80s, she felt as if some people assumed she was “losing her faculties” when in fact she was grieving the loss of her partner. According to Annie, this fear of being seen as senile was one reason people in her senior living community were reticent to show their grief, and one more reason why she usually kept her feelings hidden. Jasmine and Ina agreed that this was something that had come up for them as well.

Another theme that emerged in this stage of the therapy was the ongoing relationship with their deceased partners. The topic was first, although timidly, brought up by Jasmine. When she and other group participants realized they would not be
chastised by the therapist or by each other for these “unconventional” ideas, and that in fact other participants had similar experiences, the theme surfaced more frequently. According to those in the group who had this experience, it was not only in memory that the relationship continued, but through actual contact, at night through dreams and during the day through hearing their partner’s voice or sensing them nearby. When these conversations were initiated, I made sure to ground the discussion in physical reality, yet by the way I responded to their stories, I also demonstrated that I was open to the possibility of this contact being real for them.

Jasmine once commented with tears in her eyes that she sensed her husband appear from time to time, and felt as if he were accompanying her in whatever she was doing that moment. She would ask him questions and he sometimes answered. Jasmine had a routine of toasting Michael with a glass of wine before dinner. She dreamed one night that he told her that he was ok. He then gave her a hug, which Jasmine said felt real and comforting. She said she always treasured the times, whether while awake or asleep, when she felt as if he were close by.

Ina had her own story of how she stayed connected to her husband. She and Terrance loved to listen to music together and were great dancers. Ina was a little embarrassed to tell us that during many evenings in the first months after his death, she would dance with a pillow to the music they loved and pretended they were dancing together. One day, Ina came to group almost too excited to wait for the check-in. She had been to see a movie by herself, and during the closing credits, at the time she would usually have left the theater, a song played that had been one of Terrance and her favorites. Ina said she distinctly sensed his presence, which at first gave her goose bumps
before giving her a feeling of intense joy and serenity. She told the group that she had not been able to relax like that since his death.

Others in the group shared similar experiences. Harold said that he often talked to Louise and sometimes felt her close by. Sheila had more than once heard her husband tell her to “move on” with her life. Annie just kept asking Jerry why he had been such a fool to have killed himself, though he had not responded to her as yet. Noticing some envy and sadness in the room, I underscored that while these experiences were very moving, that not having communication with their partners did not make the love between the couples any less real.

**End of the Therapy**

In the second half of the year as the therapy progressed, the focus seemed to shift to existential questions such as why God had let this happen, was there a God and an afterlife, what was the meaning of this experience, the purpose of suffering, and the purpose of life in general? As the participants became increasingly aware of these questions, I revised the treatment plan to include more interventions, discussion, and exploration around the participants’ beliefs about such topics. I also emphasized that while nobody chose to be in this situation, they did have some choice as to how they made meaning of their experience.

At this time I used the intervention of bringing in Jean Houston’s writing on the sacred wound, and poems related to the initiatory potential of the grief process. I began to read them in the weekly opening rituals. In response to these poems and writings, Ina, Wyatt, Annie, and Jasmine in particular, said they were now starting to get a sense of who they were without their spouses, and were feeling more like a “self” than “half of a
couple.” The participants’ shattered identities were now coming together in a different way. Along with this came a change of priorities, among them a new respect for the significance of family and other loved ones in their lives.

Other changes specific to each individual included Wyatt becoming more tolerant of staying with his feelings instead of running from them. He realized one of his issues with his wife had been his inability to stay with the discomfort of what was happening in the moment because of his drive to fix things. He thought that through his grief process he had learned how to feel, how to know when to fix things, and when to just listen to others. Ina said she needed the first few months of the group to realize she was not in control of her life or her grief. From that point she learned to be with her feelings, however uncomfortable and chaotic. In the outcomes section of this chapter, I describe additional ways in which I noticed the participants change as well as changes they reported themselves.

Witnessing a growing interest in the group to excavate these existential issues, I made more time in the therapy to explore spirituality, the possibility of an afterlife, and the continued relationship with loved ones. I used the interventions of expressive art and visualizations for the participants to explore both. The week of the expressive arts project, after the opening ritual and check-in, I gave a brief introduction to the project. The group participants would write a letter to the person who died, to articulate some of their thoughts and feelings. I suggested some things they might write about, such as what they wished they had said or not said, done or not done, what they missed most, or what they would like to ask their loved one. They were given ten minutes to write. As I looked around the room, I noticed all the participants completely absorbed by their task. Ina and
Jasmine scribbled so fast that they went through several pieces of paper. Ina, Jasmine, and Harold periodically reached for a tissue to dab their eyes. When the ten minutes were up they put down their pens and sat in silence for a few minutes. The room felt thick with emotion.

At this point I asked them to do something that surprised them. I invited them to answer the letter they had just written, from what they imagined was their spouse’s perspective. Sheila and Annie looked rather nervous, while Jasmine and Ina appeared excited. During the next 10 minutes they all reached for the tissue-box.

In the debrief that followed, Ina read her letter aloud to the group. Her letter to Terrance was very moving as she told him how much she loved and missed him and how well their son was doing. She said that she had sensed him recently in the movie theatre when they played “their” song, and that it had felt so good. Lastly, she commented on his favorite team, the San Francisco Giants, and said that “he must be pulling some strings up there to have helped them do so well this season.” She asked him why he had to leave so soon, and that she thought she was supposed to be the first to go. The letter written as a response from Terrance was loving and supportive, encouraging Ina to make the most of her life and that he would always love her.

The other group participants nodded as Ina read her husband’s letter, perhaps recognizing similarities with the letters from their partners. Annie said she was surprised how much love she felt for Jerry while writing the letter, and that her anger at the way he had died had almost disappeared. In her letter to her husband, Sheila worried that her husband would be angry with her for being stuck in her grief. However, in response to
her letter he expressed more sadness than anger. He also told her that it was time to let go and move on with her life.

The following week, the intervention implemented was a guided visualization. In this visualization the group participants traveled across a lake in a boat to meet their spouses on the other side. Once on the other side, everyone was encouraged to have a conversation with them. After the visualization they were asked to journal about what happened and what it meant to them. Many participants shared in their debrief that the visualization experience was poignant and had granted them some comfort. Four of the six participants believed they had experienced something profound, while all six thought they had received messages of support from their loved ones. Jasmine, Ina, Harold, and Wyatt reported having lengthy conversations with their spouses that encouraged them to embrace life. Sheila and Annie were more private about their experience, but said they felt good about it.

In addition to their continued (albeit transformed) relationships with their deceased partners, another theme that came up towards the middle and end of the therapy was dating and starting new relationships. Harold shyly brought up the fact that he had met someone, a widow who was becoming a wonderful companion. He stressed several times that this relationship was, and would stay, platonic. His sense of guilt was palpable, and I responded by acknowledging his guilt and saying that it was courageous to be able to open one’s heart again after experiencing so much pain. Wyatt used this moment to surprise everyone, disclosing that he had also met someone else with whom he was thinking of starting a relationship. When I commented that our hearts are big enough to love more than one person, Jasmine and Ina piped in, defensively, that they were not
ready to be with anyone else and did not think they would ever be. I replied that they may not want to think about a relationship with a new partner as such, but that opening to life and new friendships (outside of this group) might feel possible.

About 12 months into her treatment, Jasmine admitted she had dated someone briefly. She concluded that she would always love her late husband and did not think that she would meet another man with whom she could fall in love, saying that “Michael was a hard act to follow.” Nevertheless, Jasmine said she was hopeful for some “companionship,” and that the senior center in Oakland had become quite important to her and she was meeting new friends.

Since her breakthrough with trusting people, Annie had also become more open to forming friendships with people, mostly women, at her senior community. This was a big change for her as she usually did not make friends easily. Similarly, Ina starting traveling again and wanted to meet “a special someone,” but was also enjoying old and new friendships.

The last months of therapy leading up to April were difficult as we started the termination process and prepared to say good-bye to one another. I was discontinuing the group as facilitator because I was due to give birth to my baby daughter. The six core participants also felt it was time for them to leave the group, with Wyatt and Annie leaving two months before the others. Three new group members had joined in the last four months and were preparing to continue with a different group leader.

Terminating the group was painful for the participants, particularly because the loss of their partners made all other good-bye’s so much harder. In this group, the six core participants had also become a very supportive community to one another. Jasmine
and Wyatt were moving out of the area, however, which made the continuation of the lunch group uncertain, especially since Jasmine had been so central to the gatherings. Jasmine expressed a great deal of ambivalence with regard to her plans to move to Oregon, but wanted more than anything to be with her daughter who lived there. The group spent many sessions processing the feelings of sadness, anger, and abandonment that came up, as a result, as well as addressing the love and gratitude for each other and the work we had been able to do together.

With hindsight, a regret I have in my work with this group was the limited use of visual expressive arts to access the participants own healing potential. While sufficiently utilizing writing projects and journaling, I now recognize the benefit of having offered art projects to 1) focus on the question of what might have helped them in their grief, a gift they could have given themselves, and to 2) record the progression of their treatment over time, asking them at the beginning of their therapy what their grief looked like, then again in the middle and at the end of treatment. An additional writing project, such as writing their story of grief as a myth, may also have been helpful to make meaning of their grief process.

A second regret was in the work with Harold. Looking back I now understand that we had not spent sufficient time working though his experience of the death of his first wife. While he resisted revisiting the issue, I noticed that he appeared to have unresolved feelings around the cause of her death, and a great deal of anger (and shame) around how she had “killed herself with alcohol.” It may have served Harold to work through his unresolved grief regarding his first wife, in order to better integrate the loss of his second wife.
Legal and Ethical Issues

The only ethical issue that came up had to do with socializing with me as their therapist outside the context of therapy. The group participants came to know each other well and made a habit of going to lunch together at the end of the group sessions. I was often asked to join them but had to decline because of the rules regarding socializing with clients that Hospice had in place.

Outcomes

According to Worden’s criteria, my clients benefited from the treatment as they worked through their grief. Towards the end of the therapy, the group participants all reported that although they still missed their partners very much, they no longer felt overwhelmed by the pain and did not feel as lonely and sad as they had when they started the group. They were able to function better in their lives, took the risk of reaching out to others again in friendships or love relationships, they had developed or deepened capacities such as courage and empathy, and seemed to have greater self-awareness than before the group.

Wyatt started another relationship while in the group and eventually moved out to the country with his new partner, which is something he had always wanted to do. He left his position in sales and started to focus on his real love, creating art. Harold met someone he felt very close to, someone who had also lost her spouse, and they provided each other with friendship and companionship.

Ina rekindled her love for travel, which is something she and her late husband did a lot together. She let go of some of her expectations of herself to stay positive and in
control at all times, and turned away from always saying yes. She learned through the work in the group that in order to be more true to herself, and her needs, she could decline an invitation every once in a while. Whereas at the beginning of the group she was critical of people who had self-pity, she now understood that it was alright to be kinder to herself and that having self-pity may in fact be a way of allowing herself to grieve. Ina eventually let life in again and lived with a renewed vitality. She also became more involved in her community, and felt she was doing so in a more authentic way.

Sheila also became less hard on herself, and shared with the group that this was a big change for her. She had been very critical of herself and others, and it had taken many months in the group to get in touch with her more vulnerable self. The months of feeling acceptance from myself and the group participants were helpful to her process. The breakthrough came with her disclosure, and my feedback, regarding the death of her therapist so soon after her husband’s death. It was at this point that Sheila could let go of her judgment about how she had been grieving incorrectly, and she clearly recognized how she had put her grief on hold and that many people in her situation would have reacted in a similar way.

Jasmine planned a trip to Monaco to visit family and friends. She had not been to Monaco for many years before the death of her husband, and said she did not have the courage to travel so far on her own before participating in the group. When she returned from her trip she decided to sell her house and move to Oregon to be closer to her daughter. She seemed to blossom into someone who was capable and she developed a more mature relationship to life. Without being able to rely on her husband’s protection and direction, she became more aware of who she really was.
Annie discovered that she was not as angry with her partner as she was before the group. She could finally remember the sweetness that was a big part of their relationship. Whereas before Jerry’s death she never cried, she now cried “all the time.” While crying at commercials was something that she was not proud of, she realized that she was at a place with herself now that she could sit with her feelings and not run from them. Annie also expressed how the work in the group had made her become aware that we are all the same underneath. This helped her be less fearful, and more trusting and empathetic of people around her. This in turn gave her the courage to be a leader. Annie took her new trust in herself and others and used it (a year later) to lead a successful political campaign involving close to two hundred people. She said that she would not have been able to do this before her experience with her partner’s death and the year of group therapy.

Recounting these stories of transformation, a poem by Rashani Rea comes to mind that elegantly illustrates the initiatory journey of grief:

There is a brokenness
out of which comes the unbroken,
a shatteredness
out of which blooms the unshatterable.
There is a sorrow
beyond all grief which leads to joy
and a fragility
out of whose depths emerges strength.

There is a hollow space
too vast for words
through which we pass with each loss,
out of whose darkness
we are sanctioned into being.

There is a cry deeper than all sound
whose serrated edges cut the heart
as we break open to the place inside
which is unbreakable and whole,
while learning to sing.
CHAPTER 4

LEARNINGS

Introduction

The learnings discussed in this chapter were drawn from 15 months of bereavement group therapy. There were six participants in this group who met weekly in a one-and-a-half hour session from January 2003 to April 2004. This chapter includes: 1) the key concepts and major principles that assisted my interpretation of the group process; 2) a description of what happened for the group participants during their treatment; 3) an interpretation of their primary imaginal structures; 4) identification of my own imaginal structures; 5) a primary guiding myth used to make meaning of the therapy; 6) an account of my personal and professional development as a result of the experience of the therapy; and finally 7) a description of how an Imaginal approaches to bereavement was applied to the therapy.

Key Concepts and Major Principles

What happened with the group through the course of treatment corresponds to established theory with regard to bereavement. In this section, the concepts and principles that will be used to inform the interpretation of the group process, including both the clients’ and my own imaginal structures, will be highlighted. Imaginal structures as a concept was coined by Omer and can be understood as core beliefs that underlie an individual’s experience. Omer defines imaginal structures as “assemblies of sensory,
affective, and cognitive aspects of experience constellated into images [which] both mediate and constitute experience.”¹ The primary imaginal structures evoked for the group participants during therapy include a reflection of their resistances to the therapy and their transference material toward me as their therapist, while my own imaginal structures include a reflection of my counter-transference material. The imaginal structures presented later in this chapter correspond to what happened in the therapy, while the key concepts and principles that will first be outlined provide a framework within which to understand these structures.

