AN ABSTRACT OF THE DISSERTATION OF

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Cass Dykeman

Grief—the reaction to a significant loss—is a near-universal human experience, from which a subset of grievers (10%–15%) have difficulty recovering, placing them at high risk for negative health and mental health outcomes (Marks, Jun, & Song, 2007). For those showing substantial distress, counseling has been shown to be an effective intervention (Boerner, Wortman, & Bonnano, 2005; Parkes, 1971). In 2000, Martin and Doka introduced a continuum of adaptive grieving styles, from intuitive (affectively focused) grief to instrumental (cognitively or behaviorally focused) grief. We know that counseling outcomes can be affected by perceptions and biases that counselors have toward clients (Luborsky, Auerbach, Chandler, Cohen, & Bachrach, 1971); however, we do not know whether a counselor's perception of a client at the start of treatment is impacted by the client's grief style. The objective of this study is to determine the influence of client grief style on initial counselor perceptions of the client.

Utilizing an analogue design, this study explored how client grief style impacted counselors' clinically related judgments following the viewing of an analogue of an initial counseling interview. Three professional actors were used

to create videotapes of three different grief scenarios (bereavement, divorce, and pregnancy loss), with each actor portraying both an intuitive and an instrumental version of each scenario. The client's grief style was manipulated by alterations in language and affective presentation in a three-by-two design that held the facts of the clinical scenarios, as well as all other aspects of the videotapes, constant.

One version of each of the three scenarios (three video clips in all) was shown to a total of 99 preservice counselors in six CACREP-accredited master's in counseling programs. There were three directional hypotheses developed based upon the extant research literature: (a) counselors would rate the global functioning of intuitive grievers higher than the global functioning of instrumental grievers; (b) counselors will rate their expectations of the therapeutic bond with intuitive grievers higher than their expectations of the therapeutic bond with instrumental grievers; and (c) counselors would be more likely to encourage emotional catharsis among instrumental grievers. Results supported the second hypothesis but not the first and third. Indeed, for the first and third hypotheses, there were significant differences found in the opposite direction. Counselors rated instrumental grievers as higher functioning than intuitive grievers (the opposite of Hypothesis 1), and the likelihood that counselors would encourage emotional catharsis was higher for intuitive grievers (the opposite of Hypothesis 3). Of particular clinical and educational importance was the finding that 66% of participants reported they would encourage

emotional catharsis “often,” “very often,” or “always” in treatment with instrumental grievers, an approach that may be contraindicated for this group.
Keywords: grief style, intuitive and instrumental grief, grief counseling

Preservice Counselors' Initial Perceptions of Client Grief Style: An Analogue Study

by
L. Catherine Beckett

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I understand that my dissertation will become part of the permanent collection of Oregon State University libraries. My signature below authorizes release of my dissertation to any reader upon request.

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L. Catherine Beckett, Author

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CONTRIBUTION OF AUTHORS

Dr. Tim Bergquist, Dr. Cass Dykeman, and Dr. Gene Eakin assisted in the analysis and interpretation of the data. Dr. Cass Dykeman assisted in the formatting and editing of the dissertation final copy.

TABLE OF CONTENTS

TABLE OF CONTENTS (continued)

Page

LIST OF APPENDICES

Preservice Counselor Initial Perceptions of Client Grief Style:
An Analogue Study

CHAPTER 1

GENERAL INTRODUCTION

Overview

The purpose of this dissertation is to demonstrate scholarly work by using the manuscript document dissertation format, as outlined by the Oregon State University Graduate School. In this format, Chapter 1 provides explanations that thematically tie together two journal-formatted manuscripts found in Chapters 2 and 3 and support the way in which they build toward research conclusions pertinent to the field of grief counseling, in particular the concept of adaptive grieving styles, and how these may impact initial counselor perceptions of the client. Accordingly, Chapter 2 is a literature review titled *A Review of the Literature on Conceptualizations of Grief and Grief Counseling*, and Chapter 3 presents quantitative research in a manuscript titled *Preservice Counselor Initial Perceptions of Client Grief Style: An Analogue Study*. The purpose of the study described in Chapter 3 is to determine the relationship between client grief style and initial counselor perceptions of the client at the beginning of treatment, as well as whether there may be differences in counseling techniques applied as a result of these perceptions. Chapter 4 will present general conclusions and tie the manuscripts together.

Grief—the reaction to a significant loss—is a near-universal human experience that can impact grievers in the emotional, physical, cognitive, behavioral, and spiritual domains. While grief in most people is self-limiting and does not require clinical intervention, a subset of grievers struggle greatly and are at high risk for negative health and mental health outcomes (Marks, Jun, & Song, 2007). It is therefore critical that counseling professionals are equipped to provide effective assistance to this group. Both of these manuscripts focus on the clinical conceptualization of grief (both normal and pathological) and what constitutes effective practice in grief counseling, including the constructs of adaptive grieving styles, potential therapist bias based on client style, and possible differences in the likelihood of applying emotional catharsis techniques in counseling.

The first research hypothesis, stating that counselors may initially perceive clients with an intuitive grief style (Martin & Doka, 2000) as higher functioning than clients with an instrumental grief style, was not confirmed; in fact, the opposite was found to be true. The second research hypothesis, stating that counselors may rate initial expectations about the therapeutic bond with intuitive grievers higher than initial expectations about the therapeutic bond with instrumental grievers, was confirmed. The third research hypothesis, stating that counselors would be more likely to apply emotional catharsis techniques with instrumental grievers, was not confirmed; again, the opposite was found to be true.

The manuscripts thematically converge on the current conceptualization of grief and the question of whether counselor bias related to the client's grief style exists. These questions have implications not only for the effective practice of grief counseling (avoiding harm and supporting positive treatment outcomes), but also for the education and training of current and future counselors.

Importance to the Profession of Counseling

Grief—the reaction to a significant loss—is a near-universal human experience that may impact grievers in the emotional, physical, cognitive, behavioral, and spiritual domains (Worden, 2009). Research suggests that the majority of individuals recovers from grief with no need for clinical intervention and is able to re-engage positively in life (Boerner, Wortman, & Bonnano, 2005; Parkes, 1971). However, a significant subset (10%–15%) struggles greatly with functioning for much longer periods in the wake of a loss and thus is at risk for health, mental health, or behavioral problems (Marks et al., 2007). For those showing substantial distress, counseling has been shown to be an effective intervention (Boerner et al., 2005; Parkes, 1971). It is therefore essential that counselors and other mental health professionals are prepared to provide effective assistance to these individuals.

Over the last two decades, there has been a profound shift in our understanding of grief and the best ways to support those who are struggling with grief. The field has wrestled with the tension between a desire to establish guidelines for "normal" and "pathological" grieving and the unavoidable risks

such guidelines bring of disenfranchising individual and cultural differences (Maples, 1998). Increasingly, research has moved further away from universal stage or task models of grief, and from what has been called the *grief work hypothesis*, toward an understanding that there may be many legitimate ways, or styles, of grieving (Martin & Doka, 2000).

The paradigm supported by the research of the past few decades is one that suggests that grief is an adaptive process characterized by individual responses influenced by culture, gender, age, and other individual differences, including the specifics of the loss (Jeffreys, 2011). In 2000, Martin and Doka proposed a continuum of grieving styles, with "intuitive grieving" at one end, "instrumental grieving" at the other, and a "blended" style in the middle. The intuitive grief style is characterized by an emotional focus; inner distress is shown outwardly, and intense emotional experience and expression are typical. These grievers need supportive places to express their distress, which at times may feel overwhelming. The instrumental grief style is characterized by a cognitive and/or action focus; emotional experience and expression are more modulated and private, and energy is channeled into analysis, problem solving/mastery, organization, and activities.

However, in spite of our new conceptualizations of grief, assumptions about grieving and grief counseling based on old paradigms and models still predominate, both in the general population and among mental health professionals (Costa, Hall, & Stewart, 2007; Kohler, 2011; Konigsberg, 2011). In

spite of a lack of both empirical and clinical evidence to support it, Kubler-Ross's 1969 stages of grief model is still the most recommended resource for grief and bereavement support: "Her stages now colour the way we discuss everything from divorce to coming out of the closet to beating addiction" (Kohler, 2011, p. 62). In fact, a 2004 editorial in the *Death Studies Journal* stated,

> There are significant disconnects between the information generated by researchers and the information that is being used to guide the provision of services to the bereaved . . . The field is at a critical juncture in terms of actively working to align research and practice—to make explicit provisions for practice and research to influence one another. ("Editorial: Summary and Conclusions," pp. 568–569)

In a 2007 study, Costa, Hall, and Stewart found a similar disconnect between research and grief support, reporting that all of their participants had experienced negative reactions to their grief from others, most often judgmental comments; in many cases, this resulted in secondary losses and increased distress. However, experiences of acceptance and validation were reported as helping individuals to heal. They concluded that assumptions based on stage models and the grief work hypothesis still inform the grief-related expectations that individuals—including counselors—hold.

> If this is the case, then support offered to bereaved individuals can sometimes be unhelpful, leading to a lack of adequate support being provided at a time when it is much needed . . . Greater attention to increasing public awareness of the variability of the grief response. . . may be necessary. (Costa et al., p. 52)

Other studies have also highlighted the importance of positive social support in grief and the damage that can be done when a person's loss or process is

disenfranchised and validation and support are therefore not present (Vachon & Stylianos, 1988). "Grief related beliefs held by both a bereaved individual, and a potential support provider, may impact how an individual's grief process is appraised, as well as the willingness of support network members to provide effective support" (Costa et al., p. 53).

Unfortunately, many bereaved individuals are unaware of the continuum of grieving styles and think that the only "normal" grief reaction is an affective one, which may add to their anxiety as they struggle to cope with their loss. As counselors, we are most likely to be sought out by those who are unable to find the support they need in their social environments; therefore, no matter what grieving process or style a client may have, it is critical that s/he not experience disenfranchisement in the counseling relationship as well. However, the same assumptions prevalent among the general public are also prevalent among mental health practitioners.

> Grievers "know" what the proper grief map looks like, and [may] blame themselves for discrepancies in their own experience. Clinicians follow similar maps that affect the care they provide to clients. Being unaware of but following the assumptions embedded in much grief literature may lead psychotherapists and other health professionals not only to misrepresent grief but to mistreat and misdiagnose it. (McCabe, 2003, p. 7)

In their work on multicultural counseling, Sue and Sue (2008) argued for increased awareness of what has been termed an "affective bias" among mental health practitioners—a culturally based bias that both privileges emotional awareness and expression and pathologizes clients who value different aspects of

experience. It seems likely that this affective bias would also lead counselors to perceive clients who typify the instrumental grieving style in more negative and/or pathologized ways than those with a more intuitive style; judgments of this kind can lead to problems in the working alliance as well as poorer treatment outcomes (Luborsky et al., 1971). Affective bias could also lead counselors to misapply treatment strategies; it is not difficult to imagine a counselor with such biases subtly (or not so subtly) encouraging an instrumental griever to focus more on emotional catharsis—a focus that is generally contraindicated for that group and that may well increase a client's sense of disenfranchisement.

There is little research on the concept of disenfranchised grief, and even less on grief styles and the way these may play out in clinical practice. Rando (1992) stridently highlighted this issue, calling the grief counseling knowledge of mental health professionals "shockingly insufficient" and writing that they, like the general public, tend to have

> inappropriate expectations and unrealistic attitudes about grief and mourning and to believe in and promote the myths and stereotypes known to pervade society at large. These not only do not help, but actually harm bereaved individuals . . . Too many clinicians actually do not even know that they lack the requisite information they must possess if they want to treat a bereaved person successfully. (p. 55)

Indeed, most counselors are not aware of and have not been trained in the new paradigms (e.g., the existence of more than one grieving style) as part of their counseling education. We do not know how this may affect counselors' perceptions of their clients, and what assumptions, biases, and different

treatment approaches might result, thereby impacting the counseling relationship, process, and treatment outcomes.

