Chapter 21

Historical and Contemporary Perspectives on Assessment and Intervention

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Historically, care for the dying and the bereaved has been the responsibility of family members and the larger community. People have traditionally sought comfort and support from those who knew the deceased and shared the loss. The development of organized professional caregiving systems to provide support and intervene with cases of problematic grief has been essentially a 20th century development, rooted in the rise of psychotherapy as a distinct intervention for mental distress of all types. The growth of organizations such as ADEC and the inclusion of mandated bereavement care in federally funded hospice services suggests that organized bereavement care systems are viewed as necessary and valuable adjuncts to informal community support in the face of loss. This chapter offers a brief review of these more formal caregiving systems, and the approaches that have developed to ameliorate problematic grief responses. It is divided into four sections: (1) historical perspectives, (2) contemporary methods of assessment, (3) interventions for grief, and (4) future directions for this area of thanatology. For reasons of space, we will focus primarily on problematic patterns of grief and on the responses of adults (rather than children) to the death of a loved one.

Historical Perspectives on Assessment and Intervention

Foundational Ideas about Normal and Complicated Grieving

Perhaps inevitably, efforts to understand problematic grief lead to questions about the boundary between "normal" and complicated responses. Indeed, the issue of what constitutes normal grief, and whether there is any form of grief response that should be "pathologized", is

one that is still contested within thanatology (N. S. Hogan, Worden, & Schmidt, 2006; Neimeyer, 2006a; Prigerson & Maciejewski, 2006). While the potential for losses to be devastating has been the subject of human reflection for thousands of years, the scientific study of bereavement can be dated to the work of Sigmund Freud (Freud, 1957). His idea that healthy mourning involved decathexis (the withdrawal of emotional energy from the deceased), while pathological bereavement involved a failure to psychologically "let go" of the deceased, has profoundly influenced both professional and public views of what is to be expected in mourning. Subsequently, most of the major 20th century bereavement theorists have set forth variations on this theme of decathexis (Bowlby, 1980; Parkes, 1996).

Closely related is the conceptualization of the mourning process as psychological work that entails experiencing and expressing the difficult thoughts, emotions, and memories that have been triggered by the loss (Rando, 1995). Seen from this broad psychodynamic perspective, grieving has been viewed as a process of painfully reviewing or "working through" and then letting go of the attachment to the deceased by way of confrontation with the reality of the death and catharsis of the resulting emotions. This has been referred to as the "griefwork hypothesis" (Stroebe, Gergen, Gergen, & Stroebe, 1992). From this perspective, assessment of the grieving process involves judging the extent to which this griefwork has been accomplished (or avoided), and interventions are designed to facilitate the resolution of the attachment by assisting in this necessary labor.The failure to confront the reality of the loss, as well as the failure to perform the psychological work involved in letting go, have been viewed as the core of a pathological grief response. Note that this viewpoint is largely intrapsychic in nature, with pathological grief residing within the "psychological skin" of the mourner.

Building upon this foundation, the 20th century also saw the emergence of various stage

and task models of bereavement. Beginning with the popularity of Kubler-Ross's book *On Death*

& Dying (Kubler-Ross, 1969), stage and task theories have been widely accepted by the

professional community as well as the public. Typically, these models suggest that mourners

begin in a state of denial of the reality of the loss, and move through a series of unwelcome

emotional phases of adaptation marked by anger, bargaining and depression before achieving

some form of acceptance or resolution. Alternatively, other theorists emphasize the necessary

activities of grieving, such as the need to accept the reality of the death, experience the pain of

the grief, and adjust to an environment in which the deceased is missing (Worden, 2002)

Correspondingly, the failure to progress through the stages or tasks implies unfinished griefwork,

and interventions are presumably designed to facilitate this uncompleted activity.

Recent Challenges to the Traditional Griefwork Model

These traditional views of mourning are being challenged on many fronts in

contemporary thanatology. For example, longitudinal studies of bereavement adaptation provide

only minimal support for a model of stages of emotional response to grief (Maciejewski, Zhang,

Block, & Prigerson, 2007; Zhang, Maciejewski, Block, Vanderwerker, & Prigerson, 2007).