Grief work is a concept based on Freud’s early work that speaks to the importance of actively working through or processing one’s grief.² The grief work or stage model hypothesis claims that it is important for bereaved individuals to work through their affect in order to come to terms with their grief and move to a post-grief state.³

According to Wilkinson, in contemporary culture, blame and entitlement often reinforce the victim position, thwarting efforts to make meaning out of a difficult situation.⁴ Wilkinson discusses what may interfere with the bereaved individual’s potential for initiation. She writes that individuals in Western culture often remain identified with the victim role instead of making meaning out of their initiatory journey. She theorizes that this is the nature of our hero and progress-oriented society, which gives individuals a sense of entitlement and fear of vulnerability. She maintains that blame and entitlement keeps people in a victim position and that initiation guidance in the form of therapy is vital to help the bereaved let go of this.

The concept of initiation is explained by several writers. Turner defines initiation as an individual and inner process of growth and individuation.⁵ Robert Moore states that:
“Initiation really refers to something that is part and parcel of the universal spiritual journey, the pilgrimage of human life. Initiation is the process of dying and being reborn.” 6

Houston contributes to the discussion on initiation by introducing the concept of the sacred wound. 7 This concept holds that our wounding reveals a larger story or reality, which is blocked to our habituated viewpoint, and that transformation occurs in the discovery of the larger story. In our wounding, we are forced to look at what has been hidden to consciousness until the time of the wounding. Houston describes the concept of the sacred wound in the following quote: “As seed making begins with the wounding of the ovum by the sperm, so does soul-making begin with the wounding of the psyche by the Larger Story.” 8

Mogenson speaks to the role of therapy in the initiatory potential of the mourning process. He writes that the therapist may help the bereaved “find an increased vitality in their own living.” 9 Wilkinson maintains that the initiatory guidance offered in therapy is important in helping the bereaved dis-identify from their victim position and find meaning in their initiatory descent, so that they may resurface with an insight, ritual, or gift for the culture. 10

In discussing how grief is approached in contemporary Western culture, Cable and Malidoma Somé are aligned when they maintain that the bereaved are expected to be self-sufficient and keep their grief to themselves. Cable suggests that the taboo of expressing emotions publicly had led to many people grieving in private, on their own. 11 According to Somé, “a singular expression of grief is an incomplete expression of grief.” 12 He writes that it is important to grieve communally within a ritual context. 13
Somé goes on to say that, in fact, without the “radical and genuine recognition and acknowledgement” provided by community, suffering will not end, but grow larger. Furthermore, Somé suggests that emotions are sacred and are the most “vital cord” that connect people to each other. Intensity of emotion, deep attention, and participation are necessary in the practice of ritual. Grieving communally within a ritual context also requires embracing the metaphoric and symbolic regions of the human experience, as it is in the world of metaphor and symbol that soul and spirit reside.

Similarly, Worden assumes the importance of social support during grieving. He suggests that a lack of a social support network is one of the issues that can change an individual’s normal grief to complicated grief. Skinner Cook and Dworkin state that in Western culture, traditional avenues of support have diminished in recent years and that families and communities, which offered care and support in the past, are usually less available to help the bereaved after a loss. Skinner Cook and Dworkin also contend that as a result, grieving individuals often have nowhere to share their grief with others on an ongoing basis. These authors believe that for some people, a grief group can offer this lost opportunity to grieve.

The concept of the wounded healer is used by Jung to describe how the woundedness of the healer enables him to help others in their healing. Allied with this concept, Madhi states that we need elders or qualified adults who have themselves been initiated to guide people through initiation ordeals and transitions. Wilkinson adds to this by maintaining that initiation guidance is necessary to help the bereaved dis-identify from the victim position, thereby helping them make meaning of their experience.
Jung writes that mourning necessitates creating a myth of the hereafter. Based on this theory, Mogenson writes that in secular modernity, the bereaved have lost touch with the collectivity of the dead and thereby, the larger tradition of mourning. Mogenson suggests that this connection needs to be recreated in order for the bereaved to find access to the mourning process. Having no myth of the hereafter makes it difficult to sit with the unknown of what comes after death for the deceased and therefore to trust the process of mourning.

Bowlby emphasizes the significance of establishing a continued relationship to the deceased by satisfying the emotional needs of the bereaved and preserving their sense of identity, while also allowing for grieving and living to proceed. Following Bowlby’s acknowledgement of the significance of this relationship, Klass, Silverman, and Nickman propose that the bereaved can maintain these ties “indefinitely” and should not be expected to eventually relinquish them. They postulate that bereaved individuals who maintain these altered bonds with the deceased seem to be better adjusted psychologically in their grieving process than those who sever the bonds.

Brinton Perera identifies the scapegoat complex as a constellation of four distinct, but related aspects of identity: 1) the condemning accuser or judge; 2) the self-righteous accuser or false priest; 3) the burdened, alienated victim or wandering goat; and 4) the victim or holocausted goat. She proposes that these aspects of identity keep an individual bound to a collective perfectionist morality. When the rules of this collective morality are perceived to be transgressed, the transgressor is exiled.
Imaginal Structures

What Happened?

A description of what happened during the course of treatment pertains to the group as a whole with examples of actions taken by particular individuals. I will describe what happened for the group in terms of: 1) the group’s affect; 2) the participants’ relationship to the group; 3) the group’s relationship to the therapist; 4) the group’s relationship to the grieving process and the continuing bond with the deceased loved ones; and 5) the group’s transformation.

Regarding group affect, the group participants resisted feeling the pain of their grief in early therapy. They would talk about mundane details of their everyday life and not express their feelings regarding the deaths of their spouses. Most of the participants, did not think they had much anger about anything pertaining to the deaths. However, anger and rage seeped out indirectly as they blamed doctors, nurses, and hospitals for their spouses’ death and their current suffering. Ina’s anger was specifically directed at her husband, Terrance’s doctor, who had given her incorrect information regarding the surgery. Sheila said she was angry at the hospital where her husband died. She was also angry at her next door neighbors for making too much noise with their home renovation. She complained that they had blocked the view from her upstairs window by adding a room to their house. Other participants had other defenses: Wyatt would discuss his spiritual and intellectual theories to avoid his feelings, while Sheila and Ina handled their grief stoically, acting as if they were just fine.

Later in the treatment, this indirect approach to expressing their feelings changed to where the participants began sharing their despair and other deep feelings with each
other. Annie expressed her anger at Jerry’s drinking and driving. Sheila and Ina realized that indeed they were not just fine, that they were actually in much pain. This recognition helped others in the group realize and express their own feelings of anger, guilt and hopelessness.

Similar transformation occurred with regard to the participants’ relationship to the group. In one of the first therapy sessions some of the participants joked about how this grief group was a club you did not want to belong to. Eventually, four months later, the group participants expressed how much they needed this group and how they valued this community. Ina said this group was a “life saver” and was helping her out of her isolation. She added: “I can be myself here and don’t have to act as if I am strong all the time.” Harold said that nobody understood his grief as did the members of this group. The participants showed much empathy for each other and kind, loving relationships developed. Annie said that the depth of suffering they all shared made her realize that they were all the same underneath, that they shared a common humanity, and the support the others offered her was invaluable.

The group’s relationship to me as therapist also changed. Initially, I wondered if the group doubted me because of the age differential. I was young enough to some to be their granddaughter, but not old enough to be a peer or older mentor. Later in the therapy as my pregnancy became more obvious, the group participants often asked how I was feeling and I wondered if they felt they needed to protect me.

As the therapy progressed, the participants stated that I as their therapist had given them hope, the hope that it was possible to endure their pain and “come through to the other side of their grief.” The fact that I had been through my own personal losses was
important to them. Ina said it meant a lot to her that I wasn’t some group leader who was just there to “help” them, but had gone through the experience myself.

The group’s relationship to the grieving process and to the deceased also evolved. The participants expressed concern that if they stopped grieving they would forget their partners. There appeared to be a lack of trust in the grieving process. There was also a hesitancy to speak about their continued relationship with their deceased loved ones. Jasmine was the exception who told the group in the first few months of therapy how every evening she would toast her late husband with a glass of wine while telling him of the day’s events. Later in the treatment, there were many discussions exploring the continued relationship with their loved ones and the possibility of life after death. The guided boat visualization and writing a letter to their loved ones were popular processes which the group participants said had given them much comfort.

Finally, transformation of the group is outlined. At the beginning of the therapy, the group participants expressed that they felt victimized by this extremely tragic and unfair event of the death of their spouse. Toward the end of the treatment, the participants became aware how this experience was changing them as people. They talked about experiencing an identity shift from feeling like half of a couple to a whole self and developing new practical skills. Annie trusted people for the first time in her life. The trust and empathy for others as well as the courage that she developed during group therapy since the death of her partner helped her become more of a leader. Jasmine reported that she had developed more courage than she had before her experience of loss while Wyatt talked about how he was now more emotionally aware and was allowing himself to follow his bliss.
The Clients’ Imaginal Structures

While it can be said that a unique set of imaginal structures was evoked for each individual during their period of treatment, the group dynamic also evoked imaginal structures at specific junctions in the therapy. In this way, the individuals moved together as they explored and expressed their experience of loss. For the purpose of this Clinical Case Study, I will examine the imaginal structures of the overall group with details specific to certain individuals.

The primary imaginal structures that were evoked for the group participants, which reflected their resistances and transference material toward me, the therapist, might be called the Stoic Warrior, Victim, and Skeptic. Later on in the therapy, with guidance from the therapist and each other, additional structures were activated including the Active Griever, the Same Tribe, as well as what might be called the Initiate.

The voices that exhibited the Stoic Warrior structure touted self-sufficiency and certainly did not need anyone’s help; not from the facilitator, nor from each other. Some of the resistance to feeling and expressing the pain of the grief and talking about the day-to-day details of their lives was a natural way for the group participants to get to know each other and build trust without being too vulnerable. They were waiting to expose their feelings until the group felt safer. Important to note is that alternating periods of accessing and avoiding feelings are a normal part of the grief process that protect the individual from getting too overwhelmed by their experience. However, in terms of the participants of this group, another aspect of this resistance had to do with their fear of being with their feelings in case they would lose control. The Stoic Warrior structure
manifested in the group as being unable to feel and express grief. This often led to the group participants talking about mundane details of their daily lives.

The Victim structure that was evoked early on in the therapy, manifested as anger and blame directed at doctors, hospitals, family, friends, and neighbors, holding these others responsible for their suffering. An additional element of this structure was to stay embedded in the unfairness of the situation with the belief that “bad things don’t happen to good people.” The principle that helps to interpret this imaginal structure assumes that in contemporary culture, blame and entitlement often reinforce the victim position, blocking efforts to make meaning out of a difficult situation.

As the therapy progressed, the Stoic Warrior and Victim structures became less dominant and the group participants allowed themselves to start feeling and expressing their grief in more direct ways without holding others responsible for their pain. It was at this point that the Active Griever structure was activated and the participants were more able and willing to stay with their feelings and share them with the rest of the group. The concept of grief work can be used to understand the Active Griever structure and the progression from resisting feelings to actively engaging with the pain of grief.

The Same Tribe structure also grew in strength as they now valued being part of the grief group and the supportive community this provided. Whereas at the beginning of therapy the group participants were ashamed to be part of the grief group, and joked how this was a club you did not want to belong to, a few months into the therapy several participants shared how important the group had become for them. They said that this was the only safe place where they could be with their grief, feel heard, and be deeply held by the others in the group. Malidoma Somé’s principle of an individual expression
of grief being an incomplete expression of grief applies here, as does the principle of how the deep witnessing of community helps to eventually lessen the suffering of the bereaved.

The Skeptic structure showed up in the group participants by not trusting the grief process or the possibility of a continuing bond with their deceased loved ones. The participants were fearful of letting go of their grief in the event that this was the only thing keeping the memory, or their connection, with their spouse alive. They were also reticent to explore the possibility of an afterlife or of an ongoing relationship with their deceased loved ones until later in their therapy, even though it was apparent that some group participants’ believed in this possibility. The scapegoat complex can explain the participants’ fear of being judged for what they perceived as unconventional beliefs.

During the course of treatment, we explored the issues of life after death and continued relationships with the deceased in discussion as well as with visualizations and expressive arts. This exploration may have helped the participants formulate a death myth, as well as be open to a continued connection with their loved ones. These developments may in turn have helped them trust the grief process, knowing that even after they stopped actively grieving their loved one, the relationship could continue, and be nurtured, on some level. Jung and Mogenson’s principle of the importance of creating a myth or conception of the hereafter in order to access the mourning process, as well as Bowlby, Klass, Silverman, and Nickman’s concept of continuing relationships with the deceased, is relevant to the group. Without having formulated a myth of the hereafter at the beginning of therapy, the participants doubted their ongoing connection with the
deceased. In this case grieving may have seemed like the only connection with their loved ones.

The Initiate structure was activated as they became aware of how this experience of the death of their loved one was changing them as people. The concept of initiation applies to the group in that toward the end of treatment, the group participants offered testimonials as to how they were different since their experience of loss and group therapy. All the group participants had dis-identified from their grief and the Victim structure to the extent that they were able to allow joy back into their lives. Most participants believed they had grown personally, and several participants reported they had deepened their capacities of self-awareness, courage, or compassion.

My Imaginal Structures

The primary structures that were evoked for me included what might be called an Incompetent structure, an Outcast structure, and an Ethical structure. With the progression of the group, other more positive structures were activated such as a Same Tribe structure, a Generative structure, and a Wounded Healer structure.

My Incompetent structure manifested early in the life of the group when the group participants frequently talked about mundane details of their daily lives. This felt invalidating to the nature of the group and thereby, invalidating to me as the group leader. Even though I realized that the group participants needed to share personal details in order to get to know each other and build trust (more so at the beginning of therapy), I wanted them to deepen their connection to their feelings. What was evoked for me was the concern that they were moving too slowly. This led to the fear that I had lost control
of the group and was being ignored. I was also anxious that they were not doing this right as a group, and that therefore, I was not doing this right as the group’s therapist.

I was concerned that the age differential between the group members and myself cast doubt among the participants as to whether or not I was capable as a therapist. My Incompetent structure manifested as insecurity around my ability to lead the group. Later in the therapy, after the participants got to know me better, I realized that the group members respected me and valued the way I facilitated the group. This affirmed that I was perceived as trustworthy, that I was able to hold the container, and make it safe for the participants. It was meaningful to me that having survived my own grief had given the participants the hope that they could too. This brought up my structure of the Wounded Healer and a sense of being a guide and initiated elder.