Research Questions

This study examines the potential impact of a client's grief style (intuitive or instrumental) on initial counselor perceptions of the client, which have been shown to affect treatment outcome (Luborsky et al., 1971). It also examines the likelihood of counselors applying emotional catharsis as a treatment technique. While the grief work hypothesis and traditional models of grief counseling support emotional catharsis as an essential component of healing grief, more recent evidence suggests that it may be contraindicated for some clients, particularly clients whose grief style is more instrumental.

The first research question asked, "Do counselors rate the global functioning of intuitive grievers higher than the global functioning of instrumental grievers?" The second research question asked, "Do counselors rate their expectations of the therapeutic bond with intuitive grievers higher than their expectations of the therapeutic bond with instrumental grievers?" The third research question asked, "Would counselors be more likely to apply the technique of emotional catharsis to clients with an instrumental grieving style?"

The research questions fill a critical gap in the literature because, although grief styles have become an accepted part of the grief counseling literature, no studies have looked at the effect of client grief style on the counseling relationship or the course of treatment. If there are indeed differences in

counselor perceptions and treatment decisions based on client grief style, this is a critical issue for both counseling practice and counselor education. The analogue design is ideal for these research questions, as it allows for the presentation of counseling vignettes in which clinical realism is preserved yet most variables outside of grief style can be held constant.

Hypotheses

The hypotheses are as follows:

H_1: Counselors will rate the global functioning of intuitive grievers higher than the global functioning of instrumental grievers.

H_0: There is no relationship between a client's grief style and a counselor's initial rating of client global functioning.

H_1: Counselors will rate their expectations of the therapeutic bond with intuitive grievers higher than their expectations of the therapeutic bond with instrumental grievers.

H_0: There is no relationship between a client's grief style and a counselor's initial rating of the anticipated bond with the client.

H_1: Counselors will be more likely to apply the technique of emotional catharsis with clients who have an instrumental grieving style.

H_0: Counselors will apply the technique of emotional catharsis equally across client grieving styles.

Glossary of Terms

Adaptive grieving styles: a spectrum describing approaches and responses to grief, with intuitive grieving at one end, instrumental grieving at the other, and blended styles in the middle (Martin & Doka, 2000).

Bereavement: the state of being deprived of something or someone significant; most commonly used to signify the death of a loved one.

Bias (as used in therapy literature): a prejudice in judgment that results in errors or inaccuracies in clinical decisions with regard to diagnosis, prognosis, or treatment (Arroyo, 1989).

Complicated or prolonged grief: a proposed DSM-V diagnostic category that describes symptoms of pathological grief (Prigerson et al., 2009).

Disenfranchised grief: An experience or expression of grief that falls outside of the cultural "window" of acceptability and is therefore not recognized, validated, or supported (Doka, 1989).

Grief: The internal experience that occurs in reaction to a significant loss.

Grief work hypothesis: The belief that, in order to heal from grief and avoid lasting negative consequences, one must engage in "grief work"—an active effort to experience and express the emotions surrounding the loss fully (rather than avoiding or suppressing them) and work toward detachment (Stroebe, 1992).

Instrumental grief style: characterized by a cognitive and/or action focus; emotional experience and expression are modulated and private, and energy is channeled into analysis, problem solving/mastery, organization, and activities.

Intuitive grief style: characterized by an emotional focus; inner distress is shown outwardly, intense emotional experience and expression are typical, and the griever may fear becoming overwhelmed.

Mourning: the acts, manifestations, or outward expression of grieving.

Stages of grief: a conceptualization of grief, created by Elisabeth Kubler-Ross in 1969, that describes basic universal patterns of integrating loss in five stages: denial, anger, bargaining, depression, and acceptance.

Organization

The organization of the dissertation follows a thematic review of the literature in Chapter 2, focusing on the constructs described in the research questions as well as the developmental shifts in these constructs. The themes include the three major paradigms of grief and grief counseling: stage models, task models, and the emerging paradigm of individual differences and adaptation, including grief styles. The section on each paradigm describes (a) the paradigm's conceptualization of grief and its definition of "normal" versus "pathological" grief; (b) relevant research contributions during that period; (c) implications for counseling; and (d) critiques of the paradigm, which in each case led to a paradigm shift. Chapter 3 is a research study focusing on the presentation of clinical analogues to discern differences in counselor perceptions based on some of the constructs described in Chapter 2, particularly grief styles (intuitive and instrumental). Chapter 4 offers general conclusions and links all chapters together.

CHAPTER 2

A REVIEW OF THE LITERATURE ON GRIEF AND GRIEF COUNSELING

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Abstract

Grief—the reaction to a significant loss—is a near-universal human experience that can impact grievers in the emotional, physical, cognitive, behavioral, and spiritual domains (Averill & Nunley, 1993; Worden, 2009). Over the last 50 years, there have been several profound shifts in our understanding of grief and the best ways to support those who are struggling with it. Increasingly, research has moved further away from a universal model of grief and toward an understanding that there may be many legitimate ways, or styles, of grieving. Studies have also helped us to recognize the importance of positive social support in grief and the damage that can be done when support is not present (Vachon & Stylianos, 1998). As counselors, we are most likely to be sought out by those who are not able to find the support they need in their social environments (Gamino & Ritter, 2009; Parkes, 1980); therefore, no matter what a client's grieving process is, it is critical that s/he not experience disenfranchisement in the counseling relationship as well.

There is little research on the concept of disenfranchised grief (Doka, 1989, 2002) and even less on grieving styles (Martin & Doka, 2000). Studies have shown that in spite of our new conceptualizations of grief, assumptions about grieving and grief counseling based on old paradigms and models still predominate, both in the general population and among mental health professionals (Costa, Hall, & Stewart, 2007; Kohler, 2011; Konigsberg, 2011; Yalom, 2010). Most counselors have not been trained in the new paradigms (e.g.,

the existence of more than one grieving style) as part of their counseling education. We do not know how this may affect counselors' views of their clients, what assumptions and biases might result, and how a client's grief style may impact the counselor's choices about treatment techniques, thereby potentially impacting the counseling relationship and the success of treatment.

Keywords: grief style, intuitive and instrumental grief, grief counseling

A Review of the Literature on Grief and Grief Counseling

This article will provide a chronological account of the three major paradigms of our conceptualization of grief and grief support. First, a brief early history of grief as a concept will be presented, and its foundations in psychoanalytic writings will be examined. This will be followed by descriptions of the three paradigms:

1. Stage models.
2. Task models.
3. Individual differences and adaptation, including grief styles.

The section on each paradigm will describe (a) the paradigm's conceptualization of grief and its definition of "normal" versus "pathological" grief; (b) relevant research contributions during that period; (c) implications for counseling; and (d) critiques of the paradigm, which in each case led to a paradigm shift.

History and Foundations

Very little research or literature on grief existed prior to the first stage model proposed in 1969 by Elisabeth Kubler-Ross. Our culture's conceptualization of grief has much of its foundation in the early writings of Freud. In "Mourning and Melancholia" (1917), he asserted that mourning comes to an end when the griever completes the work of severing his emotional attachment to the lost object and reinvests the now-free libido in a new object. He described the "work" of mourning as requiring enormous amounts of energy

and acknowledged that it cannot be done all at once. *Acute grief* was first defined as a definite and uniform syndrome in 1944 by Lindemann, a psychiatrist working during and after WWII. He outlined the expectations that grieving a death involves confronting the reality of the loss and severing emotional ties to the deceased, that this process should be time limited (lasting a few weeks to a few months), and that it should be followed by a return to normal functioning (which, in his view, could be achieved in eight to ten interviews).

Other literature concerning grief published during the 1940s and 1950s was nearly all from the field of pastoral psychology and expressed similar beliefs and expectations. One such article, written by the editors of the *Pastoral Psychology* journal in 1950, responded to a minister's question of whether a mother's grief over a lost son is "healthy or morbid" by advising,

> The mother still seems to be tied to the son . . . there is need that these ties be broken. To break these bonds, the mother needs to talk. . .. Not only to give a recital of events, but to express her feelings about her son. . . . When the bereaved has been emancipated [from the deceased], then she can be consoled. ("Editorial: Consultation Clinic," pp. 51–52)

Stage Models

The publication of Kubler-Ross's "On Death and Dying" in 1969 filled a tremendous gap in literature, education, and practice. Prior to her work, in Western culture, death was "something to be feared, something too unpleasant to talk about or even think about" (Maples, 1998, p. 229). As a psychiatric resident, Kubler-Ross was disturbed by the lack of attention to death and dying in the

medical curriculum. The five-stage model of grief (denial, anger, bargaining, depression, and acceptance) was her attempt to find common and universal patterns in the grieving process, and it emerged from her own work and interviews with a small group of terminally ill patients. In spite of the fact that her analysis was based wholly on her own observations of her dying patients and was not tested by empirical research, she was

> widely embraced as a grief guru . . . her stages now colour the way we discuss everything from divorce, to coming out of the closet, to beating addiction . . . and created standards of grief all of us feel we must now labour to meet. (Kohler, 2011, p. 62)

The stages she identified were generalized in both popular and professional circles to all kinds of grief work—across individuals, cultures, and different kinds of losses (Konigsberg, 2011).

Kubler-Ross's five-stage model was followed by additional stage or phase models of grieving. In his work on attachment theory, Bowlby (1963, 1977, 1980) delineated four phases that occur when a person experiences separation from an attachment figure such as a parent, partner, friend, or even a pet: numbness; yearning, and separation anxiety; despair and disorganization; and finally reemergence into life. Bowlby extended his model to cover losses beyond relational separation and bereavement, including losses such as functions, roles, health status, and dreams about the future.

Parkes's grief theory (1971, 1972) described a preprogrammed set of behaviors that is cued by a loss; he identified four stages that are similar to

Bowlby's: numbness, searching/pining, depression, and recovery. Sanders (1989) described phases of bereavement (shock, awareness of loss, withdrawal, healing, and renewal). She also focused on internal and external mediating factors that lead to individual differences in mourning, asserting that each person's circumstances, and the meaning he or she makes of the death, will lead to very different experiences. She warned against the concept of fixed time limits for grief and the harm that such limits may bring to the griever.

How paradigm conceptualizes grief and what is normal vs. pathological. In the stage models, grief consists of a uniform series of distinct phases. Most models move from a stage of numbness or shock, into and through a series of difficult emotions, and finally to a place of recovery. Failure to move through these phases in a timely fashion is considered problematic and predictive of later difficulties; "If the grief is unresolved or becomes fixated at some stage, mental and physical health, along with the formation and maintenance of new relationships, can be disrupted" (Maples, 1998, p. 219). The "normal" pattern is one of intense distress that diminishes over time. One must hurt, and speak this hurt out loud, in order to heal. Cases in which this intense distress is absent, prolonged, or interferes excessively with functioning are thought to be pathological. Ordinary grief shows itself through distress and moves toward resolution, whereas pathological grief does not (Weiss, 1998).