Furthermore, new research has called into question the necessity of confronting and working

through a loss for all mourners. These researchers present compelling data that suggest that, at

least after spousal loss, not everyone appears to go through a painful process of depression and

mourning. They argue that traditional models of grief have underestimated the resilience of

people's capacity to adapt to loss and trauma (Bonanno, 2004; Bonanno, Wortman, & Nesse,

2004; Wortman & Silver, 1987).

Likewise, the idea that decathexis is central to the process of grieving is being challenged by theorists who argue that the establishment of on-going bonds with the deceased is both healthier and more normative across human cultures than the notion of detachment from the deceased (Klass, Silverman, & Nickman, 1996; Rubin, 1999). While refinements are emerging in the types of continuing bond with the deceased that may be adaptive or pathological (Field, Gao, & Paderna, 2005), the field appears to be rapidly moving away from the earlier view that, successful mourning necessarily involves a relinquishment of the emotional attachment to the deceased. Instead, evidence suggests that maintaining an emotional bond with the loved one may be comforting or distressing, depending on such factors as how far along survivors are in their bereavement (Field & Friedrichs, 2004), whether they have been able to "make sense" of the loss (Neimeyer, Baldwin, & Gillies, 2006), and perhaps their level of security in important attachment relationships (Stroebe & Schut, 2005).

In the wake of growing skepticism about traditional models of mourning, new theories have been proposed. One such model is the Dual Process Model of coping with bereavement formulated by Stroebe and Schut (Stroebe & Schut, 1999), which argues that normal grief involves an oscillation between confronting the loss (Loss Orientation) and compartmentalizing it so that the mourner can attend to the life changes necessitated by the death (Restoration Orientation). This important departure from traditional thinking describes mourning as a cyclical rather than a linear and stage-like process, as the mourner repeatedly revisits the loss and its associated emotions, strives to reorganize the relationship to the deceased, and to take on new roles and responsibilities necessitated by a changed world. This formulation also extends our understanding of pathology by suggesting that the inability to distract oneself from or avoid grief may be as much a sign of pathology as the inability to confront it.

A second important development is the emergence of narrative or constructivist theories about the mourning process. In this view, bereavement is viewed as challenging the survivor's self-narrative, the basic organization of life events and themes that allows them to interpret the past, invest in the present and anticipate the future (Neimeyer, 2001). When life events such as the death of a loved one disrupt the "assumptive world" (Janoff-Bulman & Berger, 2000) whereby a person maintains a sense of coherence, identity, and direction, a prolonged struggle to integrate the loss can result (Neimeyer, 2006b). Recent evidence demonstrates that such disruptions are especially profound in cases of suicide, homicide and fatal accidents, where the inability to "make sense" of the death accounts for the more debilitating grief responses stemming from violent, as opposed to natural deaths (Currier, Holland, & Neimeyer, 2006), From this vantage point, griefwork is not simply a matter of emotional catharsis, but rather a process of meaning reconstruction whereby the mourner re-establishes the sense of coherence of their narrative structures after a loss (Neimeyer, 2002).

Lastly, although social support has generally been acknowledged as important by most grief theorists, the failure to grieve "successfully" has traditionally been understood as a problem contained within the individual mourner. Recent approaches, particularly those based in the "meaning reconstruction" view just mentioned, have begun to focus on the transactional nature of mourning (Nadeau, 1997; Neimeyer & Jordan, 2002). This view suggests that the meaning of the loss for an individual cannot be separated from the family, community, and societal meanings ascribed to death and loss and the resulting social responses to the mourner. This more social-psychological approach recognizes that the bereaved must adapt not only to a world where the deceased is no longer physically available, but where many other altered aspects of the post-loss interpersonal landscape must be confronted. While these changes have clear intrapsychic

components, they also intimately involve the interactions that mourners have with other people,

who provide approval and support for or disapproval and withdrawal from the bereaved based on

the fit of the mourner's coping style with their altered social networks. Broadly sociological

theories of grief (Walter, 1999) and data from family studies (Traylor, Hayslip, Kaminski, &

York, 2003) reinforce this perspective.