The concept of the wounded healer applies to the therapy with the group participants in that they ultimately revealed their trust and respect for me because of my personal experience with loss. They appreciated the fact that I understood the bereavement process from first hand knowledge, holding out the hope or promise that they would get through to the other side of their grief. As my pregnancy became more obvious, this may also have been a symbol of hope for the participants, concrete evidence of transformation, the literal birth of something new after my own devastating experience of loss.

With reference to the group participants fulfilling their initiatory potential, I felt validated after hearing their testimonials of transformation. However my Incompetent structure was evoked with regard to several group members whom I considered to have incomplete initiations. I realized that as therapist, I was identified with the groups’
initiation. If all the participants weren’t fully initiated, I believed I had failed as a therapist. My standard for what constituted a fulfilled initiation was high. My criteria included gaining insight about one’s life and developing an increased vitality, as well as developing capacities such as courage and empathy. I believed that two of the group participants had not reached this standard and so I judged them and myself as having failed.

The fact that Harold and Sheila developed health problems after starting the group strengthened my Incompetent structure. It brought up feelings of guilt and inadequacy as a therapist and I felt somewhat responsible for their health issues. Sheila developed non-hodgkin’s lymphoma, which was diagnosed (and went into remission) during the period of group therapy, while Harold underwent cardiac by-pass surgery a month prior to meeting for the signing of the Clinical Case Study consent forms (one year and a half after the ending of the group). I wondered whether their conditions were a somatic response to their grief and whether they might not have had these health problems if I had only done more to help them process their grief. Being aware that Jasmine continued taking anti-anxiety medication after the termination of the group also evoked some guilt around how this may have been prevented if only I had worked harder as a therapist to help her process and integrate her grief more thoroughly.

The Outcast structure was first evoked when the group participants joked about not wanting to belong to this grief club. I felt marginalized and rejected. However, I also felt some pride that I had flourished as a result of belonging to a club that terrified those who were not part of it.
The Outcast structure waned in strength when I realized that I had mid-wifed the participants in their shift from not wanting to belong to this grief club to realizing the value and necessity of being part of a community. I felt validated by this shift. It also brought up the feeling of generativity. I had the benefit of attending a grief group for two years after my own losses and knew from experience how important it had been for my healing. I wanted this for the group participants as well. When the participants began valuing the group and recognizing our community, it evoked a sense of belonging in me, as if we were members of the same tribe speaking the same language.

Believing in life after death was a bias I brought with me into the group therapy. This is a concept that prevailed before modernity, and although it is a widely held belief in contemporary middle class American culture, it is not generally acknowledged publicly. A Harris poll in 2003 reported that 84 percent of the American population believed in life after death. An additional bias was the belief in the possibility of contact with the deceased or ADC. This is also not considered a mainstream belief, although, according to Bill Guggenheim and Judy Guggenheim, 20 percent of the American population is reported to have had one or more ADC experiences.

Bringing these biases into the therapy created an ethical dilemma for me. On the one hand, I hoped these beliefs would help the participants in their grief, as they had helped me with my losses. I merely wanted to encourage the group to explore the possibility of these concepts. On the other hand, I felt that it was unethical to unduly influence the group, or force them in any way to accept the belief in an afterlife or ADC if they did not come to it on their own. In addition, I did not want to seem evangelical about my beliefs or be marginalized by the group. I was protective of my credibility as a
therapist, elder, and group leader. The scapegoat complex helps to interpret my Ethical structure. It explains that although I knew how important creating a conception of the afterlife was in my own grief process, I was afraid to bring this understanding to the group participants for fear of being judged or alienated by them. I also did not want to give the group participants a spiritual bypass route. I had seen this happen in several other groups where the participants avoided their feelings of grief and instead only focused on the joy of their communication with their loved ones.

New Learnings About My Imaginal Structures

Before writing about my own imaginal structures, I had not been aware of their complexity around Harold and Sheila fulfilling their initiatory potential. I believed that they had experienced incomplete initiations, but often avoided thinking about this. I felt very protective of both, like a mother feels protective of her children, and wanted them to get as much benefit from the group as possible. I also did not want them to have failed in their initiations, because then I would have failed as their therapist.

With hindsight I realize that I had very high expectations for the initiatory potential of the group, and I judged Harold and Sheila for not having met these expectations. Sheila had a very powerful experience in the middle of her treatment, in which she became aware of the impact that the additional trauma of the death of her therapist, six weeks after her husband’s death, had on her grief process at the time. This realization allowed her to finally return to actively grieving her late husband. However, I was concerned that this had come too late for her to dis-identify from the bitterness she had been carrying since putting her grief on hold five years ago. I nonetheless considered Sheila to have crossed an initiatory threshold because of the subsequent shift that
appeared to have taken place in her behavior and self-perception. Furthermore, she was no longer fixated on blaming her doctors and neighbors and was taking more responsibility for her feelings.

Harold was the only one who did not report as many positive changes toward the end of therapy. He seemed to be able to cope with life better, and had opened his heart to a new companion, but I did not think he had dis-identified from his grief very much or opened up to life in a new way as the others had. Harold did not appear bitter, but he was still so sad. I cared about him a great deal and wanted more for him. He felt like a father figure to me, and reminded me of how in my childhood I had been very protective of my dad, feeling that I had to protect him from my powerful mother.

How could I know what changes really had taken place in Harold’s psyche or life? Could I really label his experience an incomplete initiation when ultimately we, ourselves, are the only ones who truly know what shifts have taken place? Harold may not have shared any insights with the group, but perhaps he expressed them to someone else in his life. He may have grown in ways of which I was not aware.

Another counter-transference reaction with the group that I was aware of was the feeling that the group participants judged me for my “alternative” or “new age” beliefs about life after death. One of the imaginal structures that I was surprised to discover while writing this part of the Clinical Case Study was that I feared being marginalized for talking about life after death and after-death communication.

Similarly, it was in tracking my counter-transference with some of the group participants (particularly Ina) that I became aware of my Incompetent structure. I believed Ina to be a particularly practical and capable person and assumed she judged me
as being the opposite because of my age and appearance. I imagined her thinking that I
was too young and inexperienced or too blond and pretty to be leading this very serious
group.

**Primary Myth**

The guiding myth that is most relevant to this Clinical Case Study is the ancient
Greek story of Persephone and Demeter.\(^{33}\) In the myth, a maiden (Kore) is picking
flowers in a meadow when the ground splits open and Hades, riding in his golden chariot
pulled by black horses, comes forth from the Underworld to seize the maiden and take
her back with him to the Underworld.\(^{34}\) Demeter is grief stricken by the disappearance of
her daughter, and while Demeter looks for Kore, forbids the trees to yield fruit or plants
to grow. Eventually, Demeter learns of the abduction, and with the collaboration and
mediation of Zeus and Hades’ mother Rhea, she negotiates the return of her daughter.
Kore will spend three months of the year with Hades, reigning as Persephone, Queen of
the Underworld, and the other nine months of the year with Demeter in the Upperworld.
While Persephone resides in the Underworld, the earth is to be barren, and when she
returns to live with Demeter, the earth is fertile.

I will draw largely on Tanya Wilkinson’s analysis of the myth of Persephone to
discuss the grief therapy that I facilitated.\(^{35}\) According to Wilkinson an initiatory descent
to the Underworld is one of the oldest and predominant mythic themes.\(^{36}\) Wilkinson
defines the Upperworld as relating to the realm of the masculine, progress, control,
individualism, intellect, ego, and hero, while the Underworld is the realm of the feminine,
unconscious, emotion, nature, vulnerability, and victim.\(^{37}\) In addressing the split between
the Upperworld and Underworld in Western culture, Jung maintains that the ego-
dominated, hyper-rational, materialist position of the Western psyche results in a loss of meaning with fewer experiences that are based in “emotion, symbol, somatic experience, or spiritual life.” It could be said, therefore, that the bridging of the Upperworld and Underworld is essential to living a meaningful and soulful life, one in which we participate fully in all facets of experience.

Wilkinson delineates two forms of initiation; intentional and unintentional. She says that we generally think of initiations as intentional rites of passage for which the initiate receives extensive preparation. The preparation provides the initiate with guidance for a successful completion of the initiation. However, Campbell notes how the unexpected can happen, and that “life itself administers initiations to both the prepared and unprepared.” Wilkinson defines the initiation of Persephone as unintentional. She maintains that in unintentional initiations our culture provides the initiate with minimal or no guidance.

Wilkinson suggests that the way in which Persephone moves through her initiation by transforming her innocence into maturity can help provide a model to the initiate, guidance that is lacking in contemporary Western culture. Persephone evolves from the nameless maiden, the unconscious girl child, to the Queen of the Underworld. Her suffering is transformed through her individuation. Persephone’s new identity is able to bridge and connect the Upperworld and Underworld, symbolized by her cycle of descent and return between these worlds.

I believe the six grief group participants, like Persephone, were going about their daily business, when circumstances arose that forced them into an initiatory descent. The participants had not received any prior preparation with regard to experiencing and
coping with the death of a loved one, with the exception of Harold who had experienced
the death of his first wife. Without such preparation, each participant could be seen
responding to their crisis in ways that were culturally informed.

Wilkinson contends that the prevailing heroic ideal in our Western culture
provides only stoicism, blame, or entitlement as responses to intensely difficult situations
of modern-day initiatory experience. She maintains that these reactions do not cultivate
a real return from the initiatory descent. Instead, they freeze the victim experience in
place as the main aspect of their identity and obstruct attempts to make meaning out of
the Underworld journey. This amounts to an incomplete or stalled initiation.

This stoicism and blame could be seen in the first months of group therapy in how
the group participants talked about their experience of the death of their partners. Ina and
Annie acted as if they were oblivious to their pain, while Sheila blamed everyone around
her for her suffering, including her neighbors for making too much noise and blocking
her view with their house renovation. Ina blamed her doctor for not giving her the correct
information regarding her husband’s surgery. When Harold started group therapy he did
not blame anyone for his second wife’s death, or his subsequent suffering. However, he
had not yet let go of his anger at his first wife and said she had: “killed herself with
alcohol.” Remaining stuck in anger and blame indicated that Harold may have
experienced an incomplete or stalled initiation after the loss of his first wife.

According to Wilkinson, Mogenson, and Robert Moore, initiation guidance in the
form of therapy is vital in order to assist the bereaved let go of the victim position. Therapy can mediate the split of the Upperworld and the Underworld and help make the
initiatory descent conscious to the initiate. This reflects what I feel happened in the grief
therapy group. I believe that the participants received the guidance that helped them disidentify from their Victim and Stoic Warrior structures to the extent that other structures were activated and became more prominent. This shift allowed the group participants to make meaning of their experience, so that in the depths of the confusion and pain of their grief they were able to discover new insight and develop capacities of courage and empathy, as well as a deeper awareness of self. Campbell describes this process: “You go into a depth . . . [and] there you come to what was missing in your consciousness in the world you formerly inhabited.” 47

The participants in the bereavement group became increasingly adept at bridging the two worlds. At the beginning of therapy they would leave the Upperworld of their daily scheduled life, descend into the Underworld of grief and vulnerability during each group session, and resurface to continue their other engagements in a more mindful frame of mind, with more awareness of their felt experience. As they slowly let go of their victim and stoic warrior identity they became more able to participate in both worlds simultaneously. This sensitivity to both worlds helped them heal the wounds of grief, discover new aspects of themselves, and develop certain capacities to experience themselves and the world around them more fully.

**Personal and Professional Development**

My capacity of empathy was challenged and developed during the course of group therapy. This was especially with regard to Sheila and several other group participants who would repeatedly recount the mundane details of their daily lives. I found this aspect of the group difficult to stay present with, and to keep finding the compassion for those participants in those moments. It helped to recognize that they were
using this merely as a defense to not have to be in touch with their pain. Although it was challenging to find ways to steer the conversation back to their grief, I became more adept at this process as well as more able to gauge when the participants could handle being with their feelings.

The most difficult group participant for me was Sheila who seemed to keep everyone at arms length for the first four months. She complained about her life constantly and appeared the ultimate victim. However, the more I was able to stay present with her and come from a compassionate place while engaging her, the more I could see her deep suffering and her courage in showing up to the group every week. Some days I would become very irritated and not have much patience, but eventually I was able to find a subtle way to help deepen the conversation. After Sheila’s very moving breakthrough in the middle of the treatment period, she was increasingly able to stay with her feelings.

My capacity of reflexivity was cultivated in relation to talking about life after death. However much I wanted to throw the participants a “life line” by introducing the concept of life after death, I believed that it was not my place to change anyone’s beliefs around this delicate subject. The way I approached this topic was to wait for a participant’s cue, especially if I was aware of any shame for bringing up a story related to sensing or communicating with their deceased partner. If anyone were to broach the subject I would invite them to share their experience while indicating my interest and support. I did not want any of the participants to feel like they had to keep this part of their experience a secret, as I had witnessed in other grief groups I had both facilitated and participated in.
One of the professional skills I acquired as a result of working with this group was a better ability to track the group as a whole, as well as the individuals within the group. This helped me to encourage the more quiet people to speak up, and those who had a lot to say to give the other participants space. Along with that came the capacity to notice when someone was not speaking because of deep affect that had been evoked, for which I was sure to give them a few more moments of silence or other type of attention before the group moved on to the next person.

I came to better understand the value of structure and how it created the feeling of safety and containment for the group participants. Starting and ending on time was a big part of this as was following a structure that the participants came to expect. The structure that worked well for this group was starting with business, such as the reading of group guidelines, signing of confidentiality forms for new group participants, or general announcements. Next would come the opening ritual, which included the lighting of a candle as well as a guided mediation and reading of a poem. After the opening ritual there would be a short check-in and a longer period to share, before we ended with the closing ritual. The closing ritual consisted of joining hands, a guided meditation and blowing out the candle.

The structure and ritual provided a strong container for deep emotional work to take place and I became increasingly comfortable holding these emotional states. I also developed the skill of supporting the participants while allowing them to find their own way through their grief. An example of this was letting the clients find their own answer regarding whether or not to keep their spouses clothes and personal effects, which I think was more helpful to their healing than providing them with my opinion.
Applying an Imaginal Approach to Psychotherapy

The therapeutic framework I used in my work with this group was an imaginal approach to bereavement. I learned the importance of accompanying the participants on their journey rather than trying to fix them, with the premise that our Underworld journeys are not as much pathological as they are an honorable and integral part of our experience. I based my approach on the writing of Thomas Moore, who sees care of the soul as quite different from most modern notions of psychology and psychotherapy:

. . . it isn't about curing, fixing, changing, adjusting, or making healthy, and it isn't about some idea of perfection or even improvement. It doesn't look to the future for an ideal, trouble-free existence. Rather, it remains patiently in the present, close to life as it presents itself day by day, and yet at the same time mindful of religion and spirituality. 48

In addition, I increasingly came to perceive the participants’ process as having initiatory potential. I viewed myself, the therapist, as an elder who had undergone my own initiation after experiencing the deaths of my grandmother, first husband, and mother. As such I came to see myself as a guide for the group participants to help them on their initiatory descent, and to later help them resurface by “letting life back in” and finding joy and renewed purpose in their lives.