Stage models laid the foundation for what Stroebe (1992) later termed the "grief work hypothesis" (GWH), which posits that the griever must engage in

> an active, ongoing, effortful attempt to come to terms with a loss. Fundamental to [this] conception is the view that one needs to bring the reality of the loss into one's awareness as much as possible, and that suppression is a pathological phenomenon. (Stroebe, pp. 19–20)

Also enfolded in the GWH are the notions that strong emotions are inevitable, that lack or avoidance of distress equals pathology, that processing the loss externally and verbally is required, and that recovery/resolution within a relatively brief amount of time is the expected outcome (Costa, Hall & Stewart, 2007; Wortman & Silver, 1989). As Lindemann (1944) wrote,

> The duration of a grief reaction seems to depend upon the success with which a person does the grief work . . . One of the big obstacles to this work seems to be that many patients try to avoid the intense distress connected with the grief experience and to avoid the expression of emotion necessary for it. (p. 156)

Relevant cultural, gender, and other research contributions during that time. The majority of the grief literature during this period is focused specifically on bereavement, and nearly all of it focuses on White adults in Europe or America. It was not until the end of this period that more attention began to be paid to cultural and gender differences and influences in research and practice. Maples (1998) noted that "most of the research in this area [of grief] has been carried out with European samples" (p. 228) and suggested that further study of cross-cultural grief patterns, as well as individual differences in grieving, was warranted. Fowlkes also charged in 1990 that bereavement research had focused almost exclusively on the loss of nuclear family members—a very narrow

conception of relationship loss that leaves out many kinds of relationships that may be less socially familiar or recognized.

Implications for counseling. Lindemann (1944) voiced the belief that "By appropriate techniques, distorted pictures can be successfully transformed into a normal grief reaction with resolution" (p. 155). For both practitioners and clients, the work of Kubler-Ross was revolutionary. It gave both permission and structure to help people speak about death, a topic that had formerly been unspeakable; there was relief at having a template to follow and constructs and language to guide the work.

> If you ignored or repressed the stages, you risked getting stuck with unresolved and painful emotions. But if you plunged through them, you would eventually emerge on the other side stronger and wiser, a reward that was particularly appealing in the 1970's, as the self-help movement with its promises of personal transformation was sweeping the country. (Konigsberg, 2011, p. 3)

Counselors, therefore, needed to be trained in and to understand the stages, serve as guides to them, and encourage clients to work through them. As the five-stage model made its way into popular consciousness, it was also incorporated into training programs for health and mental health providers. It was then, and it remains to this day, the most recommended resource for grief and bereavement support (Kohler, 2011).

Critiques of paradigm. "Because belief in assumptions is likely to influence the field's research agenda and also to guide clinical practice, it is important to assess their validity" (Davis, Wortman, Lehman, & Silver, 2000, p.

499). As early as the mid-1970s, researchers were noting increasing use of mental health services by people struggling with grief but a lack of evidence base to inform the work being done (Rosenblatt, Walsh, & Jackson, 1976). When the first significant body of research finally emerged in the late 1980s and the 1990s, it completely failed to support the assumptions of existing stage models (Costa, Hall, & Stewart, 2007).

The first major critique to emerge from this new research challenged stage models on the basis of their focus on emotional and psychosocial dynamics. Corr (1992) noted that they excluded the physical and, to some extent, the spiritual experiences of grieving and were therefore limited models.

The second major critique to emerge challenged the concept of "breaking bonds" or "severing attachments"; instead, studies indicated that the relationship with a lost object continues but must change to accommodate the fact that the object is no longer present. "Now we no longer use that old sort of Freudian model . . . We really emphasize that people don't detach" (Yalom, 2010, p. 1). Klass, Silverman, and Nickman (1996) stated that in their research, they were not observing the disengagement that they had been taught to expect, "but rather people altering and then continuing their relationship to the lost or dead person" (p. xviii). They also noted that there was "little social validation for the [continuing] relationship people reported with the deceased or absent person" (p. xviii).

Beginning in 1989, three research teams (Bonnano & Kaltman, 1999; Stroebe, 1992; Wortman & Silver, 1989) published major empirical challenges to the grief work hypothesis (GWH), which asserts that "grief work" is necessary to achieve healthy adjustment to bereavement. Despite widespread endorsement of the GWH in the field, little empirical evidence existed to support it. Wortman and Silver (1989) debunked the beliefs that normal, nonpathological grief must include depression and distress, that it must be "worked through," and that it will end in recovery and resolution. In addition, their review noted,

> Perpetuation of unrealistic assumptions [about the normal process of coping with loss] held by health care professionals and the social network may unnecessarily exacerbate feelings of distress among those who encounter loss, and lead to a self-perception that their own responses are inappropriate or abnormal. (Wortman & Silver, p. 355)

The narrower the assumptions about grief, the more grievers will be categorized (potentially unfairly) as maladaptive grievers. Stroebe's (1992) criticism of the GWH focused on the lack of clear empirical support, including the absence of a clear definition of "grief work," of quality in operationalizations in research, of clear evidence supporting the hypothesis, and of research and application across populations and cultures. Bonnano and Kaltman (1999) challenged the need for "grief work" even more strongly, reporting that in their findings, indulging in the expression of painful emotions can work against effective adaptation, and that some repression or avoidance may be helpful in both the short and long term. Pennebaker, Zech, and Rime (2001) directly challenged the belief that writing or

talking about a painful loss assisted with coping. Their study found that the sharing of difficult events or emotions, "talking about your feelings," does not in and of itself lead to emotional recovery.

Both the GWH and stage models were also criticized for being culturally biased. McCabe (2003) pointed out the Western values embedded in the GWH, such as linear progression, goal completion, autonomy, and detachment. Stroebe's 1992 critique also suggested that Western industrialism may contribute to the notion of grief as a task that requires a template or "recipe" to resolve. Stage models were criticized for being too linear, too prescriptive, and having too little room for individual responses (McCabe, 2003; Worden, 2009). And, as Corr (1992) pointed out, any universal stage model risks overgeneralization and exclusion; it can "erect obstacles to individualization; a stage-based model risks stereotyping vulnerable individuals" (p. 82).

Task Models

How paradigm conceptualizes grief and what is normal vs. pathological. In the task model paradigm, grief responses are characterized not by universal stages and progression from one stage to another, but by tasks that must be accomplished, and by movement between these overlapping areas of focus. There is greater room for individual differences in the experience and expression of grief and in how these tasks are accomplished (McCabe, 2003; Worden, 2009). The griever is an active, rather than passive, agent in the adaptation process. The tasks are seen as nonlinear; grievers move fluidly

between them, in addition to moving in and out of actively grieving. The bond with the lost object changes but continues, and like the bond, the process of grief does not end but changes over time (Humphrey, 2009).

One of the best-known task models, by Worden (1991), is composed of four behaviorally oriented tasks of mourning that must be accomplished for grief to be resolved. These are acceptance of the reality of the loss, experiencing and working through the pain of loss, adjusting to an environment without the lost object, and establishing a changed but continuing bond.

Rando (1984, 1993) also proposed a model that combines "phases and processes of mourning." It involves three broad phases: avoidance, confrontation, and accommodation. Each phase contains specific processes that must be addressed for healing to occur. In *avoidance*, one must recognize the loss; in *confrontation*, one must react to separation, recollect, re-experience what has been lost, and relinquish old attachments (both to the lost object and to one's assumptions); and in *accommodation*, one must readjust to the new world and reinvest energy in new ways. When one or more processes do not occur, a person is at risk for complicated mourning.

The dual process model of Stroebe and Schut (1999) looked at gender, cultural, and individual differences and suggested that rather than moving through phases, people oscillate between two types of reactions: loss-oriented tasks and restoration-oriented tasks. People undertake these on different

timelines, with different approaches, and in different proportions, depending on both internal factors and external pressures.

The constructivist or narrative-focused model by Neimeyer (2000, 2009) suggests that loss disrupts the deeply held assumptions on which a person's life story and sense of identity are grounded. This model conceptualizes grief as a person's struggle to accomplish the primary task of building a new, post-loss framework of meaning; those in grief may therefore benefit from support around meaning reconstruction.

While task models do make more room for individual differences in the grieving process, they have embedded within them the notion that, if resolution is to be obtained, grievers must actively work through the tasks outlined in the model. This leaves two primary ways in which a person's grief might be viewed as pathological—if s/he appears to be "stuck" in one of the tasks, or if s/he is not engaged in the tasks at all. In 1995, a group led by Prigerson proposed that a diagnosis of "Complicated Grief" (renamed "Prolonged Grief" in 2009) be added to the DSM, arguing that this is a distinct, identifiable, and validated syndrome that should therefore qualify for clinical treatment. The proposed disorder is limited to bereavement-related grief and cannot be diagnosed prior to six months post-loss. This proposal has been the subject of much controversy among researchers and practitioners; many have argued against categorizing grief as a mental disorder (Bonnano, 2006; Wagner, 2010), citing varied concerns, both scientific and ethical/philosophical.

Relevant cultural, gender, and other research contributions during that time. Wortman and Silver (2001) identified many enduring conceptualizations of grief and grief counseling as "Western assumptions" and cautioned that since treatment practices are based on their validity, these must be articulated and "subject[ed] to careful scientific scrutiny. . . . If counseling for bereaved individuals is based on erroneous assumptions, it may ultimately prove unhelpful" (p. 406). Rosenblatt (1996) added that "America is a land of many cultures, yet there are efforts to medicalize and routinize grief therapy in ways that are grossly insensitive to cultural differences" and recommended a "postmodern sensibility in which the diversity of realities is acknowledged" (p. 56).

Sue and Sue (2008) have written extensively about some of the challenges of multicultural counseling and ways that traditional therapy techniques may need to be reconsidered or adapted to be effective with clients from other cultures; they are particularly critical of the emphasis counseling has traditionally placed on affective expression. Barrett (1998) described considerations for working effectively with Black clients experiencing loss and grief, noting that sensitivity to cultural traditions can be helpful in supporting recovery: "The unique experiences of Blacks contribute to a sense of mistrust that might affect caregiving and counseling processes" (p. 84).

This period also saw more studies of international variation in grief published; these all showed evidence of enormous cultural variability in the

experience and expression of grief (Golden, 2009; Rosenblatt, 1993). A reaction that is seen as normal and expected in one culture would be considered pathological in another. Rosenblatt writes that even our most fundamental assumptions (e.g., how we know whether a person is dead or alive) are not shared by many other cultures across the world and that we will never understand others "if we translate what they say into our own terms and assume the transcendent reality of those terms" (p. 14).

Studies and reviews also found gender differences in both expression and outcome of grief (Stillion & Novello, 2001; Stroebe & Stroebe, 1983; Stroebe, Stroebe, & Schut, 2001; Zinner, 2000). One study suggested that while women struggle with prohibitions against anger, men struggle with prohibitions against sadness (Cochran, 2006); both may inhibit the successful resolution of grief. Another suggested that men and women may be helped more by interventions focused on the more difficult task for that gender, with men benefitting from an emotion focus and women benefitting from a problem-solving focus (Schut, Stroebe, van den Bout, & de Keijser, 1997). Golden (2009) described gender differences in bereavement customs, roles, and expectations across cultures. Generational differences have been described as well, with older adults (particularly older men) feeling less comfortable expressing and exposing emotions (Garfinkel, 2011). Increased attention was given in the late 1990s and early 2000s to research on grief in children and adolescents (Worden, 2008). Additional studies focused on the extra challenges of healing grief when the lost

relationship is accorded little or no social validation (Kacsmarek & Backlund, 1991; Robak & Weitzman, 1994).