Implications for Understanding Complicated Grief

All of these developments in bereavement theory are changing our understanding of what

constitutes an expectable response to loss. These new ideas are also reshaping and expanding our

view of what constitutes pathological grief. This shift can be summarized by noting that

thanatology is developing a more complex and refined understanding of the heterogeneity of the

grief response, rather than its uniformity. The implications of this shift are very important for

intervention, since the general "one size fits all" approach of traditional bereavement services

fails to take into account differences in mourner personality, culture, gender, life situation, and

death circumstances. In the next section, we will focus on contemporary developments in the

assessment of grief that flow from these emerging conceptualizations of the mourning process.

Contemporary Perspectives on the Assessment of Grief

The Development of a Complicated Grief Diagnosis

The mental health community, as represented by the current edition of the Diagnostic and

Statistical Manual of the American Psychiatric Association (DSM IV-R), does not formally

recognize any pattern of grief as pathological. Bereavement is a viewed as a life problem that

may need clinical attention, but it is not, in and of itself, a mental disorder—instead difficulties

adjusting to a loss must be diagnosed in terms of depression, anxiety, or other disorders, such as

post-traumatic stress disorder (PTSD). This official position notwithstanding, there has been a

movement over the last 15 years to create a new diagnostic category called Complicated Grief

(CG). If the CG diagnosis is accepted, the particular pattern of grief response described in the

proposed criteria (see Table 1) would officially become a psychiatric disorder in the next edition

of the DSM.

Table 1. Criteria for Complicated Grief Proposed for DSM-V

Criterion A: Chronic and disruptive yearning, pining, longing for the deceased.

Criteria B: The person must have four of the following eight remaining symptoms at least several times a day or to a degree intense enough to be distressing and disruptive:

1. Trouble accepting the death
2. Inability to trust others
3. Excessive bitterness or anger related to the death
4. Uneasiness about moving on (for example, making new friends, pursuing new interests)
5. Numbness/Detachment (for example, feeling disconnected from others)
6. Feeling that life is empty or meaningless without deceased
7. Feeling bleak about the future
8. Agitation (for example, jumpiness or edginess)

Criterion C. The above symptom disturbance causes marked and persistent dysfunction in social, occupational or other important domains.

Criterion D. The above symptom disturbance must last at least 6 months.
Adapted from: Prigerson & Maciejewski (2006)

The criteria for CG essentially describe a combination of intense and prolonged yearning

for the deceased, along with signs that the mourner's adaptation socially and psychologically has

been compromised by the death. Note that the diagnosis refers to symptoms experienced by the

mourner, regardless of the circumstances of the death, which may or may not be sudden or

violent. A considerable amount of empirical research has demonstrated that the presence of CG

is associated with elevated rates of psychological distress, physical illness, and social

dysfunction (Ott, 2003; Prigerson & Jacobs, 2001). Moreover, the CG diagnosis has been shown

to cohere as a predictive symptom cluster and to differ sufficiently from major depression and

post traumatic stress disorder to be legitimately considered a separate diagnostic category

(Prigerson & Maciejewski, 2006).

The movement to develop the CG diagnosis has not been without its critics. Concerns

about this work range from the potentially deleterious effects of "medicalizing" and

pathologizing grief to the validity of the precise criteria being proposed (Hogan et al., 2006).

Nonetheless, it appears that some version of the proposed criteria will find its way into the

diagnostic nomenclature of DSM-V, and thus into the thinking of many medical and mental

health professionals. Moreover, the acceptance of this diagnostic category will likely pave the

way for new research into the causes and course of CG, methods for treating the syndrome, and

insurance reimbursement for that treatment. While other patterns of problematic response have

been described (such as avoided or inhibited grief, distorted grief, etc. (Rando, 1995), the outline

of grief described in the proposed criteria for CG is rapidly becoming the *de facto* definition of a

problematic grief response.