Complementing my imaginal approach to this work was the use of several imaginal practices. The practice of lighting a candle and offering a short guided meditation and poem at the beginning of each session was a ritual that helped provide a strong container within which the therapy could take place. A strong container helped the group participants feel secure that they could go where they needed in their work, sit with the unknown when necessary, and trust the process. The container also helped hold the participants in times of overwhelming emotion and intense vulnerability.
To help contain and regulate these deep affective states, Whitmont describes the value of ritual in the following way:

Any affect or emotion which in its raw and unaltered form is too intense to be controlled by will alone may need its ritual. Without ritual, such energies may inundate the ego and force it into acting out or into obsessive behavior. Ritual brings about containment and acceptance, control of intensity, and dosage. . . . Ritual offers us an alternative to repression for dealing with potentially overpowering affect.” 49

The expressive arts, as an imaginal practice, was also an aspect of the therapy that worked well in this group. Drawing their grief, using color, assisted the participants access and express their feelings, while journaling also helped them access their emotions and make meaning of their experience. Writing letters to their deceased loved ones and imagining the replies facilitated the group participants in an exploration of their continued relationship with their partners. Sensing not only the continued existence, but also the well-being of their loved ones provided solace. The boat visualization worked in a similar manner.

In conclusion, I have described how I applied an imaginal approach to my work with the bereaved in this particular therapy group. I came to perceive the participants’ grief process as having initiatory potential and utilized the practices of ritual and the expressive arts, both informed by this approach. An imaginal approach was beneficial to the participants in that it allowed for their soul’s journey to be attended to. The participants were not required to change, or expected to be fixed, but were provided with guidance and a safe container in which to go into the depths of their process and their suffering and eventually resurface with more than just the ability to function once more. They also returned with renewed hope and an openness with which to live life more fully. This Clinical Case Study contends that in addition to being beneficial to this particular
grief therapy group, an imaginal approach can be just as effective to the bereavement population at large.
CHAPTER 5

REFLECTIONS

Personal Development and Transformation

When I first interviewed for the doctoral program at the Institute of Imaginal Studies in 1998, I was asked by the president of the school what helped me most with my grief after experiencing my losses and what would best help others integrate their losses. It is this question that I have pondered for many years and this Clinical Case Study is part of my exploration for answers. My wish is that others, who may be undergoing the overwhelming process of grief, benefit from my research into this topic, as well as my personal learnings and insights that emerged while reflecting on my own initiatory journey.

This final chapter contains my reflections on the following: 1) how the Clinical Case Study process has affected my personal development and transformation; 2) the impact of the learnings on my understanding of bereavement; 3) the mythic implications of the learnings; 4) the significance of the learnings, including how the learnings may contribute to the literature on bereavement; 5) how the learnings could contribute to the application of an imaginal approach to psychotherapy as well as how to bridge Imaginal Psychology to mainstream settings and clients; and 6) some additional reflections.

During this Clinical Case Study process, I was submerged in the world of grief on many levels simultaneously: personally, professionally, and as a researcher. Having attended an eight week Hospice volunteer training while writing this Clinical Case Study,
I was deeply affected by the poignantly emotional videos of grieving individuals and psycho-educational material, as well as the experiential processes and inspiring talks presented by the Hospice staff. This training, while working on my Clinical Case Study, brought up fond memories of my clients who were the subjects of my Clinical Case Study, and how transformative it was for me to work with them. Furthermore, while I was immersed in the vastly interesting research gathered for the Literature Review, I felt confirmed on a theoretical level many of the therapeutic practices I was already using and had trusted on an intuitive level.

During one of my regular monthly meetings with my doctoral process group, I was struck by a realization.1 At this particular meeting we took part in a process that entailed reflecting ten years into the past. In response I shared two images, one from 11 years ago and one, a more recent image. The image from my past came to me as a memory that only just surfaced when a long-time friend called to tell me that my cat Maui (adopted by my friend many years earlier) had just died. When Maui was a kitten she had been a tremendous comfort to me after my first husband passed away. I remember sitting at my computer with Maui curled up next to the keyboard. I was writing about my experience of James’ death, completely immersed in my personal story, wrestling with all the pain and suffering of grief. I longed to be with him, to be in the other world that I believed he now inhabited. Maui helped me stay grounded in this world, in the here and now, and know that somehow all was well.

The more recent image was that of myself crouched on my living room floor holding my little 22 month-old daughter, Sophia. I was on the phone with my friend as he was relating the news of Maui’s death. Sophia became increasingly anxious as she sensed
our sadness. I held onto her to keep her near, but despite my intentions she quietly slipped away to the next room and returned moments later with a puzzle piece that she placed in my hand. The picture on the puzzle piece was one of a little flying blue bird. I told my friend what Sophia had given us both and felt somehow comforted by her gift.

In describing the images to my cohort I came to the realization that my life story, indeed my life myth, had changed. Eleven years ago it was all about death, the deaths of my first husband, mother, and grandmother. For many years since then my process was about working through the grief in all sorts of ways, but always from the place of loss. With this Clinical Case Study I have entered the world of death and grief once again, but this time from the place of new life. I have arrived to this new place after many years of processing my grief, and after having met my new husband and giving birth to our daughter. My life myth has transformed from one of death and loss to one of hope and new beginnings. This transformation, I believe, is the potential inherent in every experience of loss.

Several important factors made this transformation in my own life possible. These included participating in a partner loss group for two years after my first husband’s death, a week-long training with Kübler-Ross at her retreat center in Virginia, and a three-day grief ritual in Glen Ellen with Malidoma and Sobonfu Somé. My transformation was also fostered through writing in a computer journal, support from family and friends, and through what I believe to be contact with James and my mother in the form of dreams and visions. Most recently my process included working through my grief during course work as a doctoral student at the Institute of Imaginal Studies, specifically during the expressive arts projects.
Grieving as a participant of a bereavement group was pivotal to me. I valued the support the group gave me, and appreciated how being one of six to ten individuals experiencing the loss of a spouse helped me feel less isolated and normalized my feelings of unrelenting grief. Having guidance in my grief process from initiated elders was also an important aspect of my healing and transformation. I feel honored to have been assisted in my process by my grief group facilitator, Richard Cuadra, as well as Kübler-Ross, Malidoma and Sobonfu Somé, Omer and other faculty at the Institute of Imaginal Studies. Aside from finding hope to survive the overwhelming pain of grief, two especially poignant realizations I learned from Cuadra helped me to understand that I was not crazy (I was grieving) and that my relationships with my loved ones would continue. Kübler-Ross as well as Malidoma and Sobonfu Somé also helped normalize my experience, particularly the spiritual aspect of the process which supported me in the exploration of my continued relationship with my loved ones.

The course work at the Institute of Imaginal Studies, especially the expressive art processes, helped me further explore the wounds of my grief and brought much needed healing. The course work as well as the writing of the Clinical Case Study also helped me become more aware of the initiatory potential around the loss of a loved one, and by researching the concept of initiation from a theoretical perspective and applying it to my own experience, I was challenged to grow both personally and professionally. In particular, I found myself deepening certain capacities such as compassion, courage, and self awareness. I felt more connected to the vitality of every day, and the preciousness of every moment we spend with the ones we love.
I also felt a shift in specific imaginal structures that once dominated my outlook and behaviors. For example, my doctoral course work and Clinical Case Study brought me in touch with the Wounded Healer, in which I shifted away from the Victim and realized the power inherent in the sacred wound of grief. In writing this Clinical Case Study I also felt a shift from Student to Clinician/Researcher, in which my Clinical Case Study was not only a rite of passage, but also a document that could aid my colleagues in the field. The most dramatic shift, as eluded to earlier, was from the Grim Reaper structure which framed my outlook on life in terms of death and loss, to what might be called the Initiated Elder structure in which I more fully embodied the learnings from my personal experience and research, with a more deeply rooted desire to help others who are suffering the path of grief.

**Impact of the Learnings on My Understanding of the Topic**

My understanding of bereavement was profoundly influenced by the discovery of how empowering it is to approach the grief process through the framework of initiation. I also realized that there are two general dynamics in the grief process, one of movement and one of stagnation. The pace of movement for the individual deserves less scrutiny than the issue of stagnation, since every grieving individual will walk the path of grief at their own pace. Stagnation, however, is the general lack of movement. In the bereavement literature, it is described as complicated grief and can generally be observed when the individual is unable to express the pain of grief, when he or she is debilitated by their grief, or when the bereaved expresses a sensation of being immobilized or stuck.³

Also of note is the relative equality in terms when one speaks of initiation and successful bereavement. It could be said that when the grieving individual feels stuck,
they are not moving in the direction of healing. They feel bound to their grief. From a therapeutic perspective, the bereavement counselor can help such an individual by facilitating movement toward a certain threshold, and once beyond this threshold it could be said that the individual has experienced a transformation. For example, when the bereaved successfully makes the shift away from the Victim and Stoic Warrior structures, toward a more empowering and revitalizing structure (such as the Initiate), a transformation has taken place. The bereaved may experience this transformation in terms of improved functionality and emotional disposition. Beyond this, they may also find new meaning in their experience of loss, and may even adopt new priorities and perspectives on life. This transformation can be described as an initiation.

Therefore, all successful bereavement assumes that some degree of initiation has occurred. From an imaginal approach, what has occurred in the initiated individual is the emergence of specific capacities (such as compassion and courage), and the transformation of imaginal structures that influence the individual’s worldview, emotions, and behaviors.

Through interpreting the imaginal structures of the subjects in this Clinical Case Study as they moved through their grief process, five factors emerged that appeared to bring about a successful initiation. These include: 1) the importance of feeling and expressing the pain of grief; 2) the necessity of communal grieving within a ritual context and use of expressive art; 3) the significance of initiated elders to guide the bereaved through the grief process; 4) the benefit of exploring the concept of life after death in order to formulate a myth about the hereafter; and, 5) the value of having an ongoing
relationship with deceased loved ones. As it turns out, these same factors were all essential to my own grief process, and perhaps can be applied to others’.

To illustrate the first factor, the group participants began to re-imagine the myth of their experience and the meaning of their loss by accessing and expressing the emotions that were part of their grief, as well as dis-identifying from the Victim and Stoic Warrior structures. While the Victim and Stoic Warrior structures seemed to inhibit movement in the grief process, the activation of the Active Griever and the Initiate structures seemed to help many individuals reframe their suffering of grief as a sacred wound.

With regard to the second factor, the Stoic Warrior and Outcast structures seemed to inhibit the participants’ appreciation of the group (or community). The activation of the Same Tribe and Initiate structures helped the participants recognize the significance of communal grieving and the much-needed support they received from the group. The Stoic Warrior and Skeptic structures may have blocked the participants from embracing the group leader, while later in therapy their experience shifted to valuing a qualified or initiated elder to guide them through their grief. The Skeptic structure also seemed to hold the participants back from exploring the concept of an afterlife and creating a death myth, as well as strengthening the continued relationship with their loved ones. Later in the treatment, the Initiate structure helped them do both.

**Mythic Implications of the Learnings**

To expand upon the significance of my learnings, I will discuss the myth of Persephone and Demeter as it relates to the imaginal structures identified in this Clinical Case Study. The imaginal structures include the Victim, Stoic Warrior, Active Griever,
and Initiate structures. The characters of the myth can be seen to reflect these imaginal structures: Kore as the Victim and Stoic Warrior, Demeter as the Active Griever, both Persephone and Demeter as the Initiate, and Hecate as the crone and Initiated Elder who guides Persephone in her initiation.

When Kore is abducted into the Underworld by Hades, she is a nameless maiden, an innocent child. With the help of Hecate, watching over her in the Underworld, Kore resurfaces from her initiatory descent as Persephone, Queen of the Underworld. Persephone dis-identifies from her role as victim and embraces a new sense of self, one that is able to co-exist peacefully in, and bridge the two worlds of the Upperworld and Underworld.

In terms of the group participants, the Upperworld symbolizes their daily scheduled lives, the world of the ego, masculine and hero, while the Underworld symbolizes the unconscious, feminine, and vulnerable, and represents their decent into their grief during group therapy. The group participants became increasingly adept at bridging the Upperworld and Underworld. They descended into the Underworld of grief and vulnerability during each group session with the guidance of their therapist, who can be compared to Hecate, the initiated elder who helped Persephone in her initiation. Outside the group, the participants resurfaced to continue their every day life with more awareness of themselves and others. This sensitivity to both worlds helped them access new aspects of themselves and develop the capacities to heal the wounds of grief and experience life more fully. Like Persephone, the group participants were able to dis-identify from the Victim and Stoic Warrior structures to the extent that the Initiate structure was activated. The Initiate structure allowed the group participants to make
meaning of their experience of loss, and to live more soulfully in the Upperworld of their
daily lives with a new vulnerability and the capacities of empathy and courage.

One aspect of myths that make them so powerful in the therapeutic process is that
they can transcend the world of the living, and connect the bereaved to the unseen world
of the afterlife. In creating a death myth the group participants were able to imagine the
journey of their spouse into the afterlife, which helped to mitigate feelings of separation.
In doing so, many realized that both they and their spouse were transformed by the
experience of death, in some obvious ways differently, but in many ways the same.

Indeed, both Kore and Demeter suffer a loss and both are transformed by their
experience. Kore can be seen to represent the transformation of the bereaved or the
deceased, while Demeter represents the transformation of the bereaved. Wilkinson points
out that Kore symbolizes the “unconscious” journey of bereaved, because the journey
takes place in the Underworld, while Demeter symbolizes the “conscious” journey of the
bereaved as her journey is experienced in the Upperworld.4 Whereas Kore becomes
Persephone, the Queen of the Underworld, Demeter also undergoes a journey of
transformation from Demeter the gentle nurturer Goddess to Demeter the powerful.5

Demeter’s journey may be perceived to reflect the non-linear process of grieving.
She begins by frantically trying to find Kore, when she first disappears, and then becomes
helpless and hopeless, deeply mourning her loss. Eventually the companionship of a
human family helps her move out of hopelessness. The companionship of a human family
can be compared to the deep connection of community available to the group participants
in their therapy. Demeter then regresses to the denial of death by trying to immortalize
Demophoön (the human infant in her charge). In time she emerges from her despair and
becomes empowered through her anger. She uses her anger to get answers about Persephone’s whereabouts. Her intense wrath is mediated by Rhea (mother of Demeter, Zeus, and Hades) who helps Zeus and Demeter find a compromise. Finally, Demeter’s unification with Persephone and acceptance of Persephone being away in the Underworld for part of the year can be compared to the experience of integration of the bereaved. The bereaved finds acceptance of the physical loss of their loved one while continuing the relationship on a different level.