During this period, research also began to examine whether or not counseling is a useful and effective intervention for people experiencing grief. The question was first approached in 1980 by Parkes, whose research review found that counseling for the bereaved reduced the risk of poor bereavement outcomes, especially "among bereaved people who perceive their families as unsupportive or who, for other reasons, are thought to be at special risk" (p. 6). Several studies showed evidence for particular risk factors associated with a higher risk for poor bereavement outcomes (Parkes, 1990; Rando, 1992), suggesting that individuals with these risk factors might have a greater need for—and benefit more from—grief counseling. A review of efficacy research by Schut, Stroebe, van den Bout, and Terheggen (2001) supported these findings, noting that the more complicated the grief process, the better the chances of interventions leading to positive results (p. 731). As a summary statement of efficacy research, Gamino and Ritter (2009) concluded,

> Grief counseling practiced by competent professionals can help those individuals struggling to accommodate to their loss, and is especially helpful for those who self-identify their need, or whose personal history and circumstances make it even more difficult than usual to cope with their loss. (p. 258)

Implications for counseling. While a task model does still provide counselors with a template of sorts, there is more room for individual variance in how these tasks might be approached and accomplished by an individual client.

Worden (2009) asserted that, in comparison with stage models, the task model is more useful to the clinician, as it offers hope and implies that "mourning can be influenced by intervention" (p. 38). This paradigm marked the beginning of a shift away from a prescription of how clients "should" grieve, based in an increased awareness of individual, contextual, and cultural influences on the experience and expression of grief.

This shift presents both opportunities and challenges for counselors. On the one hand, practitioners making room for difference will increase the success of counseling interventions with a wider range of clients (Barrett, 1998; Sue & Sue, 2008) and present a smaller risk of alienating clients who are seeking support. On the other hand, a less prescriptive and more open grief concept presents more challenges for the practitioner, requiring more flexible assessment and intervention skills and an increased awareness of personal assumptions and biases. This has implications for counselor training as well; it is much easier, one might say, to teach someone a particular recipe than it is to teach that person how to cook.

Critiques of paradigm. Bonnano and Kaltman (1999) offered the overarching observation that the empirical challenges to the GWH left a sizeable hole and created a "theoretical vacuum" (p. 771). They suggested that the next decade of research support an integrative perspective, focusing on the role of factors such as context, subjective meaning, and coping/emotional regulation, as well as the interplay between these and other factors. Yet despite the clear and

growing research evidence against the GWH, the shift away from this paradigm was not penetrating popular understanding or practice. "Individuals in pain often look to this 'recipe' for help and may be not only disappointed but disempowered, viewing themselves as flawed or 'crazy' for not following the proper maps of grief experience" (McCabe, 2003, p. 12). It is these grievers, whose grief templates and social networks provide less support, who are the ones most likely to be seen in treatment, and also the ones most likely to benefit from it (Vachon & Stylianos, 1988).

In 1989, Doka created the term *disenfranchised grief* to describe grief that is outside of the cultural "window" of acceptability and is therefore not acknowledged, validated, or supported. Disenfranchisement can result from unrecognized relationships, losses perceived as insignificant, exclusions of particular grievers, or grieving styles or timelines seen as outside the norm. The impact of disenfranchisement can be social, intrapsychic, or both; indeed, "The very nature of disenfranchised grief creates additional problems of grief, while removing or minimizing sources of support" (Doka, 1989, p. 7). Gilbert (1996) recognized what she termed *differential grief* in families: the common phenomenon of family members being on different timelines and experiencing and coping with their grief in very different ways. She asserted that this incongruence often led to increased pain and stress, unless family members could be helped to accept and make room for individual differences. These works and others called attention to the idea that both stage and task models contribute to

the maintenance of grieving norms, which may help some clients but exclude or alienate others.

Doka's groundbreaking work was followed by Fowlkes's 1990 critique of bereavement research recognizing the social conventions that dictate an individual's "right to grieve," particularly in intimate relationships that are socially undervalued or devalued, and the impact this has had on what is known. She noted that the vast majority of research on bereavement has focused on the loss of immediate nuclear family members—most often, spouse, parent, or child, all of which are socially legitimized relationships—and that this is far too narrow a view of intimacy. She suggested that denial of this legitimized right to grieve and the resulting "unknowing, indifferent, or hostile" social climate may impact the griever's resiliency and ability to resolve the grief (p. 649). She argued for a research agenda that would "expand the empirical study of grief beyond what is socially normative to encompass the full variability of what is socially real" (p. 650).

Corr (1998) criticized the tendency of grief researchers and practitioners to focus primarily on bereavement. He sought to broaden the scope of disenfranchised grief beyond categories of death to encompass losses of any attachments, including both the existence of the reaction and the expression of the reaction. This proposal seemed to be supported by Romanoff, Israel, Tremblay, O'Neill, and Roderick (1999), who studied groups experiencing a variety of losses and found that the loss group differed from the nonloss group

but that specific loss groups (death, divorce, and illness) did not differ much from each other.

A review by Davis et al. (2000) questioned the assumption of some task models that the search for meaning is an essential part of every grief process. They reported that while approximately 80% of grievers do seek some reason for their loss, others do not. Further, they noted that many who do seek this kind of resolution do not find it (thus experiencing significant pain), and that in fact, "those who appeared to be coping best were those who had not asked themselves the question at all" (p. 500).

Individual Differences and Adaptation

How paradigm conceptualizes grief and what is normal vs. pathological. In 1998, Weiss wrote, "It may be that grief work, rather than being necessary . . . is only one among several possible coping strategies. What may be needed at this point is research investigation that could make evident the different coping strategies grievers use" (p. 350). In this current paradigm, individual differences—both internal and external—and the unique experience of grief are emphasized. The paradigm of individual differences does not replace the task model per se, but instead augments and broadens it; it suggests that those experiencing grief may still need to accomplish tasks but will do so in very different ways and will require different kinds of support (Humphrey, 2009).

Martin and Doka's identification of adaptive grieving styles in 2000 was intended to address and mitigate the occurrence of disenfranchisement. In their

early work, they identified “feminine” and “masculine” grieving styles, but upon determining that grief style is influenced but not determined by gender, they created a continuum of styles, with “intuitive” on one end and “instrumental” on the other, with a “blended” style in between. Grief style influences a person’s experience and expression of grief, as well as his/her preferred adaptive strategies. *Intuitive grievers* experience intense emotion that can sometimes feel overwhelming and have the need to express their feelings, effectively mirroring their internal experience of distress. *Instrumental grievers* experience grief in more cognitive and/or behavioral ways; they are more modulated and private in their feelings. They tend to put their energy into directed activity (such as problem solving, organizing, or analyzing) in attempts to master themselves and their environments. Grievers with a *blended* style show some characteristics of both of the previous styles and may be able to shift more easily from one to the other as situations demand.

Though research focused on grief style is still very limited, a grief style measurement tool was successfully piloted in 2006 (Martin & Wang, 2006), and an Internet tool designed to educate grievers about grief style, assist them in self-assessment, and provide further resources had a measurable positive short-term impact on bereaved individuals (Dominick et al., 2009).

Additionally, this third paradigm appears to shift away from a pathology orientation and toward positive coping and adaptation—in which there is an increasing focus on what factors help some grievers adapt well (Gamino, Sewell,

& Easterling, 2000). More researchers are now calling attention to the fact that, where grief is concerned, resiliency is the norm (Bonnano, 2009) and that in the wake of grief, a variety of benefits and positive outcomes may appear (Frantz, Farrell, & Trolley, 2001).

Relevant cultural, gender, and other research contributions during that time. In 2002, Lindstrom published a challenge to what she called "mainstream thinking" about bereavement; she attempted to bring together two opposing strategies—those that call for expressing the pain, and those that claim that avoidance and distraction may result in better outcomes. Instead of rigidly adhering to either extreme, she promoted principles of mindfulness in grief counseling: recognizing whatever comes into the mind, without judging or fighting it, and then letting it go. She termed this a "middle perspective": one that "recognizes the bereaved person's need for reacting and reflecting and the need for stopping sadness and pain when grief becomes too burdensome" (p. 16).

Rosenblatt (2008) has continued his culturally focused grief research and noted that "the primary message of culturally-sensitive literature is that culture creates, influences, shapes, limits and defines grieving, sometimes profoundly" (p. 208). He noted that the fit between an individual's grief and the expectations of his or her culture is crucial and determines how well or poorly his or her grief may be supported. He also asserted that ongoing research is needed that strives to be as free from ethnocentrism as possible, in order to keep the field from being

"limited, controlled and shaped by researchers who study, write about, and attempt to help others deal with loss" (p. 219).

Gender research has also continued; Wolfelt (1990) wrote that men in our culture still do not have permission to openly mourn in affective ways, noting the discomfort that occurs "when a man openly admits to painful emotions of hurt and loss, weeps outwardly, admits being disoriented or shudders with fear" (p. 20). Golden (1997) realized after years of practice specializing in grief counseling that

> the type of therapy I had been taught to do was designed for women. The vast majority of clients who visit therapists' offices are female, and due to this, therapy is shaped accordingly to fit and be effective with women. I slowly began to realize that there wasn't something wrong with men—there was something wrong with the therapy. (p. 2)

The Association for Death Education and Counseling (ADEC), founded in 1976, published its own Code of Ethics in 2006, outlining for the first time basic tenets and standards of ethical practice in the areas of death education, grief counseling, and thanatological research. This publication has many implications for the practice of grief counseling, which will be discussed further in the "Implications for Counseling" section below.

Finally, the question of whether counseling is a useful and effective intervention for people experiencing grief has received increased research attention over the last decade. More recent studies have followed the work done by Parkes (1980, 1990) and Rando (1992), which initially suggested that grief

counseling is particularly helpful for individuals who have more risk factors and/or who have less social support.

In 2000, a period of professional contention began when Neimeyer published a research summary that included the results of an unpublished meta-analysis by a doctoral student named Fortner (1999), whose analysis showed a treatment-induced deterioration effect (TIDE) in 38% of his sample, suggesting that counseling for grief not only is not helpful for some, but may also be harmful. Neimeyer's summary, including the TIDE statistic, was then cited by a large number of additional researchers and was picked up by the popular media, leading to headlines such as this one in the *New Yorker* in 2004: "The Grief Industry: How Much Does Counseling Help—or Hurt?" In 2007, Larson and Hoyt published a scathing attack on Fortner's work, claiming that their review showed "no statistic or empirical basis for claims about deterioration effects in grief counseling" (p. 347) and criticizing the citation of the work, which had never been subjected to peer review, as poor scholarship.

Meta-analyses and reviews of research from the first decade after 2000 now seem to have found several principles on which they can generally agree. First, the majority of people experiencing grief will not require counseling but will recover without intervention, making "grief therapy for normal bereavement difficult to justify" (Neimeyer, 2000, p. 546). Second, there is good evidence to support the efficacy of grief therapy for "a range of people contending with a range of losses . . . if they are assessed as contending with substantial clinical

distress to begin with" (Neimeyer & Currier, 2009, p. 355). Allumbaugh and Hoyt's meta-analysis found that, additionally, clients who self-selected for grief counseling made greater improvements than those who were recruited for intervention (Allumbaugh & Hoyt, 1999), and another by Wittouck, Van Autreve, De Jaegere, Portzkey, and van Heeringen (2011) found that while treatment interventions were effective for complicated grief, preventative interventions were not. In summary, when grief counseling is focused appropriately on those who need and seek it, evidence supports positive treatment effects (Bonnano & Lilienfeld, 2008; Larson & Hoyt, 2007).