Risk Factors and Assessment Methods

Bereavement outcome research over the last forty years has identified a number of factors

that are associated with and predictive of the development of problematic grief responses,

including CG. These include a lack of forewarning about the death, violence in the manner of

death, the lack of perceived social support following the death, previous exposure to loss and

trauma, a history of psychiatric disorder (particularly affective disorders such as depression), and

an insecure attachment style (Parkes, 1990; Stroebe & Schut, 2001). Moreover, certain categories

of mourners are more likely to experience elevated rates of problematic grief. The relevant

variables appear to be close kinship relationship to the deceased (for example, bereaved mothers)

and survivors of certain types of losses (for example, suicide) (Jordan, 2001).

A number of paper and pencil measures for the assessment of the grief response have been developed. Although widely used, early measures such as the Texas Revised Inventory of Grief (Faschingbauer, 1981) and the Grief Experience Inventory (Sanders, Mauger, & Strong, 1985) have a questionable psychometric foundation (Neimeyer & Hogan, 2001). Several newer bereavement measures offer the promise of more psychometrically valid and clinically useful tools. These include the Hogan Grief Reaction Checklist (Hogan, Greenfield, & Schmidt, 2001), the Core Bereavement Items (Middleton, Burnett, Raphael, & Martinek, 1996), the Grief Evaluation Measure (GEM) (Jordan, Baker, Matteis, Rosenthal, & Ware, 2005), and the Inventory of Complicated Grief (ICG) (Prigerson & Jacobs, 2001). Of particular interest is the ICG, which has been developed as a measure that specifically taps into the symptoms of CG outlined in the proposed diagnostic criteria. Some specialized bereavement measures have also been created for specific types of losses, including suicide (Barrett & Scott, 1989), sibling loss (Hogan & De Santis, 1992), and perinatal loss (Toedter, Lasker, & Alhadeff, 1988). All of these measures show promise in helping the assessment process in bereavement care become more evidence based and effective in coming years.

Key Elements to Consider in Assessing the Grief Response

As a prelude to bereavement counseling, a thorough assessment of the mourner should cover a broad range of domains. These include:

1. *The mourner's narrative of the death and of their reactions to the loss.* This domain includes the trajectory of any illness and circumstances of the death, the mourner's participation (or lack of it) in the dying process, the funeral, and the subsequent experience of living without the deceased. Of particular relevance is the individual's perception of how prepared they were for the death, as well as any aspects of the death

that were horrifying or terrifying for the survivor, since they are likely to indicate

traumatic as well as grief responses.

2. *An exploration of the meaning of the loss for the mourner.* This domain is obviously a

    broad topic, and facilitating discovery of the meaning of the loss can be a central goal of

    grief counseling itself. Topics might include the role of the deceased in the mourner's

    life, the nature of the relationship with the deceased, the changes that the loss is bringing

    about in the mourner's psychological and interpersonal world, and the degree to which

    the coherence of the mourner's assumptive world has been challenged.

3. *The grieving person's own evaluation of his or her response to loss.* Asking, "Is there

    anything about the way that you are responding to this loss that especially concerns you?"

    can alert the clinician to a range of less obvious problems, such as his or her sensed

    failure to function in other important relationships (such as those with children), as well

    as acute problems such as suicide ideation. It can also help bring to light aspects of

    grieving that might be disallowed and hard for the griever to acknowledge or accept, such

    as anger or guilt.

4. *An assessment of the ethnic, cultural, religious, gender based, and social class factors*

    that affect the mourner's experience of the loss. These aspects often give a sense of the

    implicit "grieving rules" to which the survivor is striving to conform.

5. *The quality of perceived social support from family and the larger community.* This

    domain includes the degree to which mourners feel understood by others in their grief

    and the amount of interpersonal strain or abandonment that has occurred around the loss.

    Also important is an assessment of the mourner's interpersonal skills and willingness to

    elicit social support from others in their network.