**Significance of the Learnings**

While some literature on bereavement acknowledges the initiatory potential of grief, there is not a cohesive body of work that synthesizes the essential factors that could enhance the initiatory potential of this major life experience. There are studies that advocate certain factors that aid the mourning process, although they do not specifically discuss grief within the context of initiation. For example, Bowlby advocates the significance of continuing relationships with the deceased to help temper existential feelings of loss, but he does not frame this significance within the context of initiation. Other studies do not specifically address grief, but rather address the initiatory potential for a variety of difficult life experiences. Madhi, for example, discusses the importance of elders in the initiatory process in various coming-of-age rituals, while Wilkinson discusses the necessity of receiving initiatory guidance after a trauma to help the individual dis-identify from the victim position.

There are only a very few authors, such as Mogenson, who articulate factors that may enhance the initiatory potential of the grief process specifically. However, there is no study or author that comprehensively brings together the ingredients that this Clinical
Case Study imagines to be necessary to enhance the initiatory potential of the bereaved. Malidoma Somé comes closest in his description of the indigenous wisdom that informs the approach to grief of the Dagara tribe in Burkina Faso, West Africa. Indeed, his account contains most of the components found in this Clinical Case Study. Somé’s account, however, is not articulated within a contemporary psychotherapeutic setting. The learnings gained in this Clinical Case Study, therefore, may possibly contribute to the literature in bereavement by outlining the elements which could strengthen the initiatory potential of this particular life transition within the context of psychotherapy. This writing acknowledges the significance of indigenous wisdom to approaching grief, and aims to bridge indigenous wisdom to contemporary Western grief work.

The synthesis of factors that likely enhance the initiatory potential of bereavement found in this Clinical Case Study might also be applied to other challenging life transitions. The combination of learnings in this area may help aid, empower, or inform those experiencing other psychological challenges or significant life transitions such as divorce, end of employment, marriage, childbirth, or retirement. Some factors can be more readily applied to other areas, such as the importance of dis-identifying from the victim position and reframing the experience as a sacred wound, as well as the necessity of initiatory guidance and the practice of communal support within a ritual context. Greater self-awareness, changed priorities, a shift in worldview, or the deepening of capacities such as compassion and courage are all possibilities that may be realized by the individual who is willing to work through their difficult experience and who receives the appropriate guidance and support.
Applying an Imaginal Approach to Psychotherapy

It could be said that working with grief using the framework of initiation is an imaginal approach to grief. This approach, like others in the Jungian tradition, recognizes the opportunity inherent in suffering for long-term personal growth and individuation. In particular, Imaginal Psychology suggests that when the bereaved individual stays identified with the victim position and does not receive the guidance necessary to view his or her experience as a sacred wound, an opportunity for growth and individuation is missed. R. M. Rilke speaks to this opportunity when he writes, “Love and death are the great gifts that are given to us; mostly they are passed on unopened.”

To the newly bereaved this may sound harsh and unsympathetic. I wish to express how much I respect the horror and suffering of the loss of a loved one, while at the same time reinforce the promise of the bereaved individual, with the appropriate support, to go into the depths of suffering and come back with a jewel of wisdom for him or herself and others. This is the initiatory potential that processed (or metabolized) grief has to offer every person.

With the possible application to other life transitions and psychological issues, it is feasible to bridge my learnings and, indeed, Imaginal Psychology, to mainstream settings and clients. In particular, two practices profiled in this study, ritual and the expressive arts, can be utilized to help contain overwhelming emotion and to metabolize painful imagery related to any situation. For example, lighting a candle and reading a poem about loss can be an opening ritual at the beginning of the therapy session.

Examples of expressive art practices include a visual art process in which participants may express their feelings through drawing and the use of color, and a journal writing process through which participants can access some of their more difficult
emotions. Both ritual and the expressive arts help the client gain an awareness of the sacred wound, and enhances the potential for initiation within the context of their suffering. As suggested by the process of the participants in this study, it seems possible to bring both the intent of initiation and the practices of ritual and the expressive arts to therapeutic work in mainstream settings with mainstream clients. Also of note was the fact that I was able to bring these practices into my partner loss group at Hospice with full support from supervisors, even though Hospice is considered a mainstream setting.

**Other Reflections Unique to this Clinical Case Study**

My additional reflections include my analysis of the bereavement literature with respect to death preparation. Indeed there exists very little research on the conscious preparation for death, which is likely a reflection of the Western culture at large. Intellectually we know that everyone dies, yet there is very little emotional preparation for death. There is copious acknowledgement of death, mostly portrayed through violent death images on television and in the movie theater. This presentation of death is based on the dominant culture death myth of the Grim Reaper, where death is portrayed as the enemy and the fear of death is sought to be metabolized through these images. This death myth may also be linked to the fact that Western culture or modernity has science at the heart of its worldview, and although science provides an explanation of the underlying order of the physical universe, it does not have much to offer in terms of the meaning of life, life-energy, soul, or the hope of an after-life. Looking around one discovers adequate resources for physical preparation of death such as funeral arrangements, wills and trusts, but little is found that attends to the psyche of the bereaved. It is telling that in my community outreach as grief counselor I have found that
funeral homes typically do not offer grief counseling services. The grief resources they offer are usually limited to general bereavement web-site links, and are not part of their onsite service packages.

Becker eloquently writes of our society’s deep need for the denial of death, which he argues also leads to a turning away from life. He states that “The irony of man’s condition is that the deepest need is to be free of the anxiety of death and annihilation; but it is life itself which awakens it, and so we must shrink from being fully alive.”

There are a growing number of contemporary authors including Kübler-Ross, Sogyal Rinpoche, Stephen Levine, Steven Foster, Meredith Little, and Eberle who discuss and offer practical guidance for the conscious emotional preparation of death. The authors suggest that the conscious preparation of death allows the individual to live life more consciously.

Kübler-Ross is widely known for conceptualizing the five psychological stages of a terminal illness. However, she also addresses death preparation for those who are in their final days (as well as those who are healthy) and talks about the significance of unpacking people’s life stories and repressed negative emotions in order to help live life more fully. Kübler-Ross created a process called externalization which helps participants complete their unfinished business in a workshop setting, a process similar to what she had seen dying people do on their deathbed. The other afore mentioned authors draw upon indigenous or spiritual wisdom to address conscious death preparation. Rinpoche looks to Tibetan Buddhism and the Tibetan Book of the Dead to give practical instruction and spiritual guidance with regard to preparing for death, while
Foster, Little, and Eberle draw on the ancient Mayan ceremonies of the Great Ball court and native American teachings.\textsuperscript{14}

Foster and Little pioneered the modern form of the vision quest which prepares individuals for symbolic death, while also intensifying their passion for life. Eberle combines the vision quest work with his Hospice work, and joined Little as co-creator and co-director of “The Practice of Living and Dying.” Little and Eberle’s focus is on the emotional preparation for death while the person still has good health, using the four-part allegory of the Great Ball court to offer metaphors for the preparation of the dying process.\textsuperscript{15} The premise of their work is that learning how to die is the same as learning how to live fully. Eberle states, “Each requires that you give careful attention to human relationships, and to whatever else that gives your life meaning. The greatest challenge in life may be to learn how to do this while we’re still healthy, rather than waiting for our final days.”\textsuperscript{16} Eberle considers his work, as well as the work of Kübler-Ross, Foster, and Little, to be a modern-day reawakening of the “lost art of dying.”\textsuperscript{17}

Nonetheless, even with the pioneering work of these few individuals, this idea of working through death “before” the passing (or ill-health) of the individual is generally still a novel one in contemporary Western culture. Progressive organizations such as Hospice, Zen Hospice, and the Center for Attitudinal Healing, provide an invaluable emotional and spiritual service to the terminally ill and their caregivers, as well as bereavement services to families and friends of the deceased.\textsuperscript{18} Additionally, Hospice not only provides their clients with medical support, but is also one of the only organizations that provides anticipatory grief services to the families of those who have been given a prognosis of six months or less to live.\textsuperscript{19} However, this service becomes available only
when confronted with a terminal illness, which both reflects and reinforces the dominant cultural paradigm, as it is often not until days before the passing that the inevitability of the death is acknowledged and grief is given any attention. In this cultural climate of fear and denial of death, it is not surprising that people are not too eager to sign up for a workshop on how to prepare for the loss of a loved one.

Other avenues that could serve as preparation for the loss of a loved one are a person’s faith and the experience of ritual. In Western culture’s dominant Christian religion, faith in a greater power may give an individual the strength needed to persevere, and often provides comfort though images of compassion and an after-life in heaven. Conversely, faith in a higher power could also lead to an existential crisis within the bereaved, in which they begin to question how a loving God could allow their loved one to die, and even question the very principles and foundation of their faith. Eastern religions, on the other hand, such as Tibetan Buddhism acknowledge the impermanence of life and teach the individual to become acquainted with and prepared for death. Death is considered to be a time when great spiritual realization may be gained, after which the true self or spiritual essence of a person lives on.

Regardless of one’s faith, ritual can be used to provide a sacred container for any rite of passage. It can hold the overwhelming affect of grief that comes with a loved one’s death. Ritual is also a vehicle for initiation that may help the bereaved on their initiatory descent, so that in the depths of suffering they can make meaning of their experience and discover new insight and awareness of self. The sacred aspect inherent in ritual offers the bereaved life-affirming images which help to metabolize painful death images.
The concept of continuing relationships between the bereaved and the deceased can also be helpful in transforming painful death images into images of a more hopeful, life-affirming nature. It is interesting to note that the prevailing view of grief emphasizes the significance of severing bonds with the deceased. Also of interest is how Freud, the theorist who first introduced the concept of decathexis as a severing of bonds between the bereaved and the deceased, seems to have changed his mind later in life after experiencing his own losses. After the deaths of his mother, daughter, and grandson, it appears from correspondence regarding his personal experience with grief that he acknowledged the need for some sense of felt continuity with his deceased family members.20

Bowlby breaks from traditional psychodynamic theory and writes in his final published book that retaining a sense of the continuing presence of a deceased spouse is a common feature of healthy mourning. However, this seems to be in contradiction to his earlier work, as he does not amend his model of mourning which proposes that the bereaved must gradually sever ties with the deceased. Challenging this ambiguity, Klass, Silverman, and Nickman question the therapeutic goal of severing ties, and consider the “indefinite” continuing bonds between the bereaved and deceased to be a healthy and important feature of the resolution of grief.

Indeed, the concept of continuing bonds in psychodynamic literature is usually only accepted as long as it stays abstract, or is described as inner representations (mental constructs) of the deceased. It is interesting to note that while several reports by the authors in the book edited by Klass, Silverman, and Nickman describe the experiences of continuing bonds as ADC, the majority of them are labeled as inner representations of the
deceased. There is in fact a general tendency in the bereavement literature from various psychological orientations, including psychodynamic, cognitive/behavioral, and biological psychology, to pathologize continuing bonds when taken too literally. The ADC experience is often described as illusion or hallucination.\textsuperscript{21} The sociocultural, transpersonal, and imaginal approaches tend not to pathologize the ADC experience, avoiding judgment of its phenomenology, and accepting it as a necessary tool for some individuals in their grief process. Many sociocultural theorists respect ADC’s within the context of ancestor relations, as seen and normalized in indigenous and Asian traditions.\textsuperscript{22} The transpersonal orientation values many ADC’s as spiritual experiences that can help an individual in their grief process. The orientation of Imaginal Psychology embraces both indigenous wisdom and the spiritual relevance of continuing bonds or contact with deceased loved ones, so long as it does not function as a spiritual bypass, or as a way of avoiding emotions and digressing from the initiatory process. Additionally, it recognizes how significant it is for the bereaved to formulate a myth of the hereafter, or conception of death and what happens afterwards, in order to aid them in their mourning.

As a bereavement therapist, I consider ongoing contact in the form of ADC to be a source of comfort to the bereaved. In my personal and professional experience, anomalous or spiritual experiences at the time of death, as well as ADC’s, are often marginalized. I have both facilitated and participated in grief groups in which members were inclined to keep these experiences to themselves for fear of being ridiculed or discredited. However, I am of the persuasion that this type of disclosure and the resulting discussion helps the group participants explore their own particular death myth.
I was intrigued to read about the Induced After Death Communication method introduced by Allan L. Botkin, and how he used a variation of Eye Movement Desensitization and Reprocessing (EMDR) with Vietnam War veterans to help them re-connect with the deceased in order to process their grief and war trauma. In my own work with clients, I encourage expressive art processes and discussion to explore continuing relationships and ADC experiences. I often see this as an effective way for the bereaved to get a sense of the continued well-being of their loved ones, and how the love between them carries on. This can help relieve some of the pain of the grief, as I found it did with my own ADC experiences with my late husband and mother. This should not be construed as a cure-all, however, since the sadness of having to continue life without the physical presence of a loved one remains.

In Western therapeutic culture in which the cure is often the focus of the work, initiatory success is not easily measured. While assessing the initiatory experiences of the group participants of this Clinical Case Study, the relative success of their initiation was always in question. I began to wonder what constituted a failed initiation. Robert Moore defines a failed initiation as “burn-out” due to the lack of appropriate containment and ritual elder leadership. Malidoma Somé uses the term “unresolved” initiation and describes it as continued suffering or prolonged grief, which results from the absence of radical and genuine recognition and acknowledgement of the bereaved individual by community. Destructive coping behavior such as alcohol dependency may be seen as continued suffering and thus a failed initiation. Some questions remain for me about what failed and successful initiation look like. In terms of appropriate language, would it better serve to use the terms “incomplete”, “stalled”, “interrupted”, or (the adjective Somé
chooses to use) “unresolved” initiation? Furthermore, is it pragmatic to talk about, or is it even possible, for one to realize their full initiatory potential? Is one’s full initiatory potential quantifiable?