Implications for counseling. Multicultural counseling has taught us that it is important to recognize the power inherent in the practitioner position; counselors' expectations of clients and those around them impact their expectations, and therefore the process of their grief. An individual whose grief response does not conform to what that individual or others expect or view as "normal" may be denied support or be harshly judged. "More flexible expectations may lead to empathic and supportive interactions with a bereaved individual" (Costa et al., 2007, p. 30).

One challenge presented by this broadening trend, however, is that the further we get from a clear picture of what is "normal," the more difficult it is to determine what should cause concern. As important as it is to make room for individual differences, it is hard to look at a client who is severely distressed and unable to function years after a loss and think, "Well, that must just be this

person's unique way of grieving." Diagnostic category debates aside, most practitioners of grief counseling would agree that the symptomatology described by Prigerson et al. (2009) for a proposed "Prolonged Grief Disorder" should evoke some level of concern (these symptoms describe grief which is chronic, unremitting, and which significantly interferes with a person's functioning). Humphrey (2009) suggested that, rather than "normal" versus "pathological," we think in terms of "uncomplicated" versus "complicated" grief. *Uncomplicated grief* has symptoms common to grief, but these symptoms diminish in intensity over time and generally move toward healing and resolution. *Complicated grief* is prolonged, and symptoms intensify rather than abate; the griever does not appear to be accepting or integrating the loss.

The publication of ADEC's Code of Ethics has implications for grief counseling practitioners. In particular, the first Basic Tenet of the Code states that "Death education and grief counseling are based upon a thorough knowledge of valid death-related data, methodology, and theory rather than stereotypes or untested hypotheses. Thus the practice of death education and/or grief counseling requires knowledge of current thanatological literature" (ADEC Code of Ethics, 2006, Basic Tenets, 1). It should be noted that this is written to apply not only to "grief specialists," but also to all those who, "on a full-time, part-time, or occasional basis, function as grief counselors or therapists" (ADEC Code of Ethics, Section GC).

This expectation, while sensible, is likely to require a seismic shift in the current knowledge base of counselors and in the programs that train them. Doka has observed that most therapists do not get much specific training in grief counseling, and that many practitioners of grief counseling appear to still be working in the Kubler-Ross model, which is many years out of date. He also echoed the concern expressed by Sue and Sue (2008) that much of the clinical training for counseling professionals is affectively based, which may result in an expectation and bias among mental health professionals toward affective expression, thereby privileging intuitive grievers.

> There are a number of ways that our understanding of grief has changed . . . There's a lot of poor information out there, which I think is being filtered into some therapeutic context. I think people who are going to do grief counseling really need to keep abreast of the literature on it. (Yalom, 2010, p. 8)

Critiques of paradigm. Research focused on differences, styles, and adaptation in the grieving process is in its infancy; very little yet exists. The primary critique of this paradigm seems to lie in the ongoing question of whether these new understandings have penetrated professional understanding; and even if they have, whether they have led to any changes in our expectations, judgments, and practice (Costa et al., 2007; Middleton, Moylan, Raphael, Burnett, & Martinek, 1993). Doughty's 2009 Delphi study found agreement among a panel of grief counseling and research "experts" that the grieving process is greatly impacted by both internal factors (such as grief style) and external factors (such as culture and the specifics of the loss). However, Doughty noted that "more

research is needed regarding the beliefs of counselors who do not specialize in grief issues . . . [to determine] to what degree counseling professionals are aware of the latest research . . . beyond stage progression models of grief" (p. 475).

In the journal *Death Studies*, a 2004 editorial summary asserted that while bereavement is a universal human experience, "research indicates that there is tremendous variability in 'normal' responses to bereavement. . . . There are significant disconnects between the information generated by researchers and the information that is being used to guide the provision of services to the bereaved" ("Editorial: Summary and Conclusions," p. 568). The summary concluded that

> the field is at a critical juncture in terms of actively working to align research and practice—to make explicit provisions for practice and research to influence one another—as the bereavement and grief research enterprise matures and moves forward. (p. 569)

Indeed, an increasing number of researchers and practitioners have noted this current lack of alignment between research and practice—most notably, they have observed an apparent lack of incorporation of newer and more empirically supported models of treatment into practice work.

Summary

This review of the literature has provided a history of three major paradigms in our conceptualization of grief and grief support, beginning with its foundations in early psychoanalytic writings, and progressing through (a) stage models; (b) task models; and (c) individual differences and adaptations, including

grief styles. Each section has examined the paradigm's conceptualization of grief, including definitions of "normal" versus "pathological" grief; relevant research contributions during that period, research on cultural and gender influences, as well as research on the efficacy of grief counseling; implications for counseling practice; and finally critiques of the paradigm, which in each case led to a paradigm shift.

The first stage model, published in 1969 by Kubler-Ross, filled an enormous gap in literature, education, and practice; though it was based in Kubler-Ross's work with terminally ill patients, it was quickly generalized and became known as the stages of grief. It provided a language for doctors, counselors, and laypeople to talk about death and grief, as well as a template for beginning to understand pieces of the experience. Her work was followed by other stage or phase models of grief, which collectively formed the foundation of what was later termed the *grief work hypothesis* (GWH): the belief that successful resolution of grief can only come through actively experiencing and processing, rather than avoiding or suppressing, the intense emotional distress of a loss.

Beginning in the 1980s and 1990s, many of the assumptions embedded in the GWH began to be challenged on the basis of a lack of empirical support. In fact, this first wave of significant grief research failed to support the assumptions of existing stage models (Costa et al., 2007). This led to a shift away from stage models and toward task models, such as that of Worden (2009), in which the griever must move between and accomplish tasks of healing. Task models were

seen as less narrow, less linear, and better able to accommodate differences in individuals' approaches to grief—based on age, gender, culture, loss history, and many other factors (Jeffreys, 2011)—and therefore less likely to inappropriately pathologize individual approaches to grief. Both culture and gender research from this period identified and cautioned against what Sue and Sue (2008) termed *affective bias*—the tendency of mental health professionals to emphasize and privilege affective expression, thereby alienating clients whose value systems may be different. Research on the efficacy of grief counseling also proliferated during this period, generally concluding that for clients in high distress, whose grief was not self-resolving, counseling interventions were often helpful.

The hole created by the empirical challenges to the GWH served as both gap and opportunity. Researchers noted the need for an integrative conceptualization of grief, leading to the third paradigm, individual differences and adaptation. The concepts of disenfranchised grief (Doka, 1989) and adaptive grieving styles (Martin & Doka, 2000) emerged during this period, but neither concept yet has a substantial body of research to support and illuminate it. In this most recent paradigm, many researchers and practitioners alike struggle to balance making room for differences in grieving with knowing what may be outside the realm of "normal" and should cause concern.

Additionally, there seems to be a growing disconnect between research and practice, in that while our empirical understanding has moved beyond Kubler-Ross's five stages and the GWH, much education, practice, and popular

understanding has not. There is real concern that this gap may lead to ineffective practices in grief counseling, and potentially to clients experiencing disenfranchisement in the counseling process. "Grief-related beliefs held by both a bereaved individual and a potential support provider may impact how an individual's grief process is appraised, as well as the willingness of support network members to provide effective support" (Costa et al., 2007, p. 53). Part of the work to be done in this new paradigm is examining how outdated beliefs may be impacting the effectiveness of grief support, and what is needed to update and improve the support being given to those in need.

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CHAPTER 3

PRESERVICE COUNSELORS' INITIAL PERCEPTIONS OF CLIENT GRIEF STYLE: AN ANALOGUE STUDY

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Abstract

Grief—the reaction to a significant loss—is a near-universal human experience, from which a subset of people have difficulty recovering. The objective of this study was to determine the influence of client grief style (intuitive or instrumental) on initial preservice counselor perceptions of the client. This study utilized an analogue design to test three hypotheses: (a) that counselors may initially rate the global functioning of clients with an intuitive grief style as higher than that of clients with an instrumental grief style; (b) that counselors may rate their initial expectations about the therapeutic bond with intuitive grievers higher than their initial expectations about the therapeutic bond with instrumental grievers; and (c) that counselors will be more likely to apply the technique of emotional catharsis with clients who have an instrumental grieving style, even though this technique may be contraindicated for this group.

Ninety-nine second-year students in CACREP-accredited master's of counseling programs in Oregon and Washington completed rating scales to test these three hypotheses. Results supported the second hypothesis but did not support the first and third; however, for the first and third hypotheses, significant differences were found in the opposite direction. Of particular clinical significance was the fact that 66% of participants reported they would encourage emotional catharsis "often," "very often," or "always" in treatment with instrumental grievers, suggesting that there may be a need for further counselor

training regarding best practices and appropriate interventions for use with this client group.

Keywords: grief style, intuitive and instrumental grief, grief counseling, counselor education

Preservice Counselors' Initial Perceptions of Client Grief Style: An Analogue Study

Grief—the reaction to a significant loss—is a near-universal human experience, which may impact grievers in the emotional, physical, cognitive, behavioral, and spiritual domains (Worden, 2009). Research suggests that the majority of individuals recover with no need for intervention and can positively reengage in life (Boerner, Wortman, & Bonnano, 2005; Parkes, 1971). However, a significant subset (10%–15%) of those who experience grief struggle greatly with functioning for much longer periods in the wake of a loss and thus are at risk for health, mental health, or behavioral problems (Marks, Jun, & Song, 2007). For those showing substantial distress, counseling has been shown to be an effective intervention (Boerner et al., 2005; Parkes, 1971). Counselors and other mental health professionals must therefore be prepared to provide effective assistance to these individuals.

Over the last two decades, there has been a profound shift in our understanding of grief and the best ways to support those who are struggling with it. The field has wrestled with the tension between a desire to establish guidelines for "normal" and "pathological" grieving and the unavoidable risks these guidelines bring of disenfranchising individual and cultural differences (Maples, 1998). Increasingly, research has moved further away from universal stage or task models of grief and from what has been called the "grief work hypothesis" toward an understanding that there may be many legitimate ways, or styles, of grieving (Martin & Doka, 2000). Studies have also helped us to

recognize the importance of social support in grief and the damage that can be done when a person's loss or process is disenfranchised and support is therefore not present (Vachon & Stylianos, 1988). As counselors, we are most likely to be sought out by those who are unable to find the support they need in their social environments; therefore, no matter what grieving style a client may have, it is critical that s/he not experience disenfranchisement in the counseling relationship as well.

There is little research on the concept of disenfranchised grief, and even less on grieving styles. Studies have shown that in spite of our new conceptualizations of grief, assumptions about grieving and grief counseling based on old paradigms and models still predominate, both in the general population and among mental health professionals (Costa, Hall, & Stewart, 2007; Kohler, 2011; Konigsberg, 2011; Rando, 1992). Most counselors have not been trained in the new paradigms (e.g., the existence of more than one grieving style) as part of their counseling education. We do not know how this may affect counselors' perceptions of their clients, and what assumptions, judgments, and biases might result, thereby potentially affecting the counseling relationship and treatment outcomes. Based on Sue and Sue's conceptualization of an affective bias among mental health professionals (Sue & Sue, 2008), we predicted that counselors would show evidence of some bias favoring clients with intuitive grieving styles, and against clients with instrumental grieving styles, on measures of both client functioning and therapeutic bonding. Second, we predicted that

counselors would be more likely to apply counseling techniques focused on emotional catharsis to clients with instrumental grieving styles, which are contraindicated with this group.

The present study was designed to examine three hypotheses. In alternative hypothesis form, these hypotheses are as follows: (a) H_1: Counselors will rate the global functioning of intuitive grievers higher than the global functioning of instrumental grievers; (b) H_1: Counselors will rate their expectations of the therapeutic bond with intuitive grievers higher than their expectations of the therapeutic bond with instrumental grievers; and (c) H_1: Counselors will be more likely to apply the technique of emotional catharsis with clients who have an instrumental grieving style.