6. *The psychiatric history of the mourner.* Of particular relevance are major affective disorders (depression and bipolar disorder), post traumatic stress disorder, and substance abuse problems. If the mourner has a positive history for psychiatric disorder, follow-up should investigate whether the person has received treatment, its success, and any signs of the disorder(s) reoccurring within the context of the grief

7. *The stability of the mourner's life situation*, including employment, marital and family relationships, and living arrangements.

8. *Additional stressors the mourner may be confronting*, such as health, financial, interpersonal, and work related difficulties.

9. *The quality of the mourner's past relationships*, both in their family of origin and in subsequent relationships. Of particular importance is the quality of close relationships with attachment figures, and of relationships that may have been abusive or traumatizing.

10. *The coping skills possessed by the mourner.* The mourner's ability to both confront the reality of the loss when necessary (Loss Orientation in the Dual Process model) and to avoid the grief to make necessary changes in their world (Restoration Orientation) is very pertinent. Also significant are the person's previous coping methods when faced with emotional injuries and losses, with particular attention paid to coping efforts that are self-defeating or self-destructive (for example, substance abuse, suicidal behavior, etc.). The manner in which the mourner has adapted to earlier life losses can also suggest personal, social and spiritual resources that could be useful in dealing with the current loss.

11. *The mourner's expectations about counseling and how it might be of help.* Previous experiences with therapy (whether bereavement related or not), and their perceived helpfulness or unhelpfulness, will also be important to assess.

Interventions for Bereavement

Types of Interventions

There is simply no universally agreed upon intervention to assist with problematic grief, or even to facilitate the normal grieving process. There also is very little data on the numbers of people who actually receive some type of formal intervention after the death of a loved one. In the United States, hospices routinely provide some type of bereavement follow-up with families that have received services. Hospices are probably the largest providers of bereavement care in the U.S. The typical hospice offers some type of follow-up (phone call, home visit, etc.) with the bereaved over the first year. Hospices also may provide a general bereavement support group for adults, as well as specialized bereavement services for particular populations, such as summer camps for grieving children.

Other community organizations that provide bereavement care may include funeral homes, churches, hospitals, and social service agencies, with the great majority of these providing facilitated bereavement support groups. Likewise, there are "self-help" organizations, such as the Compassionate Friends (Klass, 1999) or Widow to Widow (Silverman, 2005), that offer "drop-in" type bereavement support groups or other forms of support. Most agency sponsored support groups are conducted by a mental health professional or clergyperson, while self-help groups are typically facilitated by a lay survivor(s). Researchers have conducted very few controlled studies of the effectiveness of the typical community based grief support group. Nor has there been much standardization of the models used to guide these types of groups, although creative curricula to guide the conduct of such groups have been offered, incorporating not only emotional self-expression and group problem solving, but also a wide range of storytelling, expressive arts, music, meditation and body work procedures (Rogers, 2007).

A variant of the support group model is Critical Incident Stress Debriefing (CISD) or

Management (CISM). This procedure employs a structured protocol for a group meeting

(typically a single session) after a traumatic event, such as a natural disaster or a terrorist attack.

Participants are encouraged to recount their experience with the distressing situation and are

offered information about the nature of the post-traumatic response. Originally developed for

emergency response workers such as police and fire personnel, this form of intervention has been

widely adopted by organizations involved with disaster response, such as the American Red

Cross. More recently, however, CISM has been criticized as lacking in empirical support, and

possibly even harmful for some participants (Gist & Lubin, 1999; Litz, 2004).

Still another important variant of the support group model is the Dougy Center in

Portland, OR (www.dougy.org). This pioneering children's bereavement service offers

developmentally attuned play or discussion support groups for bereaved children of all ages, plus

discussion/support groups for parents. The program has been extensively replicated in the United

States and around the world, and is widely accepted as a valuable form of bereavement care for

children, although again, formal studies of the efficacy of the program appear to be lacking at

this time.