Through the writing of this Clinical Case Study, I became aware that we do not fully know how the experience of loss affects the bereaved, or what shifts take place in his or her psyche. I also noticed that I had high expectations of the participants in terms of fulfilling their initiatory potential, when in fact my standards of what comprised a successful initiation were nebulous. When I discovered this paradox, I realized my expectations had to change, and that I could not hold the whole group to a common standard. I could also not hold an individual participant to a specific standard. Each participant had a unique potential for initiation just as they each had their own particular way of grieving their loss. As a grief therapist, all I could do for certain was to hold the intention of helping them transform their perception of themselves as victim of meaningless suffering, to being open to the possibilities inherent in their sacred wound.

However, this Clinical Case Study shows that several factors may have helped the participants enhance the initiatory potential of their experience. This synthesis of factors emphasized the importance of accessing and expressing the pain of grief, especially within the context of a group or community, and the value of specific practices in the grief process, such as ritual and the expressive arts. Additional factors which helped move the initiatory process forward included the guidance of initiated elders and the exploration of the concept of life after death, particularly as it related to formulating a myth of the hereafter and establishing a nurturing bond with the deceased loved one. These factors seemed to enable the bereaved to transform their perception of their
experience from unfair and hopeless suffering to the possibility of new awareness, insight, and passion for life.
APPENDIX 1

INFORMED CONSENT FORM

To ________________________ :

You are invited to be the subject of a Clinical Case Study on Bereavement. The study’s purpose is to better understand bereavement after the death of a loved one.

For the protection of your privacy, all of my notes will be kept confidential and your identity will be protected. In the reporting of information in published material, any and all information that could serve to identify you will be altered to ensure your anonymity.

This study is of a research nature and may offer no direct benefit to you. The published findings, however, may be useful to those who are grieving and may benefit the understanding of bereavement.

The Clinical Case Study does not directly require your involvement. However, it is possible that simply knowing you are the subject of the study could affect you in ways which could potentially bring up uncomfortable feelings and/or cause you to revisit your grief and difficult memories. If at any time you develop concerns or questions, I will make every effort to discuss these with you.

If you decide to participate in this Clinical Case Study, you may withdraw your consent and discontinue your participation at any time and for any reason. Please note as well that I may need to terminate your being the subject of the study at any point and for any reason; I will inform you of this change, should I need to make it.

If you have any questions or concerns, you may discuss these with me, or you may contact the Clinical Case Study Coordinator at the Institute of Imaginal Studies, 47 Sixth Street, Petaluma, CA 94952, telephone: (707) 765-1836.

I, ________________________, understand and consent to be the subject of the Clinical Case Study written by Ilka de Gast, on the topic of Bereavement. I understand private and confidential information may be discussed or disclosed in this Clinical Case Study. I have had this study explained to me by Ilka de Gast. Any questions of mine about this Clinical Case Study have been answered, and I have received a copy of this consent form. My participation in this study is entirely voluntary.

I knowingly and voluntarily give my unconditional consent for use of both my clinical case history, as well as for disclosure of all other information about me including, but not
limited to, information which may be considered private or confidential. I understand that Ilka de Gast will not disclose my name or the names of any persons involved with me, in this Clinical Case Study.

I hereby unconditionally forever release Ilka de Gast and the Institute of Imaginal Studies (and all of its trustees, officers, employees, agents, faculty, successors, and assigns) from any and all claims, demands, and legal causes of action whether known or unknown, arising out of the mention, use and disclosure of my clinical case history, and all information concerning me including, but not limited to, information which may be considered private and confidential. The Institute of Imaginal Studies assumes no responsibility for any psychological injury that may result from this study.

The terms and provisions of this consent shall be binding upon my heirs, representatives, successors, and assigns. The terms and provisions of this consent shall be construed and interpreted pursuant to the laws of the State of California.

Signed this ______ day of ______, 2005, at __________________, _______________.

Day                  Month                                   City                            State

By:_____________________________________

Client’s signature

________________________________________


APPENDIX 2

BOAT VISUALIZATION

Very gently picture yourself standing on a long grassy slope. You are waiting by the side of a wide river for a boat with a single oarsman. As you wait, you notice the trees and the flowers. The sun is warm on your face and you take a deep breath. You feel a sense of quiet peace.

In the distance over the horizon a boat approaches. This is a very special outing. You know that this oarsman will take you to a lost loved one on the other side. You will be given an opportunity to say words you want to say. Perhaps that you haven’t said before. You are being given a chance for completion . . . for resolution.

As the boat stops at a small landing you step in. You feel a sense of trust with this person. You know you will be carried safely to the other shore. You will stay for a time and then return in a safe crossing after saying the things you need to say.

You sit down on some cushions in the front of the boat and you watch as the oarsman masterfully guides the boat away from the shore, out into the river. You want to ask questions, yet you remain silent. You stay with your own thoughts. Thoughts which naturally turn to your loved one, and what you want to share. . . .

Pause . . .
The other shore appears more quickly than you expected. There is a mist with sunrays shining through it. As the boat approaches you notice someone standing on shore who seems to be waiting for you. You pull up at a small landing and get out. The boat waits there for you. You step forward and the one you have come to see comes forward to meet you.

Pause . . .

You greet one another and then together you walk until you come to a lovely, peaceful place where you sit down. There is a feeling of unconditional love.

Pause . . .

You look at each other and you begin to share. You ask how they’ve been and then you find yourself saying all the things you’ve wanted to say and listening for what is said to you.

Long pause . . . (two minutes)

It is almost time to go now. But before you go ask your loved one, who is now in a place of wisdom beyond this world’s worries and cares, to give you a symbol or a gift, or to speak some words that will help you to go on living your life with a greater sense of purpose, peace, and love. See your loved one giving you that gift now.

Pause . . .
Now in return look inside and see if there is something you desire to give your loved one in return. See yourself giving your loved one that gift now.

Pause . . .

Now it is time to go. You embrace, and as you say goodbye you know when you see them again the time apart will be like the blink of an eye. But for now you turn in different directions and you slowly make your way back to the waiting boat. As you join the oarsman for the trip back home you are aware of a greater sense of inner peace and resolution.

Pause . . .

The crossing is tranquil and goes quickly and you find yourself thinking about all that has passed between you and your loved one.

Pause . . .

As you disembark from the boat you turn and thank the oarsman. The silence is friendly as the boat slips out into the river and disappears from view. With a sense of greater understanding and gratitude you walk up the grassy slope. You feel ready to come back and to turn your energy toward the living.

Pause . . .

You are now free to bring a greater sense of peace, love, and harmony to all that you do.
NOTES

Chapter 1


3. Ibid.

4. Ernest Becker, The Denial of Death (New York: Simon and Schuster Inc., 1973), 11. In the foreword to this work, Sam Keen writes that: “Elisabeth Kübler-Ross and Ernest Becker were strange allies in fomenting the cultural revolution that brought death and dying out of the closet. At the same time that Kübler-Ross gave us permission to practice the art of dying gracefully, Becker taught us that awe, fear, and ontological anxiety were natural accompaniments to our contemplation of the fact of death.” Ibid., xii; Becker acknowledges the significance of the work of Sigmund Freud and how he theorizes that the cause of psychological illness is generally a fear of self, of one’s emotions, impulses, memories, and potentialities. However, Becker suggests that the primary repression for human kind is the denial of death rather than the repression of sexuality. Ibid., 51-52.


12. My grandmother died in March 1994 of complications related to old age, followed in June by my first husband who passed away from AIDS. Then only 15 months later, my mother died due to lung cancer.

Going home. I had been gone for over two hours. My wife is waiting for me. Walking through the door I try to smile to keep us both from falling. I can see she has been crying as she looks up at me from across the kitchen, hope hanging by a thread of light from her tear laced eyes. We hold each other tight. She cries. I cannot. I am not there. Not yet.


I'm scared
It is the unknown
The thoughts that blind the mind
The unlived hours, days and years
The possibilities that breathe at our neck
While standing off in the distance
Blending with the point of vanishing
They draw us out into darkness
Taking the floor from our feet
But I was talking about me.
And the letter I should write my father
Telling him I have AIDS
But can I? Do I?
Do I have a disease?
Am I living with death?
Am I dying everyday?
Sounds like life to me.
No different than you.
The world has even stopped watching.
Only family and friends are concerned
And you, dad, do you want to join
the ranks, do you want another
reason to care, another reason to
drink, another pain to spin around
in your wine glass along with the
ice guided by an index finger that
knows the feel of steel and wood
and the sweet softness of a woman's
breast.
But you too are me.
And as you I know already.
When you first held me in your
arms you knew; as you looked
into my eyes you saw the pain
that was yours - the love you
wanted but couldn't receive, the
chance you asked for but wouldn't
take, the life you desired but
didn't live.
All this for fear, a lack of loving acceptance
Or a fear of loving acceptance
I love you and always have.
All is clearer now
I feel like you know me now
And I know myself more too
This is true knowledge
This is love.
16. De Gast, *A Sense of Spirit*, 115. James described the beautiful colors he was seeing:

James would occasionally sink deep into himself, as if journeying to a different reality. This drifting back and forth between dimensions was fascinating to observe and I eagerly awaited his descriptions of what he saw. He seemed spellbound by the beauty he witnessed and said that he saw many magnificent colors, shapes, and forms. He kept repeating, "I'm so fortunate," as his eyes shone bright in wonder.

17. De Gast, *A Sense of Spirit*, 123. Ilka’s experience of James’ death:

I sense his spirit slowly move out of his body. As I see him leave; it feels as if I go with him, and for several moments melt into an indescribable sensation of light and love. . . . Then, James continues on, and to my unending disappointment, I am catapulted back, like a rubber band. . . . I run down the hall to the waiting room to alert his mother and brother, trying to contain my excitement. As I go to open the door I am aware of the totally inappropriate, euphoric smile I am wearing and manage to change it just before I enter the room and tell them the news. . . . Minutes later I walk back to James’ room, the ecstasy is still with me, but when I see his lifeless body before me, I am hit by a wave of desperate pain and grief.

18. Our family came together in the Netherlands for my mother’s surgery in March, my two brothers traveling from Malawi, Africa, and Italy. I flew in from the US. It was a frightening time and we realized how grateful we were to have each other. Thankfully, the brain tumor was successfully removed. However, in May it was discovered that my mother had lung cancer and that the tumor in her brain had metastasized from her lungs. De Gast, *A Sense of Spirit*, 45-46.

19. De Gast, “Mother’s Last Night,” in *A Sense of Spirit*, 58. Ilka’s experience of her mother’s death:

Yet, that unforgettable night, she was clear as a crystal bell when she asked the night nurse to call us into her room at 1:30 a.m. She had asked for my brother earlier, perhaps to work something out with him. I must admit, rather ashamedly, that although I knew Mam had called for Haico, I went into Mam's room with him, as I was scared she'd slip away before we all would be with her. She seemed to have things perfectly planned out, though, and called us all in afterwards. She was still experiencing much discomfort and pain, and her breathing was very labored.

I was deeply moved when Mam proceeded to ask each of us for permission to leave. She then connected with each of us again and initiated a farewell. Although, when it got to my turn, she burped rather loudly and re-positioned herself on her pillows. It hurt me when this happened but I also knew we had already said our farewells earlier. We had spent so much wonderful time together in the past months.

Mam's farewell from Dad was absolutely heart wrenching, perhaps the most painful farewell I have ever witnessed. She was holding onto his arm and just could not let go. The expression in her eyes and face was indescribable, such excruciating sadness. He had to physically help her let go of his arm and lie back down, eventually.

Then a serene peace came over her as a blanket of iridescent shimmering light enveloped us all. I sensed her mother and sister nearby, along with a host of other invisible light beings above and around her, as Mam slipped into a deep peaceful sleep.

The four of us found sleeping places around Mam and being weary ourselves were soon asleep too. Over the next two hours, we gradually found our way back to our own beds in our own rooms. Then at 4:30 a.m., the night nurse woke us again. At 5:05 a.m., with the four of us sitting around her bed, Mam took her last breath. I saw my little brother glance around him, searching for something, as Mam's spirit left her body. He told us later, that he was looking around the room for the very bright lamp that he felt burning his forehead as Mam passed on.

Again, just as when James left his body, the moment of transformation was amazing, so peaceful, so beautiful, yet the moments afterward were agonizing to the core. We sat with Mam's body for a while, in silent awe at the sacredness of this merging of realities.
I do not have a clear memory of what happened next, I don't even know if I cried or not. All I can remember is that I felt terrible, exhausted, and empty. I had a horrendous headache and felt so nauseous that I was ready to throw up. I just had to crawl into my bed. . . . I had just lost my mother, the one who had brought me into this world. I felt as if I were some root vegetable, that someone had ruthlessly and prematurely ripped up out of the soil, my roots severed before being capriciously tossed aside. I am left with no connection to the earth, no grounding, no guidance, abandoned and lifeless.

It wasn't until the following morning, when I went into Mam's room and saw her lying there so peacefully, with the rose dad had placed in her hands, resting softly on her pajama shirt, that I could feel the ecstasy of her spirit. Again, as when James passed on, there was the enigma of how the death experience can evoke the most agonizing of emotions and simultaneously touch the soul with such indescribable euphoria.

De Gast, “Butterfly Flown,” in A Sense of Spirit, 59. Ilka describes her experience after her mother’s death:

I can still see my mother lying in an open coffin at our family home, in a sectioned-off part of the master bedroom, her face lifeless, radiant . . . different. She was wearing the red lacy shirt and black pants that I had picked out for her, a last intimate sharing, making sacred this last moment between mother and daughter. I knew she would have appreciated my choice; she always loved that shirt, it looked good on her and red and black symbolize a woman's power colors, after all. A red rose was delicately balanced in her hands. Her hands clasped together as if in prayer, and her nails shiny and clean. Cleaning Mam's nails had felt very strange indeed, but I wanted them to be clean for all the family and friends who were planning to visit.

Yet, however important these final personal touches felt, they did not bring her back. They did not bring to her body even the tiniest spark of life. Even after I applied a little of her favorite orange-tinted lip stick to her pale lips with the tip of my index finger and some rouge and light tan eye-shadow to her ashen cheeks and sunken eye lids, with the little black brushes I had found in her make-up purse . . .

Still no sign . . . the butterfly had flown.
It was no longer her, wearing her colors.
She was dancing high above her body,
spiraling in the light, free . . .