Methods

Research Design

This quantitative study used an analogue design and correlational analysis to determine whether client grief style influenced a counselor's initial perceptions of the client and clinically related judgments. Subjects viewed videotaped segments of three separate initial counseling interviews focused on grief scenarios (bereavement, divorce, and pregnancy loss); each classroom group of participants viewed one version (either intuitive or instrumental) of each of the three grief scenarios. The independent variable was the client's adaptive grieving style (intuitive or instrumental); the dependent variables were the subjects' perceptions and clinical judgments and ratings of the client.

Participants

Subjects were second-year students in CACREP-accredited master's of counseling programs; all such programs in Oregon and Washington were initially invited to participate (n = 11). The names of professors teaching fall term sections of internship and second-year research classes were solicited through academic contacts in each program. In programs that separate mental health and school counseling internship students, only professors of mental health sections were solicited. These professors were then contacted via email and follow-up phone calls to request that they allow their class(es) to participate in the study. Some schools declined to participate; others did not offer the targeted courses during the fall term. The six schools that agreed to participate included Oregon State University, Southern Oregon University, Portland State University, George Fox University, Eastern Washington University, and Gonzaga University. Professors at these schools selected a class date on which the research would be conducted. Data collectors were selected in these geographical areas, and all were trained on the study protocol and materials.

In five of the six schools, the research was conducted during class time; therefore, students did receive a form of course credit (class attendance) for their participation. However, they were advised that they could opt out of taking part in the study if they wished, or discontinue their participation at any time without prejudice. The sixth school held a voluntary data collection session outside of class time. Each participating class was shown three videotapes and asked to fill

out measures following the viewing of each tape. Data was collected from all who participated, a total of 99 students.

Of the 99 participants, 46 participants identified as being aged 18–29, 30 identified as 30–39, 13 identified as 40–49, and 10 identified as 50 or older. Seventy-seven were female and 21 were male, with one participant identifying gender as "other." Eighty-four identified as Caucasian/Non-Hispanic, 10 as a Person of Color, and 5 as being of 2 or more races. All students were second-year students enrolled in an internship or research class at their CACREP-accredited master's of counseling programs.

Participants were also asked to estimate the number of hours of training they had received in- and outside of their master's programs, as well as how many additional hours they anticipated receiving prior to program completion. In their programs, 32 reported receiving no training in grief counseling, 53 reported receiving 1–10 hours of training, and 14 reported 11 or more hours. Outside of their programs, 44 participants had had no training in grief counseling, 36 had had 1–10 hours, and 19 had had 11 or more hours. Fifty-three participants did not anticipate having any additional training prior to graduation, while 46 anticipated having some additional hours.

Question J on the personal information form asked participants, "Are you familiar with Martin and Doka's model of Adaptive Grieving Styles?" If they answered yes, they were asked to identify how they had learned about this topic. This item was included in the questionnaire in the hopes of being able to test

whether knowledge of grieving styles mitigated any differences in counselor perceptions of the two styles. However, only 7 participants out of 99 indicated having knowledge of grief styles, and one of the 7 respondents marked "yes" but wrote in Kubler-Ross's five stages (denial, anger, bargaining, depression, and acceptance). Of the remaining six who indicated awareness of grief styles, five reported that they had not gotten this information in their counselor training programs but through bereavement volunteer work and/or individual pursuit of information related to their own grief experiences.

Measures

Following each videotape, subjects completed measures related to the research hypotheses. Specifically, participants completed (a) a Global Assessment of Functioning (GAF) rating scale, (b) the Bond scale from the Working Alliance Inventory–Short Revised (WAI–SR) (Hatcher & Gillaspy, 2006), and (c) a question concerning use of emotional catharsis.

The GAF is a numeric scale, presented and described in the DSM–IV–TR (p. 34). This scale is used by health and mental health professionals to rate the social, occupational, and psychological functioning of adults. A single numerical score is given on a 0 to 100 scale, with brief anchors at 10-point intervals; higher scores indicate better functioning. The GAF is used extensively and routinely across clinical practice settings and is taught in all accredited graduate mental health programs. The U.S. Veterans Benefits Administration uses the scale to determine appropriate levels of disability compensation to be paid to veterans

who suffer from psychiatric disorders connected to their service. A study by Moos, Nichol, and Moos (2002) found significant relationships between GAF and other measures of current symptoms and functioning. In 2005, Greenberg and Rosenheck evaluated the GAF for use as an outcome measure for large mental health care systems; their analysis supported the discriminant validity of the GAF and found that overall, the GAF had high internal consistency (standardized alpha of 0.85) in addition to being highly consistent across facilities over time.

Participants also completed the Bond scale of the WAI–SR (Hatcher & Gillaspy, 2006). The WAI–SR has been shown by confirmatory factor analysis to represent alliance dimensions more clearly than the WAI and the WAI–S (Hatcher & Gillaspy, 2006). The scale was also tested by Munder and colleagues in 2010; their study found good reliability ($\alpha > 0.80$) and good convergent validity ($r > 0.64$) with Luborsky's 1976 Helping Alliance Questionnaire (Munder, Wilmers, Leonhart, Linster, & Barth, 2010). Since participants were being asked to answer these questions by projecting (e.g., basing answers on their predictions as opposed to actual work with the client), the wording of two of the four items was altered. For example, the item, "I believe _____ likes me" was altered to read, "I believe this client would like me."

The likely use of emotional catharsis as an intervention was assessed by use of the item, "I would be likely to encourage emotional catharsis (emotional experiencing, expression and release) for this client in counseling." Participants

rated this question using a seven-point Likert scale with the following anchors: 1=*never*; 2=*rarely*; 3=*occasionally*; 4=*sometimes*; 5=*often*; 6=*very often*; 7=*always*.

Materials

Videotapes. Arroyo (1989) noted that the basic analogue research design has generally involved the use of written clinical vignettes and that this design has been criticized for being insufficiently realistic and devoid of clinical and contextual nuance. Her study aimed to demonstrate that the use of videotape could profoundly enrich the analogue design, since participants are able to experience a client in a much more nuanced and holistic way. This ability to present not only a client's words, but also her voice, body language, and affective expression, seemed critical to illustrating grief style effectively.

Clinical interview vignettes were presented in videotape format. Each of the analogue vignettes was approximately four minutes long and depicted the beginning of an initial counseling interview with a client focused on one of three grief scenarios (death, divorce, or miscarriage). Each of the three scenarios had both an intuitive version (INT) and an instrumental (INS) version, for a total of six analogue vignettes. Each participating classroom viewed one version (INT or INS) of each of the three scenarios for a total of three analogue videos per classroom. The order of the three videotape scenarios (death, divorce, and miscarriage) shown to each class was randomized. Which version (INT or INS) of each of the three grief scenarios was shown to each class was also randomized, while controlling to ensure that all versions were shown an approximately equal

number of times. The randomization process was conducted using the website www.random.org. Differences in class size resulted in uneven numbers of subjects per sequence and version condition.

The scripts for the six videotapes were written by the study author, based on Martin and Doka's research and writings on grief style, as well as a review of the grief counseling literature and 15 years of grief counseling experience. Scripts were reviewed by a professional screenwriter for dialogue authenticity and by Dr. Ken Doka for accuracy of grief style language and content.

Scripts were created for three different common grief scenarios: bereavement, divorce, and pregnancy loss. To minimize variables, all scenarios portrayed Caucasian female clients, though client age varied (24, 36, and 52 years). For each scenario, two different scripts (INT and INS) were created. While the facts of the characters and scenarios remained the same, the dialogue was designed so that the intuitive grief style would be portrayed in one script and the instrumental grief style would be portrayed in the other.

Three professional actors were hired through a posted audition process, one for each grief scenario. Their ages were 26, 41 and 49; all three were Caucasian women. The actors practiced their scenarios over the course of six weeks, including one group rehearsal with the study author, during which the concept of adaptive grieving styles and the differences between intuitive and instrumental grievers were explained and discussed. Outside of the variation in dialogue, language, and affect related to grief style, auxiliary factors such as dress,

appearance, and basic character portrayal were kept as consistent as possible across grief style versions. Having the same actors portray both versions of each scenario is an example of the "same person matched guise technique," which minimizes variance based in real differences of speech, voice, personality, or physical appearance of clients in the tapes (Arroyo, 1989). Videotapes were shot on the same day to further minimize unintended variation. In addition to memorization, a teleprompter system was used during filming to ensure that actors performed the scripts exactly as written. Tapes were scrutinized and found to have no noticeable differences outside of the dialogue, though minute variations not apparent in these observations might be present.

A professional film production team produced the videotapes. Technical aspects of the filming (e.g., background, lighting, equipment, and sound) were held constant to optimize internal validity. Other features such as dialogue, setting, and acting were not only standardized, but also designed to closely approximate a genuine clinical situation in order to enhance realism and external validity.

Equipment. Video vignettes were duplicated onto DVDs. Each of the six vignettes was assigned a letter (A through F); names of the grief situations and styles portrayed were not indicated in the titles or the DVD menus. Professors who agreed to have their classes participate confirmed that they had access in their classroom to appropriate projection equipment. Once randomization of video sequencing had been accomplished, one DVD was created for each

participating class. To guard against error, each DVD contained only the three vignettes to be shown in that class, listed on the DVD menu in the order in which they were to be shown. Data collectors verified via proctor form which vignettes they had shown in each class and in what order.

To ensure that participants were able to see nuances of the vignettes, the study protocol indicated that videos must be shown in a self-contained classroom setting, with the door closed, on screens with a diagonal measurement of at least 71 inches (a standard classroom size). It required that professors lower window shades if possible and turn off overhead lights during video viewing (turning the lights back on in between viewings for participants to fill out questionnaires).

The protocol also required that professors begin this portion of their class at a time that ensured that students would have plenty of time to view all three tapes and complete all of the measures, with no classroom breaks occurring during this period. If students arrived after the study introduction or left before the data collection was completed, they could not be included as participants.

Procedures

Study packets mailed to data collectors included (a) a hard copy of the study protocol, including the DVD specific to each class; (b) a sufficient number of materials packets for that class, printed and collated by the study author to ensure uniformity; (c) a proctor checklist for the data collector to fill out regarding research administration (e.g., whether the protocol was followed and written confirmation of which three videotapes were shown and in what order);

(d) a set of envelopes for students to self-address if they wished to receive a summary of the findings; and (e) a pre-addressed envelope for completed materials to be returned to the researcher. As outlined in the study protocol, participants viewed tapes in classroom groups, during class time, in a single data collection session. Data collection sessions occurred at the six schools over a total period of seven weeks during the fall term of 2012. The purpose of the study was described in the informed consent letter (which comprised the first two pages of the questionnaire packets) as "gaining knowledge about counseling clients dealing with loss and grief." In the letter, students were advised about informed consent and instructed not to discuss their experience with classmates until the presentations at their particular program had been completed.

Data collectors distributed the questionnaire packets to participants and monitored them during video viewing and data collection. The average time taken to view the three vignettes and complete all questionnaires was 35 minutes. Students were given the option of being debriefed by mail upon study completion; they were asked to self-address envelopes if they wished to receive a final report.