With regard to individual grief counseling, again, there is no one model that has been

studied or universally accepted. Worden (2002) and Rando (1993) have authored the most

widely used textbooks in grief counseling, and their published works have been extremely

influential with bereavement care professionals. Generally speaking, the dominant

psychodynamic view of mourning described earlier has meant that most interventions focus on

providing support for the client to confront the reality of the loss, engage in emotional catharsis,

and diminish the attachment to the deceased. Perhaps the best known technique of grief

counseling is the "empty chair" (Worden, 2002), wherein the mourner is instructed to have an imaginal conversation with the deceased. This procedure can be viewed as an opportunity to deal with "unfinished business" and say goodbye, or as an occasion to develop and strengthen a continuing bond with the deceased. However, "chair work" can be quite evocative, and so is probably best undertaken by clinicians who are well grounded in emotion focused and experiential therapies (Greenberg, Watson, & Lietaer, 1998)

A small number of family oriented interventions for bereavement care have also been presented. Shapiro has described a model that draws on psychodynamic, family developmental, and cross cultural perspectives to provide support for grieving families (Shapiro, 1994). Walsh and McGoldrick (Walsh and McGoldrick , 2004) and Nadeau (Nadeau, 1997) have also articulated principles that emerge from a systemically informed constructivist or meaning making point of view.

Research on Bereavement Interventions and Promising Evidence Based Programs

While having intuitive appeal and face validity, most of the intervention services in bereavement care lack any empirical evaluation. The well known Institute of Medicine report in 1984 indicated that our research based knowledge about bereavement interventions was quite limited (Osterweis, Solomon, & Green, 1984). A recent similar summary of the progress in the field reported that while there is considerably more data now about the nature of grief, there is still a relative lack of empirical evidence on which to base interventions (Center for the Advancement of Health, 2004). Jordan and Neimeyer (2003) have reviewed the empirical meta-analyses of grief counseling and concluded that there is relatively little evidence that grief interventions (whether group or individual) are effective or even necessary for uncomplicated grief reactions. However, they did suggest that for high risk mourners, interventions appear to be

more efficacious, highlighting the need to identify and intervene with this population. Jordan and

Neimeyer also found that the design of the research on bereavement interventions often lacks

methodological rigor or sophistication, making it difficult to draw conclusions about the

effectiveness of the services. A recent review of the outcome of controlled evaluations of grief

therapy for children yields similar conclusions (Currier, Holland, & Neimeyer, 2007).

Despite the general lack of an empirical foundation for most bereavement care, there are

some examples of promising programs that are derived from theory, clearly operationalized, and

evidence-based in their evaluation. Sandler and his colleagues have developed the Family

Bereavement Program, a well conceptualized group support program for parentally bereaved

children and surviving caretakers that has shown long term efficacy for helping parentally

bereaved children (particularly girls) (Sandler et al., 2003). Likewise, Kissane and colleagues

have reported on Family Focused Grief Therapy, a family oriented intervention for use in

palliative care that shows evidence of effectiveness with certain types of family styles (Kissane

et al., 2006). Goodkin and his colleagues have published studies on the effectiveness of

bereavement support groups for people bereaved through the loss of a loved one to AIDS.

Impressively, these groups have shown measures of not only psychological but physiological

(for example, immune system) improvement in the participants (Goodkin et al., 1999). Shear and

her associates have reported data on the first treatment protocol specifically developed for the

treatment of complicated grief (Shear, Frank, Houch, & Reynolds, 2005). This treatment is a

multi-faceted intervention that includes psychoeducation about the grieving process, cognitive

restructuring of negative grief related thoughts, a social network intervention, homework

assignments to engage in new activities, repeated review of the mourner's reactions to the death,

and an "empty-chair" dialogue with the deceased. This treatment was found to be superior to

another treatment often employed in bereavement or depression situations called Interpersonal

Therapy. Lastly, a German research group has recently reported impressive outcomes for an

individualized internet-based intervention for people with complicated grief, which like the

Shear et al. intervention has a strong narrative component (Wagner, Knaevelsrud, & Maercker,

2006).