21. My supervisor and other Hospice staff called the bereavement services offered to Hospice clients, grief counseling.

22. Boat Visualization in Appendix 2.


This category can be used when the focus of clinical attention is a reaction to the death of a loved one. As part of their reaction to the loss, some grieving individuals present with symptoms characteristic of a Major Depressive Episode (e.g., feelings of sadness and associated symptoms such as insomnia, poor appetite, and weight loss). The bereaved individual typically regards the depressed mood as “normal,” although the person may seek professional help for relief of associated symptoms such as insomnia or anorexia. The duration and expression of “normal” bereavement vary considerably among different cultural groups. The diagnosis of Major Depressive Disorder is generally not given unless the symptoms are still present two months after the loss. However, the presence of certain symptoms that are not characteristic of a normal grief reaction may be helpful in differentiating bereavement from a Major Depressive Episode. These
include 1) guilt about things other than actions taken or not taken by the survivor at the time of death; 2) thoughts of death other than the survivor feeling that he or she would be better off dead or should have died with the deceased person; 3) morbid preoccupation with worthlessness; 4) marked psychomotor retardation; 5) prolonged and marked functional impairment; and 6) hallucinatory experiences other than thinking that he or she hears the voice of, or transiently sees the image of, the deceased person.

24. Omer, Personal Communication (Petaluma, CA: Institute of Imaginal Studies, December, 2006). Aftab Omer’s definition of imaginal structures is as follows:

. . . assemblies of sensory, affective, and cognitive aspects of experience constellated into images; they both mediate and constitute experience. The specifics of an imaginal structure are determined by an interaction of personal, cultural, and archetypal influences. These influences may be teased apart by attention to the stories that form personal character and the myths that shape cultural life. During the individuation process, imaginal structures are transmuted into emergent and enhanced capacities as well as a transformed identity. Any enduring and substantive change in individual or group behavior requires a transmuting of imaginal structures. This transmutation depends upon an affirmative turn toward the passionate nature of the soul.

Omer defines capacities as deeper human potentials or virtues. Omer, Imaginal Process course notes (Petaluma, CA: Institute of Imaginal Studies, 1998). “A capacity is a distinct dimension of human development and human evolution that delineates a specific potential for responding to a domain of life experience. For example, Compassion responds to Suffering; Courage responds to Danger; Destiny responds to the Future; Dignity responds to Failure; Fierceness responds to Injustice; Faith responds to Uncertainty; Reflexivity responds to Personal Identity, and so on.” Omer, Personal Communication (Petaluma, CA: Institute of Imaginal Studies, December, 2006).


26. Ibid., 73.


28. Bowlby writes that a natural and healthy aspect of the mourning process is that widows and widowers retain a strong sense of the continuing presence of their deceased partner. Bowlby, Loss: Sadness, and Depression, 96.


30. Aspects of identity that keep an individual bound to a collective perfectionist morality. When the rules of this collective morality are perceived to be transgressed, the transgressor is exiled. Sylvia Brinton Perera, The Scapegoat Complex: Toward a Mythology of Shadow and Guilt (Toronto Canada, Inner City Books, 1986): 83 and 18-25.

Chapter 2


7. Ibid.


9. Ibid., 37-44; Bowlby list these factors as being: 1) the identity and role of the person lost; 2) the age and sex of the person bereaved; 3) the causes and circumstances of the loss; 4) the social and psychological circumstances affecting the bereaved about the time of and after the loss and; 5) the personality of the bereaved, with special reference to his capacities for making love relationships and for responding to stressful situations. Bowlby, *Loss: Sadness, and Depression*, 172.


11. The diagnostic category for bereavement in the Diagnostic and Statistical Manual of Mental Disorder is: V62.82 Bereavement (Principal) American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 684-685; Ibid.

This category can be used when the focus of clinical attention is a reaction to the death of a loved one. As part of their reaction to the loss, some grieving individuals present with symptoms characteristic of a Major Depressive Episode (e.g., feelings of sadness and associated symptoms such as insomnia, poor appetite, and weight loss). The bereaved individual typically regards the depressed mood as “normal,” although the person may seek professional help for relief of associated symptoms such as insomnia or anorexia. The duration and expression of normal bereavement vary considerably among different cultural groups. The diagnosis of Major Depressive Disorder is generally not given unless the symptoms are still present two months after the loss. However, the presence of certain symptoms that are not characteristic of a “normal” grief reaction may be helpful in differentiating bereavement from a Major Depressive Episode. These include: 1) guilt about things other than actions taken or not taken by the survivor at the time of death; 2) thoughts of death other than the survivor feeling that he or she would be better off dead or should have died with the deceased person; 3) morbid preoccupation with worthlessness; 4) marked psychomotor retardation; 5) prolonged and marked functional impairment; and 6) hallucinatory experiences other than thinking that he or she hears the voice of, or transiently sees the image of, the deceased person.


13. Their schema of defining complicated grief or a disorder of grief outlines two categories of symptoms: 1) symptoms of separation distress such as yearning and searching for the deceased,
preoccupation with thoughts of the deceased and loneliness; and 2) symptoms of traumatic distress, such as feelings of shock, anger, disbelief, mistrust, detachment from other people and experiencing somatic symptoms of the deceased. Ibid.


16. Ibid.


20. Ibid.

21. Ibid.

22. However, Bowlby believes that in the course of evolution, instinctual equipment developed around the fact that losses are retrievable and the behavioral responses that make up the grieving process are geared towards reestablishing a relationship with the lost object. Bowlby, Loss: Sadness, and Depression, 7.

23. Worden, Grief Counseling and Grief Therapy, 9 and 11-20.


25. Ibid., 58; Silvan Tomkins elaborates further on the affects. “Affects are sets of muscular, glandular, and skin receptor responses located in the face (also widely distributed throughout the body) that generate sensory feedback to a system that finds them either inherently acceptable or unacceptable. These organized sets of responses are triggered at subcortical centers where specific programs for each distinct affect are stored, programs that are innately endowed and have been genetically inherited.” Silvan Tomkins, The Negative Affects, vol. 2 of Affect, Imagery, Consciousness (New York: Springer, 1963), 137.


27. Ibid., 136.

28. Ibid., 98.


30. Ibid.

31. Ibid., 51.

32. Ibid., 98.

33. Ibid., 60.

35. Worden, Grief Counseling and Grief Therapy, 2.


37. Ibid.


40. W. Stroebe and M. Stroebe, Bereavement and Health: The Psychological and Physical Consequences of Partner Loss (Cambridge, England: Cambridge University Press, 1987). However, they encourage further studies that would include alternative explanations and more definitive evidence.


43. Worden, Grief Counseling and Grief Therapy, 1.


46. Worden, Grief Counseling and Grief Therapy, 70.


48. Worden, Grief Counseling and Grief Therapy, 70.


50. Ibid.

51. Worden writes that grieving was historically facilitated through the family, church, funeral rituals and other social customs, but that this type of support is not available to many people today. This is a reason why grief counseling can be so valuable to those lacking other forms of grief support. Worden distinguishes between grief counseling and grief therapy. He suggests grief therapy is used to treat complicated grief. Worden, Grief Counseling and Grief Therapy, 51.

52. Preston, O’Neal, and Talaga, Handbook of Clinical Psychopharmacology for Therapists, 60.

53. Therese A. Rando, Grief, Dying, and Death: Clinical Interventions for Caregivers (Champaign, IL: Research Press, 1984).


58. Ibid.

59. Rando, “Living and Learning the Reality of Loved One’s Dying,” 44.

60. Ibid.


62. Ibid.


65. Ibid

66. Ibid.

67. Ibid.

68. Ibid., 674-675; David D. Burns, Feeling Good: The New Mood Therapy (New York: Signet, 1980), 208.

69. Malkinson, “Cognitive-Behavioral Therapy of Grief,” 674-675; From the perspective of affect theory, Donald Nathanson maintains that “cognitive therapy can work to alter the conscious experience of emotion by changing the thoughts that accompany affect.” He suggests that this may then relieve a person’s mood. This may apply to complicated grief by helping the bereaved become aware of the dysfunctional or distorted cognitions. Nathanson, Shame and Pride: Affect, Sex and the Birth of Self, 52.


71. Ibid., 682.


73. Ibid.

74. Ibid.

75. Ibid.


79. Ibid., 161.

80. Ibid., 176; Ibid., 165-176, Neimeyer outlines six propositions that offer a different vantage point from which to consider bereavement. He is referring to Stroebe’s Dual Process Model.

1) Death as an event can validate or invalidate the constructions that form the basis on which we live, or it may stand as a novel experience for which we have no constructions. 2) Grief is a personal process, one that is idiosyncratic, intimate, and inextricable from our sense of who we are. 3) Grieving is something we do, not something that is done to us. 4) Grieving is the act of affirming or reconstructing a personal world of meaning that has been challenged by loss. 5) Feelings have functions and should be understood as signals of the state of our meaning-making efforts. . . . Ironically, despite the emphasis of traditional grief theories on the emotional effects of bereavement, affective grief responses are typically treated as merely problems to be overcome with the passage of time or “treatment.” 6) We construct and reconstruct our identities as survivors of loss in negotiation with others. . . . At the most basic level we have a choice of whether to attend to the distress occasioned by our loss, to feel and explore the grief of our loved one’s absence, or to disattend to or suppress our private pain and focus instead on adaptation to a changed external reality.

According to Maglio, in cognitive behavioral grief therapy there may be a tendency to “overlook or disregard unconscious processes, view feelings as entities to be controlled, and have a judgmental differentiation between therapist and client.” He proposes therefore, that cognitive/behavioral approaches to grief may not be appropriate for all clients. Christopher Maglio, *Grief Counseling and Grief Therapy: A Cognitive-Behavioral Perspective*, 1991.


82. Worden, *Grief Counseling and Grief Therapy*, 89.

83. Ibid.


85. Freud, “*Mourning and Melancholia*,” 586.


87. Ibid; Also see Alicia Skinner Cook and Daniel S. Dworkin who draw on Freud’s work to describe the primary work of grieving as a withdrawing of the energy (life force, libido, identity) the bereaved shared with the deceased. Skinner Cook and Dworkin, *Helping the Bereaved* (New York: BasicBooks, 1992), 12.

88. Freud, “*Mourning and Melancholia*,” 586.

90. Freud, “Mourning and Melancholia,” 586; Freud abandoned his earlier theory that the process of identification was indicative of pathological mourning. He came to consider it as a healthy grief reaction. Bowlby, *Loss: Sadness, and Depression*, 30.


95. Ibid., 360.

96. Ibid., 362.


99. Ibid., 70

100. Skinner Cook and Dworkin, *Helping the Bereaved*, 12.


103. Ibid., 30 and 39.


105. Bowlby, *Loss: Sadness, and Depression*, 100; Bowlby states that this strong sense of continuing presence of their partner is retained “without the turmoil of hope and disappointment, search and frustration, anger and blame that are present earlier [in the mourning process].” He suggests that this is further evidence of the healthy nature of this phenomenon. Bowlby, *Loss: Sadness, and Depression*, 96.


108. Ibid.

109. Ibid.

110. Ibid., 100.

111. Ibid.

112. Ibid.


115. Ibid., 22.


117. Ibid., 9.


119. Ibid.

120. Ibid.


123. Worden, *Grief Counseling and Grief Therapy*, 42.

124. Bowlby, *Loss: Sadness, and Depression*, 28 and 29; Bowlby writes that he also disagrees with Freud that the presence of hatred and identification with the lost object are indicative of pathological mourning. Bowlby writes that Freud did abandon his theory that identification with the lost object is indicative of pathological mourning. Ibid., 30.

125. Ibid., 212.

126. Ibid., 224.


129. Bowlby, *Loss: Sadness, and Depression*, 213; Bowlby lists these variables as being: 1) the identity and role of the person lost; 2) the age and sex of the person bereaved; 3) the causes and circumstances of the loss; 4) the social and psychological circumstances affecting the bereaved about the time of and after the loss and; 5) the personality of the bereaved, with special reference to his capacities for making love relationships and for responding to stressful situations. Ibid., 172.


136. Ibid., 162.


139. Ibid., 162.


142. Kübler-Ross personal communication to participants in the training, End of Life Training notes (Elisabeth Kübler-Ross Retreat Center, Virginia, August, 1995) She told participants in the training to throw her model of the five stages “out of the window.” She said she wanted people to discard her model because it had been misrepresented. She emphasized that the stages do not occur consecutively.


144. Ibid.


147. Worden, *Grief Counseling and Grief Therapy*, 27-37. Worden revised the second and third (current) edition of his book to reflect a change in his fourth task of mourning. His fourth task of mourning used to entail, “withdrawing emotional energy from the deceased and reinvesting it in another relationship.” He writes that this was based on Freud’s theory of decathexis. Worden says that he is now more aligned with Klass, Silverman and Nickman’s concept of continuing bonds. He has changed his model of mourning to suggest that the fourth task is to find a place for the deceased that will allow the mourner to remain connected to the deceased, but in a way that will not block him from moving forward with life. Worden continues on to say, “We need to find ways to memorialize, that is, to remember the dead loved one—keeping them with us but still going on with life.” Ibid., 35.


150. Doka and Davidson, eds., *Living with Grief: Who We Are, How We Grieve*, 4.

151. Ibid.


154. Ibid.


156. Eberle, The Final Crossing, 100.


159. Eberle, The Final Crossing, 100.


163. Eberle, Medical Director of Hospice of Petaluma, Hospice Volunteer Training notes (Hospice of Petaluma, March 23, 2006); Eberle, The Final Crossing, 17.

164. Ibid.

165. Irish, Lundquist, and Nelsen, Ethnic Variations in Dying, Death, and Grief, 1-10.

166. Ibid.


168. Ibid.

169. Dana G. Cable, “Grief in the American Culture,” in Living with Grief: Who We are, How We Grieve, eds. Doka and Davidson, 65.

170. Ibid.


172. Ibid.


175. Cable, “Grief in the American Culture,” 63.

176. Ibid.
177. Ibid., 65.


179. Ibid.

180. Malidoma Somé, _Ritual_, 73.

181. Ibid., 75

182. Ibid., 73

183. Ibid., 75


185. Ibid.


187. Ibid.

188. Ibid.


192. 63 percent of those individuals were non-Christian. This showed that 63 percent of those believing in life after death were not Christian, or necessarily religious. Ibid.