Data Analysis Procedures

Data for all three hypotheses was analyzed using simple correlation analysis (*t*-tests). While the author chose to specify directionality on all three hypotheses based on what the literature suggested was more likely, correlation was tested bi-directionally, using two-tailed *t*-tests, to ensure that significant

differences in the opposite direction would not be overlooked. Hypothesis 1 relied upon GAF scores; Hypothesis 2 used the mean of responses from the four WAI–SR Bond scale items; and Hypothesis 3 used the emotional catharsis question scores. Analysis of variance (ANOVA) was also used to examine whether video sequencing was a confounding factor. For all analyses, the level of statistical significance was defined as $p \leq .05$ (two-tailed). Microsoft Excel was used to conduct statistical analyses. One participant chose not to give responses on several Bond subscale items; these cells were left blank.

Results

Data was collected and analyzed to explore three hypotheses: (1) Counselors will rate the global functioning of intuitive grievers higher than the global functioning of instrumental grievers; (2) Counselors will rate their expectations of the therapeutic bond with intuitive grievers higher than their expectations of the therapeutic bond with instrumental grievers; and (3) Counselors will be more likely to apply the technique of emotional catharsis with clients who have an instrumental grieving style. Results for each hypothesis will be examined below.

Hypothesis 1

Data did not support the first hypothesis, that counselors would rate the global functioning of intuitive grievers higher than the global functioning of instrumental grievers; in fact, a significant difference was found in the other direction ($z = -7.534$; $p < .001$). In combined video viewings, the average GAF

was significantly higher for the instrumental grief style (M = 70) than for the intuitive (M = 62). The GAF is a 100-point scale; scores between 61 and 70 are defined as indicating that a client has "some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships" (DSM–IV, 2000, p. 32). Means for both grief styles in this study fell into this range of mild impairment: the intuitive group on the lower end of the range and the instrumental group on the higher end.

Because participants viewed three videos, an ANOVA test was performed to identify any possible confounding effects of the temporal order of video viewing (i.e., first, second, or third). The ANOVA test for different means between the three video viewings showed a statistically significant difference (F = 8.125; p = .0004). The mean GAF for the second video viewing was slightly higher than for the first and third viewings (an average of 69 for the second, as opposed to 63 for the first and 65 for the third), regardless of grief scenario or grief style.

Hypothesis 2

The second hypothesis, that counselors would rate their expectations of the therapeutic bond with intuitive grievers higher than their expectations of the therapeutic bond with instrumental grievers, was supported. The four items of the bond scale were averaged and then compared. Intuitive clients had a mean of 5.63, and instrumental clients had a mean of 5.16 (z =5.726; $p < .001$). These

questions were comprised of positive statements about the anticipated therapeutic bond, on a scale where 5 represented "often," and 6 represented "very often." Means falling between 5 and 6 suggest that counselors anticipated a positive bond with both intuitive and instrumental grievers, though slightly more positive with intuitive grievers.

Again, an ANOVA test was performed to identify any possible confounding effects of temporal order of video viewing. The ANOVA test for different means between the three video viewings showed a statistically significant difference ($F = 92.339$; $p < .001$). The mean Bond scale score for the second video viewing was lower, regardless of grief scenario or grief style, than composite scores for the first and third video viewings.

Hypothesis 3

The third hypothesis, that counselors would apply the technique of emotional catharsis more to clients with an instrumental grieving style, was not confirmed; the data showed the opposite to be true ($z = 3.701$; $p < .001$). Over combined video viewings, the average likelihood of counselors encouraging emotional catharsis in counseling was higher for the intuitive clients (M = 5.6) than for the instrumental clients (M = 5.0). Both means fell between scores of 5 and 6 on the scale, where 5 indicated "often," and 6 indicated "very often," suggesting that counselors would be likely to encourage emotional catharsis with both grief styles, though slightly more often with intuitive grievers.

An ANOVA test was performed once again to identify any possible confounding effects of the temporal order of video viewing. The ANOVA test for different means between the three video viewings showed a statistically significant difference ($F = 3.193$; $p = .0425$). The mean score on the catharsis item for the second video viewing was lower, regardless of grief scenario or grief style, than scores for the first and third video viewings.

Discussion

The findings regarding counselors' perceptions of client functioning, anticipated therapeutic bond, and the likelihood of encouraging emotional catharsis in treatment will each be discussed in turn. This section will also address the clinical significance of the findings.

Hypothesis 1

In regards to the first hypothesis, the average GAF was 8.1 points higher (on a rating scale from 1 to 100) for the instrumental grief style than for the intuitive**.** Our initial hypothesis, that participants would rate intuitive grievers as more functional, was based on the precepts of the grief work hypothesis, which asserts that a lack of emotional expression in grief may indicate a problem. Instead, it appears as though this group of counselors saw intuitive grievers as slightly more impaired in functioning and perhaps more needy. Even though the vignettes were carefully written to indicate that both intuitive and instrumental grievers were still able to complete activities of daily living in spite of the challenges posed by their grief, participants seemed to equate emotional distress

and expression with a lower degree of functionality. In spite of the statistical significance of this finding, it should be noted that means for both grief styles in this study fell into this range of mild impairment: the intuitive group on the lower end of the range and the instrumental group on the higher end. This may indicate a lower clinical significance; participants viewed the functionality of both grief style groups as being mildly impaired.

Hypothesis 2

The second hypothesis targeted the counselor's expectation of his or her potential bond with the client (items, adapted from the WAI–SR, included "I believe this client would like me," "I am confident in my ability to help this client," "I appreciate this client as a person," and "This client and I could build a mutual trust"). Participants rated their expectations of the therapeutic bond with intuitive grievers higher than their expectations of the therapeutic bond with instrumental grievers, which was in line with our hypothesis. This may support the existence of some level of "affective bias" (Sue & Sue, 2008) among mental health practitioners. However, in terms of clinical significance, it should once again be noted that these questions were comprised of positive statements about the anticipated therapeutic bond on a scale where 5 represented "often," and 6 represented "very often"; both group means falling between 5 and 6 suggests that counselors anticipated a positive bond with both intuitive and instrumental grievers, though slightly more positive with intuitive grievers.

Hypothesis 3

Findings for Hypothesis 3 were mixed: on the positive side, counselors in this sample reported being less likely to encourage emotional catharsis with instrumental grievers, for whom those techniques may be contraindicated. However, the mean response (5.0 for instrumental grievers as opposed to 5.6 for intuitive grievers, where 5 indicated "often") still indicate that counselors would be very likely to use these techniques, suggesting a potential need for further training regarding best practices with instrumental grievers. In fact, 66% of participants, when responding to instrumental vignettes, gave scores of 5, 6, or 7 ("often," "very often," and "always") when asked about the likelihood that they would encourage emotional catharsis in treatment.

This is perhaps the most clinically significant finding of the study. It suggests that instrumental grievers are still likely to be treated in therapy with interventions that may be inappropriate. This may be due to the lack of awareness of different grief styles (only 6% of participants in this study had such knowledge). It may also be due to a more general lack of fit between the clinical tools with which most counselors are equipped and the processing style and support needs of the instrumental griever. If much of counselor education and supervision is weighted heavily toward encouraging emotional catharsis, then the high likelihood of utilization may simply be an illustration of the proverb, "If the only tool you have is a hammer, then everything you encounter is going to be treated as a nail." Some counselors may find themselves at a loss when

confronted with clients who process more cognitively than emotionally and may feel less knowledgeable about, or equipped to provide, interventions appropriate to this group.

In sum, the findings from all three hypotheses seem to indicate that participants saw instrumental grievers as slightly higher functioning than intuitive grievers, but saw both as falling in the "mildly impaired" range; that participants felt slightly less positive about their ability to form a working alliance with instrumental grievers, but that overall they anticipated positive bonds with both groups; and that, while participants would be less likely to encourage emotional catharsis with instrumental clients in treatment, they would still be very likely to do so. The findings of this study seem to suggest that there is a need to equip counselors with interventions and tools more useful for instrumental grievers in order to ensure that the needs of this group can be met in therapeutic settings.

Limitations

ANOVA tests suggest that temporal order of video viewing, regardless of grief scenario or style, was a confounding variable for each of the three hypotheses. Results indicate that the temporal order in which participants viewed video vignettes was a relevant factor in scoring. Any future studies attempting to replicate this design may want to explore ways, via design or analysis changes, to reduce or control for this confound.

Limitations also exist in regards to the generalizability of these results. The participant group was comprised of second-year students in CACREP-accredited master's in counseling programs in Oregon and Washington; conducting the same study with different student or practitioner populations might yield different results. Additionally, very few participants came into the study with an awareness of the existence of grief styles; practitioners with this knowledge might perceive these vignettes differently. Finally, to limit the number of variables, the clients portrayed in the vignettes were all Caucasian females, and results must be interpreted accordingly. Whether grief styles would be perceived in the same way across vignettes portraying more diverse clients is a question for future research to explore.

Implications for Practitioners

Study findings suggest implications for practitioners in the realms of both counselor education and clinical practice. Counseling programs and educators should note that, in spite of the increasing call for practitioners to be familiar with current research and models, current preservice counselors appear to be lacking this knowledge. Out of 99 participants, only six reported awareness of the existence of different grief styles, and most of those six had obtained this knowledge not as part of their counseling education, but through their own therapy or life experience. Given the strong likelihood that all counselors, regardless of practice setting, will be called upon to support clients struggling with grief and loss, programs must ensure they are adequately prepared to do so.

This need for a familiarity with current information applies to current counseling practitioners as well. Many current professionals completed their education prior to the emergence of the more-recent research and newer conceptualizations, and are therefore in need of training to ensure effective grief counseling practice. The results for Hypothesis 3 serve as a good illustration of this need, and may also carry the most important implications for clinical practitioners. Analysis of the data indicates that counselors would often encourage emotional catharsis with instrumental grievers, for whom those techniques may be contraindicated. In fact, 66% of respondents indicated they would often, very often, or always encourage emotional catharsis for instrumental grievers. However,

> instrumental grievers . . . often find grief counseling, with its strong bias toward affective ventilation, of limited value. In fact, many instrumental grievers may perceive it as threatening, for their own approaches, strengths and strategies are discounted. . . [Affective ventilation strategies] concentrate instead on addressing what is perceived as their glaring weakness—the lack of strong affect. (Doka & Martin, 2010, p. 157)

Whether counselors' apparent likelihood to employ strategies which may be unhelpful (or even harmful) stems from a misunderstanding of the needs of instrumental grievers or from a lack of more appropriate strategy options is not clear; however, in either case, these findings suggest that there may be a need for further training regarding best practices and appropriate interventions for use with this client population.

Implications for Researchers

At present, there is very little research of any kind regarding how counselors may perceive and work with clients who have different grief styles. Replication of these results may tell us more, particularly given the confounding variables that emerged in this study. Deepening our understanding in these areas will require expansion into different populations of participants as well as portrayals of more diverse clients. The need to minimize variables in this study demanded that analogue clients be of the same race and gender, but it would be quite interesting to know more about how grief styles are perceived in the context of varying gender and race. Finally, while this study intended to examine whether or not knowledge of grief styles mitigated differences in perception and clinical judgments, there were too few participants who had this knowledge to test the question. Future studies with larger samples and/or samples of counselors who are aware of grief styles may be able to tell us more about whether knowledge does in fact make a difference.

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CHAPTER 4

GENERAL CONCLUSION

This dissertation included two linked manuscripts thematically examining how preservice counselors' initial perceptions of clients may differ based on the clients' grief style. A review of the psychotherapeutic literature traced the shift in the field's understanding of grief and the best ways to support those who are struggling with grief. Increasingly, research has moved further away from universal stage or task models of grief and what has been called the grief work hypothesis toward an understanding that there may be multiple legitimate ways, or styles, of grieving. The paradigm supported by the research of the past few decades is one that suggests that grief is an adaptive process characterized by individual responses influenced by culture, gender, age, and other individual differences, including the specifics of the loss (Jeffreys, 2011).