Future Trends in Assessment and Intervention

An organizing theme in this chapter has been the sweeping changes in theory and practice

in bereavement care that thanatology is witnessing. We would like to conclude with some

thoughts about the implications of these changes for the future of assessment and intervention in

bereavement care. A fundamental conclusion of the research on bereavement outcome over the

last 25 years is that most mourners probably do not need formal or professional intervention after

the death of a loved one. Human resilience in the face of loss has been the subject of literature

and the arts for many years. It appears now that social science is confirming that such resilience

may be more the norm than the exception for most people after most losses.

In contrast, another important conclusion is the recognition that for a subset of mourners,

the risks of an unfavorable bereavement trajectory may be high. Both clinical practice and

empirical study are revealing that mourners with certain types of backgrounds (for example, a

history of insecure attachments, abuse, trauma, or excessive loss), or who have endured certain

types of death circumstances (for example, sudden, violent death), or for whom good social

support is missing (for example, stigmatization for suicide survivors), the probability of

developing a CG response is much higher. Thus, we believe that in the coming years

bereavement care professionals will increase their focus on identifying these high risk mourners

and then designing services that address their often complex needs.

This fundamental observation about the differences between high risk and low risk mourners has additional implications. We believe that the effort to develop the new CG diagnosis, while not without its potential problems, is an impressive and empirically grounded effort to identify those at risk for a more problematic course of bereavement. If this new diagnostic category is adopted, we expect that it will lead to a valuable increase in research and clinical innovation in ways to provide help to high-risk survivors. Accompanying this activity will be an increase in more objective methods for assessing complicated bereavement reactions, and an increase in awareness by caregivers (medical, human service, and clerical) about the necessity of providing help for mourners who are not likely to recover on their own.

A second trend that seems likely to grow is the recognition that both assessment and intervention in thanatology must become more culturally sensitive. While this statement obviously refers to developing culturally competent responses to mourners of differing ethnic, racial, and religious heritages, it also applies to the other social differences that people bring to encounters with organized bereavement care systems. Differences that arise out of gender, sexual orientation, age, ability, social class, family style, and individual personality all need to be better studied and incorporated into the design of interventions for the bereaved. At the risk of over-generalizing, most bereavement care interventions have evolved to meet the needs of Caucasian, middle class, older female mourners. We hope and expect that over time, our ability to assess and offer assistance that is customized to the particular needs of a much wider range of mourners will increase, so that individuals and families seeking help will be able to comfortably utilize the resources provided, rather than struggling to adapt to services that may seem alien to those whose bereavement coping style does not fit the limited range of services currently offered.

Thirdly, we believe that there will be a growing interest in bridging the great gap that exists between bereavement caregivers who are "in the field" and researchers and academics "in the ivory tower" (Bridging Work Group, 2005; Jordan, 2000). Perhaps more than most human service areas, much of the assistance given to the bereaved in formal support programs is provided by "para-professionals" – clergy, hospice volunteers, lay leaders of self-help groups, etc. We believe that the findings of social science research should be made available to bereavement care providers at all levels of professional standing in all types of settings. Likewise, we hope that researchers and theoreticians will do more to study the grief support programs that are routinely delivered in the settings where the bereaved are being served. Researchers should look not only to caregivers, but also to "consumers" of bereavement care, that is, the bereaved themselves, for inspiration and support in developing studies that have more relevance in the "real world". We are encouraged by the growing efforts at bridging the gaps between caregivers and providers through organizations such as ADEC and its certification process for the field.

Finally, we believe that in the future the specialization of bereavement care will pay more attention to fostering growth and resilience after loss, not simply ameliorating psychopathology. The new research on resilience, the focus on the development of continuing bonds with the deceased, and the promising studies of post traumatic growth all suggest that loss can be a source of psychological maturation for human beings, not simply emotional injury. The field has just begun to consider how good bereavement care might foster this kind of growth in the bereaved. We look forward to the emergence of new approaches and techniques that invoke the potential inherent in all loss for the growth of self-awareness, interpersonal connection, and a deeper understanding of what it means to be alive.