193. Bill Guggenheim and Judy Guggenheim, _Hello from Heaven_ (New York: Bantam Books, 1995), 21; Contemporary Western sources on life after death and After Death Communication (ADC) include: Bill Guggenheim and Judy Guggenheim, _Hello from Heaven_, Raymond Moody, _Life After Life_ (Covington, Georgia: Mockingbird Books, 1975); Jane Roberts, _The Afterdeath Journal of an American Philosopher: The World View of William James_ (Manhasset, NY: New Awareness Books, 2001); Allan L. Botkin, _Induced After Death Communication: A New Therapy for Healing Grief and Trauma_ (Charlottesville, VA: Hampton Roads Publishing Company Inc., 2005); James Van Praagh, _Talking to Heaven: A Medium’s Message of Life After Death_ (New York: Penguin Putman Inc., 1997). Roberts from the afterdeath perspective of William James writes about the different forms of communication between the living and the dead, including dreams. One kind of communication was a direct communication, which according to James was somewhat difficult for the communicator (the one who has passed on), because they experience so much more deeply than we are able to understand in our reality. They can thus only share with us that which is within our comprehension. A second type of communication takes place in the form of informal dream encounters. Here the encounter is still direct and is less likely to include requests for proof and unnecessary details which might get in the way of more important connection (conversations). A third, less direct form of communication, according to James, is "often accomplished by the maintenance of a general, distant, but lively concern and by mental messages of comfort, support, or inspiration sent anonymously, usually delivered exactly when the recipient expects it least, in sleep or when the mind is otherwise occupied. Otherwise the startling effect of such encounters often blots out the message, overstates it, or distorts it in one way or another." Roberts, _The Afterdeath Journal of an American Philosopher_, 122-123.


197. Greg Mogenson, *Greeting the Angels*, xi; Ibid.

198. Ibid.

199. Ibid., 26.

200. Ibid.


206. Ibid; Corbin describes the relationship between the person and the image, or angel, as “an archetypal dimension because it grounds every being in another self, which keeps eternally ahead of him.” Corbin, *Alone with the Alone*. Like Corbin, Cobb describes images as angels or diamones: “Those ambiguous beings of the middle realm, neither Gods nor mortals, but capable of mediating between them, and intermediaries also between the realm of divine intelligence and the physical senses.” Cobb, *Archetypal Imagination*, 30-31.


209. Thomas Moore, *Care of the Soul*, xv.

210. Jung, *Memories, Dreams, Reflections*, 319-320; The following paragraph offers an example of Jung’s personal experience with death and bereavement and is illustrative of his beliefs regarding an individual’s relationship to a deceased loved one: James Hollis writes that when Jung’s wife Emma died, Jung suffered a “reactive depression” and was “bereft and disoriented” for many months. A dream of Emma changed this. In the dream he was in the front row of an empty theater. When the curtain opened there was Emma standing in front of him in white dress. She was smiling at him. In that instance “he knew the silence was broken. They were together, whether together or apart.” Hollis, *Swamplands of the Soul, New Life in Dismal Places* (Toronto, Canada: Inner City Books, 1996), 46; Hillman defines mourning as a process that takes place in the realm of imagination, the anima mundi (soul of the world). Hillman, *A Blue Fire* (New York, Harper and Row Publishers, Inc., 1989).

211. Mogenson, *Greeting the Angels*, xv.
212. Ibid., xii.
213. Ibid.
214. Ibid., xi.
215. Ibid., 38.
216. Ibid., 130.
217. Ibid.
218. Ibid., 38.
219. Ibid., 131.
220. Ibid.
222. Mogenson, Greeting the Angels, 38
223. Ibid., xii.
224. Jung, Memories, Dreams, Reflections, 302-304; Mogenson, Greeting the Angels, 38-39.
225. Ibid.
227. Mogenson, Greeting the Angels, 135.
228. Victor Turner, “Betwixt and Between: The Liminal Period in Rites of Passage,” in Betwixt and Between, eds. Madhi, Foster, and Little, 3; Jung, Memories, Dreams, Reflections, 395.
231. Ibid.
232. Omer, Imaginal Process course notes (Petaluma, CA: Institute of Imaginal Studies, 1998); Omer further defines a capacity as “a distinct dimension of human development and human evolution that delineates a specific potential for responding to a domain of life experience. For example, Compassion responds to Suffering; Courage responds to Danger; Destiny responds to the Future; Dignity responds to Failure; Fierceness responds to Injustice; Faith responds to Uncertainty; Reflexivity responds to Personal Identity, and so on.” Omer, Personal Communication (Petaluma, CA: Institute of Imaginal Studies, December, 2006).
234. Ibid.

237. Ibid., 22-23.

238. Ibid., 184-186.

239. Houston, *In Search of the Beloved*, 104.

240. Ibid., 106.

241. Ibid., 23.


243. Ibid.


245. Madhi, *Betwixt and Between*, xii.

246. Ibid.


250. Madhi, *Betwixt and Between*, x.


252. Ibid.


254. Ibid.


258. Somé, *Ritual*.

259. Ibid., 73.

260. Ibid., 25.


264. Ibid., 282; Somé writes that there is an continuous succession of unresolved initiations in the contemporary Western world due to “isolationism” and the “personalization of trouble.” Ibid.


268. Ibid., 105-118.

269. In defining myth, Campbell states that a “prime function of mythology and rite is to supply the symbols that carry the human spirit onward,” and the “common denominator of all these mythic systems is their meaning-provoking capacity.” Campbell, *Myths to Live By* (New York: Bantam Books, 1973); cited in *Betwixt and Between*, eds. Madhi, Foster, and Little, 361; Wilkinson’s definition of myth is “a form of imaginal knowing that is more expansive and multi-layered than linear, rational knowing.” Wilkinson contends that a myth that describes a particular emotional and psychological situation offers us a “felt experience of archetypal power.” She continues on to say that myths and fairy tales weave together the material, psychological and spiritual worlds, and that keeping in mind this interconnection can help us understand the situation more deeply. Wilkinson, *Persephone Returns*, 15; The source for the myth told here is Wilkinson, *Persephone Returns*.


271. Ibid., 25.


273. Ibid.

274. Ibid.

276. Ibid; Ibid., 100.

277. Worden, _Grief Counseling and Grief Therapy_, 43.


279. Worden, _Grief Counseling and Grief Therapy_, 88; Parkes study of London widows explores the relationship between social isolation and anger. He writes that the widows who were the most angry following the death of their spouses also experienced the highest degree of social isolation. This often occurs six months or so into the grief process when family and friends are no longer as involved with the bereaved individual and the anger felt or expressed by the person pushes family and friends even further away. Ibid.

280. Ibid., 44.

281. Sherkat and Reed, “The Effects of Religion and Social Support on Self-esteem and Depression Among the Suddenly Bereaved,” 259-275.


283. Somé, _Ritual_, 75.


285. Ibid., 21 and 24.

286. Skinner Cook and Dworkin, _Helping the Bereaved_, 93.

287. Ibid., 97.

288. Ibid.

289. Ibid., 97-99.


291. Skinner Cook and Dworkin, _Helping the Bereaved_, 99.

292. Ibid., 97.


294. Ibid.

295. Ibid., 430.


297. Ibid.
Chapter 3

1. I had originally started this ongoing partner loss group when I was an intern with Sutter, VNA and Hospice in 2000. The participants seemed to gradually form a core group and typically meet together for approximately six months to one year. Wyatt had come in at the tail end of one group and become part of the core group that is featured in this Clinical Case Study. Annie had started the group two months ahead of the four new participants.

2. The structure of the group was as follows: attending to the business of confidentiality forms and group guidelines, lighting a candle in honor of the loved ones of the bereaved, guided meditation, reading of a poem, a short check-in, more time to share, closing.

3. Worden’s four main tasks of mourning include: 1) accepting the reality of the loss, 2) working through the pain of the grief, 3) adjusting to an environment in which the deceased is missing, and 4) emotionally relocating the deceased and moving on with life. Worden, Grief Counseling and Grief Therapy, 27-37.

4. Whitfield coined the term spiritual bypass and described it as a sophisticated way of identifying with transcendence rather than the feelings and qualities of the immediate place and time. He also called it “premature transcendence” and “high level denial.” Whitfield, A Gift to Myself: 238.

5. Boat Visualization in Appendix 2.

6. As therapist during this visualization and debrief I was looking for the participants’ ability to reintegrate their experience rather than show dis-associative tendencies and pathological denial.

7. Worden gives three criteria with which to evaluate the results of grief therapy. These include subjective experience, behavior, and symptom relief in Worden, Grief Counseling and Grief Therapy, 115.

8. Rashani Rea, “Beyond Brokenness” (Reprinted with permission of Rashani Rea.)

Chapter 4

1. Omer, Personal Communication (Petaluma, CA: Institute of Imaginal Studies, December, 2006). Omer defines imaginal structures as:

   . . . assemblies of sensory, affective, and cognitive aspects of experience constellated into images; they both mediate and constitute experience. The specifics of an imaginal structure are determined by an interaction of personal, cultural, and archetypal influences. These influences may be teased apart by attention to the stories that form personal character and the myths that shape cultural life. During the individuation process, imaginal structures are transmuted into emergent and enhanced capacities as well as a transformed identity. Any enduring and substantive change in individual or group behavior requires a transmuting of imaginal structures. This transmutation depends upon an affirmative turn toward the passionate nature of the soul.

   Omer defines capacities as deeper human potentials or virtues. Omer, Imaginal Process course notes (Petaluma, CA: Institute of Imaginal Studies, 1998). “A capacity is a distinct dimension of human development and human evolution that delineates a specific potential for responding to a domain of life experience. For example, Compassion responds to Suffering; Courage responds to Danger; Destiny responds to the Future; Dignity responds to Failure; Fierceness responds to Injustice; Faith responds to
Uncertainty; Reflexivity responds to Personal Identity, and so on.” Omer, Personal Communication (Petaluma, CA: Institute of Imaginal Studies, December, 2006).

2. Freud initially coined the term work of mourning to describe the difficult process of “severing attachment to the non-existent object.” Freud, “Mourning and Melancholia,” 166.


5. Turner, “Betwixt and Between: The Liminal Period in Rites of Passage,” in Betwixt and Between, 3; Jung developed the concept of individuation which is about how an individual grows towards wholeness, psychologically. Jung, Memories, Dreams, Reflections, 395.


8. Ibid.

9. Mogenson, Greeting the Angels, 135.


12. Somé, Ritual, 75.

13. Ibid.


15. Ibid., 200.


17. Ibid., 202.

18. Worden, Grief Counseling and Grief Therapy, 88.

19. Skinner Cook and Dworkin, Helping the Bereaved, 93.

20. Ibid.


22. Madhi, Betwixt and Between, xii.


25. Mogenson, Greeting the Angels, 38.

26. Ibid.

27. Bowlby, Loss: Sadness, and Depression, 98.


31. Humphrey Taylor, *The Religious and Other Beliefs of Americans*, Harris poll; 63 percent of the 84 percent of those individuals who believed in life after death were non-Christian. This indicates that belief in the afterlife is not necessarily linked to belonging to a religious denomination.


33. Campbell states that a “prime function of mythology and rite is to supply the symbols that carry the human spirit onward,” and the “common denominator of all these mythic systems is their meaning-provoking capacity.” Campbell, *Myths to Live By*.


35. Wilkinson, *Persephone Returns*. Although Wilkinson generally theorizes on trauma such as physical and sexual abuse, her analysis of the myth of Persephone can be applied to those who are grieving the loss of a loved one. The potential of initiation is inherent in the experience of the loss of a loved one just as it is in the experience of other trauma.

36. Ibid., 23.

37. Ibid., 225; Wilkinson’s concept of hero is more aligned with Campbell’s solar hero or the naïve, forceful hero, rather than the lunar hero or the real, wise hero who goes through deep transformation. See Campbell, *The Hero with a Thousand Faces*, 30, and Larsen, *The Mythic Imagination*, 96-107.


39. Ibid., 25.


42. Ibid.

43. Ibid.

44. Ibid., 25 and 227.

45. Ibid., 25.


49. Whitmont, *Return of the Goddess*. 
Chapter 5

1. Cohort six from the Institute of Imaginal Studies still meets on a monthly basis as a community and psychological process group.

2. De Gast, *A Sense of Spirit*, 29-39. Excerpts of contact with James after his death. The contact included dream encounters and direct communication, especially during the first six months after his death:

   On July 7, I dreamed that James came back to life after being clinically dead for three hours. We were sitting at a huge round table with many of his friends from the other side. I asked him what those three hours of death had been like and if it had been real. He said yes, it was absolutely beautiful. He proceeded to tell me of the incredible white light. Using images to communicate, he showed me what it was like in this other world, the details of which I unfortunately could not remember upon waking. I was lucid in the dream and felt as if I was actually having a two-way conversation with James. I believed that he came to let me know that he was alright and to give me an idea of what it was like where he was. It felt as if I was talking to a much expanded version of James, he was radiant.

   On July 23, I dreamed that I was in a big house. James was upstairs in meetings talking to various people. He would come downstairs periodically, smile at me and tell me it was OK. When I asked him why he had to be so far away so much, he replied that he needed to spend time up there with those people, that it was important. He assured me that he was doing well and that his being away did not affect our relationship. He said we were also doing well and that he would keep coming downstairs to check on me. This was a symbolic and comforting dream to me, which I took to mean that our relationship would continue.

   There were many other dreams in which James and I visited and talked together. I also sensed his presence at various times while awake.

3. Worden suggests that complicated grief reactions may be outlined under four headings: 1) chronic grief is a grief reaction that is “excessive in duration and never comes to a satisfactory conclusion”; 2) delayed grief is also called an inhibited, suppressed, or postponed grief reaction. This involves a past loss that was not mourned sufficiently causing the excessive intensity of grief over a current loss; 3) exaggerated grief is a reaction which is “excessive and disabling.” This heading includes clinical depression and anxiety disorders; and 4) masked grief is where, “patients experience symptoms and behaviors that cause them difficulty, but they don’t recognize that they are related to the loss.” Worden, *Grief Counseling and Grief Therapy*, 89-95.


5. Ibid., 31-38.


8. Boat Visualization in Appendix 2.


11. Ibid.


14. Sogyal Rinpoche, The Tibetan Book of Living and Dying (New York: HarperCollins Publishers, 1992); The Great Ball court ceremonies helped ballplayers prepare for a highly ritualized game that during special festivals would culminate in the sacrificial death of the captain of the winning team, who was then believed to be turned into a god. In Eberle, The Final Crossing, ix-x.

15. Eberle, The Final Crossing, x.


17. Eberle, The Final Crossing, x.


19. In addition to supporting the family and friends of their clients, Hospice also offers grief support to bereaved individuals from the community.


21. According to the DSM the presence of certain symptoms are characteristic of a normal grief reaction. These include hallucinatory experiences in which the bereaved thinks that he or she hears the voice of, or transiently sees the image of, the deceased person. In American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 684-685; Bowlby describes some of the experiences of sensing the presence of a loved one as illusion or hallucination. Bowlby, Loss: Sadness, and Depression, 97.

22. The earliest writing of an approach to the hereafter from 4000 years ago. In Eberle, The Final Crossing, 14.

23. Botkin, Induced After Death Communication.

24. See note 2, Contact with James.


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