In 2000, Martin and Doka proposed a continuum of grieving styles, with "intuitive grieving" at one end, "instrumental grieving" at the other, and a "blended" style in the middle. The intuitive grief style is characterized by an emotional focus; inner distress is shown outwardly, and intense emotional experience and expression are typical. These grievers need supportive places to express their distress, which at times may feel overwhelming. The instrumental grief style is characterized by a cognitive and/or action-oriented focus; emotional experience and expression are more modulated and private, and energy is channeled into analysis, problem solving/mastery, organization, and activities.

However, in spite of our new conceptualizations of grief, assumptions about grieving and grief counseling based on old paradigms and models still predominate, both in the general population and among mental health professionals (Costa, Hall, & Stewart, 2007; Kohler, 2011; Konigsberg, 2011).

The literature review also asserted that a subset of grievers (10%–15%) has difficulty recovering, placing them at high risk for negative health and mental health outcomes (Marks, Jun, & Song, 2007). For those showing substantial distress, counseling has been shown to be an effective intervention (Boerner, Wortman, & Bonnano, 2005; Parkes, 1971). It is therefore critical that counseling professionals are equipped to provide effective assistance to this group. Both of these manuscripts focused on the clinical conceptualization of grief (both normal and pathological) and what constitutes effective practice in grief counseling, including the constructs of adaptive grieving styles, potential therapist bias based on client style, and possible differences in the likelihood of applying emotional catharsis techniques in counseling.

As Shapiro noted (2005), "[Current research] has suggested that one-size-fits-all approaches to 'grief work' mandating exploration of distressing feelings can intensify distress for a significant number of mourners" (p. 262). Most counselors have not been trained in the new paradigms (e.g., the existence of more than one grieving style) as part of their counseling education. However, mental health professionals who are not aware of the current research on grief may not be well equipped to provide effective assistance (Rando, 1992). In

particular, “instrumental grief styles are often viewed negatively within counseling, self-help, and grieving literature” (Doka & Martin, 2010, p. 5). We know that counseling outcomes can be affected by perceptions and biases that counselors have toward clients (Luborsky, Auerbach, Chandler, Cohen, & Bachrach, 1971); however, we do not know whether a counselor’s perception of a client at the start of treatment is affected by the client’s grief style.

This study employed an analogue design. Three professional actors were used to create videotapes of three different grief scenarios (bereavement, divorce, and pregnancy loss), with each actor portraying both an intuitive and an instrumental version of each scenario. The client’s grief style was manipulated by alterations in language and affective presentation in a three-by-two design that held the facts of the clinical scenarios, as well as all other aspects of the videotapes, constant. One version of each of the three scenarios (three video clips in all) was shown to a total of 99 internship students in six CACREP-accredited master’s in counseling programs. Subjects completed rating scales that tested three hypotheses: (a) that counselors would rate the global functioning of clients with an intuitive grief style (Martin & Doka, 2000) higher than that of clients with an instrumental grief style; (b) that counselors would rate their initial expectations about the therapeutic bond with intuitive grievers higher than their initial expectations about the therapeutic bond with instrumental grievers; and (c) that counselors would be more likely to apply the

technique of emotional catharsis with clients who have an instrumental grieving style, even though this technique may be contraindicated for this group.

Using correlational analysis, significant differences were found between the two styles for all three hypotheses. Results supported the second hypothesis but did not support the first and third; however, for the first and third hypotheses, significant differences were found in the opposite direction. Of particular clinical significance was the fact that 66% of participants reported that they would encourage emotional catharsis often, very often, or always in treatment with instrumental grievers, suggesting that there may be a need for further counselor training regarding best practices and appropriate interventions for use with this client group.

The literature and implications presented in these manuscripts are relevant for counseling, but also extend beyond the realm of counseling. They may also have relevance for related disciplines, including counselor education, psychology, social work, psychiatry, nursing and medical practice, as well as any others that assist people struggling to cope with loss and grief. If counseling practitioners are to be prepared to effectively assist a range of clients with grief, they must continue to build their knowledge about current conceptualizations of grief and what therapeutic approaches are most appropriate with different client groups.

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APPENDICES

Appendix A

Grief Counseling Study Protocol

Thank you for assisting with data collection for this dissertation research!

Data is to be collected during a meeting of your Internship class. Please ensure that:

- The class is meeting in a self-contained classroom with the door closed
- The research portion of the class is started with plenty of class time remaining to complete the data collection
- There are no breaks given during the research portion of class
- Videos are shown on a screen measuring at least 71" diagonally
- If any students arrive late, or need to leave early, they are welcome to watch the videotapes but should not participate in data collection.

1. Please hand out one research packet to each student. Ask students to read the informed consent letter (pages 1–2). If any students elect not to participate, they may remain in the room if they wish.

2. Turn off overhead lights; if classroom has windows, please cover them if possible.

3. Play Video #1.

4. Turn on overhead lights and ask students to complete Questionnaire #1. Give all students sufficient time to finish.

5. Turn off overhead lights and play Video #2.

6. Turn on overhead lights and ask students to complete Questionnaire #2. Give all students sufficient time to finish.

7. Turn off overhead lights and play Video #3.

8. Turn on overhead lights and ask students to complete Questionnaire #3 and Personal Information Form. Give all students sufficient time to finish.

9. Collect all research packets.

10. Distribute envelopes to any students who would like to receive results summary; collect these when students have finished self-addressing them.

11. Complete Proctor Form. Place completed research packets, Proctor Form, and self-addressed envelopes in the manila return envelope. Please return to researcher at your earliest convenience.

Appendix B

Grief Counseling Research Proctor Form

Your name: _____
Institution: _____ Date implemented: _____
Number of students present in class: _____

Protocol Checklist

_____ The class met in a self-contained classroom with the door closed.
_____ There were no breaks given during the research portion of class.
_____ Videos were shown on a screen with a diagonal measure of at least 71", with the room darkened for viewing.
_____ Students were given packets and asked to read informed consent (pp 1-2).

Please confirm which videos were shown, and in what order, by writing the video numbers below:

1. _____
2. _____
3. _____

_____ One Questionnaire was completed after each video; the Personal Information Form was completed last.
_____ Envelopes were distributed to students who wished to receive a results summary and were collected again after students self-addressed them.
_____ Completed research packets, completed Proctor Form, and self-addressed envelopes were placed in the manila return envelope.

Please note any circumstances or difficulties which resulted in deviations from the study protocol: _____
_____
_____
_____
_____

Please feel free to share any feedback for the researchers about the design, protocol, or implementation of this study: _____
_____
_____
_____

By signing below, I attest that I served as proctor during the implementation of this study protocol, that the protocol was followed carefully, and that any exceptions to or deviations from the protocol have been noted above.

_____ _____

Signature Date

Appendix C

Informed Consent Letter

Dear Participant,

This is a request for your agreement to participate in a research project being conducted by Catherine Beckett, Doctoral student at OSU, and Cass Dykeman, Associate Professor of Counseling at OSU. The purpose of the study is to gain knowledge about counseling clients dealing with loss and grief. Participants in the study are all graduate students in counseling over the age of 18. The procedures entail viewing three short videotapes of mock initial counseling sessions, featuring actresses who have been employed to play the roles of clients in these vignettes, and completing GAF ratings and short questionnaires about your perceptions, as well as a demographic form. The procedure will take approximately 30 minutes.

We know that, as counseling students, you may not feel familiar with all of the issues presented in the tapes; we only ask that you share your perceptions as honestly as you can. We also ask that you answer the questions in the order in which they are presented and not look ahead. Please do not discuss your perceptions or your answers with anyone in your class until this session has concluded. Also, please do not discuss your perceptions or your answers with other students in your program outside of your class, as this may affect their participation.

This study seeks to improve both counseling services for grieving clients, as well as counselor education in grief counseling, and thus could benefit all students in counseling programs, as well as improving services provided to clients. The risk of participation in this study involves the potential for minor psychological discomfort related to experiences of grief and loss presented in the analogue videos. Should you find yourself experiencing any psychological discomfort during or after your participation, please contact this national 24-hour hotline for support and appropriate referral: 1-800-273-TALK.

The decision to participate in this study is completely voluntary, and you are free to withdraw from the study at any time, without jeopardizing your relationship with your graduate program or affecting your grade in class. Your responses will be completely anonymous. You may skip any question you do not wish to answer. No individual results will be reported; any data you provide will have no link to your identity. There is no financial or extra credit compensation for your participation. Your completion of the questionnaires will constitute your informed consent to participate in this study.

If you would like to hear more details about the research when this project is over, please ask the session facilitator for an envelope; self-address the envelope and leave it with him or her. We will be happy to send you a brief summary of our findings once the study has been completed. If you do request a summary, your identity will remain strictly confidential, and it will in no way be matched to the information you provide today.

If you have questions about your rights of welfare as a participant, please contact the Oregon State University Institutional Review Board (IRB) Office at 541-737-8008, or by email at IRB@oregonstate.edu. If you have any questions or concerns specifically about this unfunded research project, please contact Principal Investigator Cass Dykeman at dykemanc@onid.orst.edu.

Sincerely,

Catherine Beckett, LCSW

Cass Dykeman, PhD

Appendix D

Global Assessment of Functioning Scale

The following is a link to the Global Assessment of Functioning scale used in the study:

https://www.msu.edu/course/sw/840/stocks/pack/axisv.pdf

Appendix E

Counselor Perceptions Questionnaire

Circle the number you believe to be the most accurate response.

Question	**Rating *(circle one)***						
1. I believe this client would like me.	1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
2. I am confident in my ability to help this client.	1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
3. I appreciate this client as a person.	1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
4. This client and I could build a mutual trust.	1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
5. I would be likely to encourage emotional catharsis (emotional experiencing, expression and release) for this client in counseling.	1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always

Appendix F

Personal Information Form

Circle the number you believe to be the most accurate response.

#	Item	Response *(circle one)*
A	Your Gender	1=Female 2=Male 3=Other
B	Your Race/Ethnicity	1=American Indian/Alaska Native 2=Asian, Black/African American 3=Hispanic/Latino 4=Native Hawaiian/Pacific Islander 5=White/Non-Hispanic 6=Two or More Races 7=Other/Unknown
C	Your Program	1=OSU Cascades 4=George Fox 2=PSU 5=Gonzaga 3=SOU 6=EWU
D	Your Age Range	1=Aged 18–29 2=Aged 30–39 3=Aged 40–49 4=Aged 50+
E	How many hours of instruction in grief/grief counseling have you had in your graduate program? (including instructional time and assigned reading)	1=0 hours 2=1–10 hours 3=11+ hours
F	Do you anticipate any additional hours of program instruction on this topic?	1=Yes 2=No
H	If you answered "Yes" to Item F, how many additional hours do you anticipate?	1= 0 hours 2= 1–10 hours 3= 11+ hours
I	How many hours of instruction in grief/grief counseling have you had outside of your graduate program? (workshops,	1= 0 hours 2= 1–10 hours 3= 11+ hours

	reading)	
J	Are you familiar with Martin & Doka's model of adaptive grieving styles (intuitive & instrumental)?	1=Yes 2=No

If you answered "Yes" to Item J, please share how you learned about adaptive grieving styles: _____
_____
_____

Please give us your feedback on these videotapes and/or questionnaire, if you wish. Feedback can include criticism, positive comments, questions, things you did not understand, ideas about how to make them better, etc. _____
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