Complicated Grief and Art Therapy

Rachel Brandoff
rachelbrandoff@gmail.com

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COMPLICATED GRIEF AND ART THERAPY

A DISSERTATION
Submitted by

RACHEL BRANDOFF

In partial fulfillment of the requirements
For the degree of
Doctor of Philosophy

LESLEY UNIVERSITY
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Ph.D. in Expressive Therapies Program

Dissertation Approval Form

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Rachel Brandoff
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ABSTRACT

Complicated grief (CG) has come to be a common enough occurrence in mental health treatment to warrant research, literature, and discussion of markers, causes, prevalence, symptoms, measures, and treatment protocols. Art therapy presents one possible mode of treatment for individuals suffering from CG, and yet few art therapists know about CG or have training in this area. A systematic review of art therapy programs and educational requirements showed no current standards or training requirements for grief or CG. Art therapists are master’s trained clinicians who work with people with a variety of mental health challenges, and training in CG may benefit the clients art therapists serve. Incorporating a unit on CG into graduate art therapy programs may be an effective way of addressing this relevant topic and introducing it into the education of art therapists.

The aim of this research was to elicit recommendations for CG education for art therapists by engaging professional art therapists in a CG workshop. Ten participants attended the CG and art therapy workshop and focus group; three participants were professional art therapists, two were art therapy master’s students, one was a high-school student, and four were counseling master’s students. After the didactic part of the workshop, participants engaged in an art-making experience, completion of an individual questionnaire, and a focus group discussion. I coded data with preset themes I took from the literature on CG and with emergent themes.

I used the findings to generate recommendations for the field, which include teaching a unit or module on CG to art therapists during their master’s training. This module should include a history of grief theory, CG definition, causes, symptoms, prevalence, measures, interventions, differential diagnoses, current research, art therapy
and creative approaches to grief, and a history of art as a vehicle for grief. It should also include an opportunity to create art and explore grief and CG, both academically and personally, as well as post-art group processing experience. Training art therapists in CG could allow them to serve their clients better.
CHAPTER 1

Introduction

Clinical professionals recognize grief as an expected and natural occurrence in life. Bereavement over the loss of a loved one can overshadow other life events and activities. Eventually the griever integrates the feeling of loss into his or her life experiences as he or she resumes normal activities without that loved one. For some people, however, this period of acute mourning persists for more than a year. Mental health care professionals call this complicated grief (CG). For this dissertation, CG is grief-related behaviors of an extreme nature that occur after a full year from the event or awareness of the event.

It is important to note that there is an entire field dedicated to working with bereaved people, known as grief counseling. There is a significant amount of research in the grief counseling field on working with bereaved persons, and a specialization of grief counseling education dedicated to training counselors to work with bereaved clients. In this study, I examine the phenomenon of CG specifically, and not the larger specializations of grief counseling or grief therapy. Furthermore, I look at CG as a phenomenon that is in the domain of all psychotherapists, counselors, and art therapists, and not only that of grief counselors.

After experiencing the loss of a loved one, some people seek counseling or psychotherapy to cope with grief. Intervention is particularly helpful for people who are dealing with acute grief associated with loss of a loved one for an extended period, since untreated CG may have adverse health consequences (K. Shear et al., 2001, M. K. Shear et al., 2016).
Art therapists are master’s trained clinicians who work with people of all ages, and specifically those with mental health challenges. Art therapists can treat aspects of medical illness, mental health, wellness, or quality of life issues through psychotherapy. A systematic review showed a lack of CG training in art therapy programs, and the American Art Therapy Association (AATA) education standards currently do not include any requirement for grief counseling or working with CG in the training and preparation of art therapists. Incorporating a unit on CG into an existing graduate art therapy course may be an effective way of addressing this relevant topic and including it in the education of art therapists. To address this potential, I explored the possible content and benefit of post-master’s CG training for art therapists.

In this dissertation, I first discuss pertinent literature on the topic of CG. A pilot study, which I discuss at the end of Chapter 2, consisted of a systematic review of the CG training and education protocols for art therapists in nationally accredited master’s programs, and a thorough review of the AATA standards for art therapy education. The pilot provided the context for the present study, in which I used data I collected via questionnaires, a focus group, and an interview from those who attended a training workshop on CG and art therapy to elicit information to make recommendations about CG training for art therapists. I also used art making as a means of priming participants to interact with the workshop material, and I included the artwork of participants in the CG and art therapy training workshop.

This inquiry into CG and art therapy may promote better understanding of the preparation that master’s art therapists have for working with clients experiencing CG,
and may better assess whether standards in CG could benefit art therapists, and ultimately the clients that they serve. This research addressed the following questions:

1) What elements are important in developing a curriculum on CG specifically for art therapists?

2) What guidelines can educators develop for art therapy education on CG based on data from professional and student art therapists?

Answering these questions will assist the field of art therapy in developing relevant professional accreditation standards.

Many art therapy clients are bereaved individuals, and a recent study estimated that 7% of bereaved individuals suffer from CG (M. K. Shear et al., 2016). Another study found that 15% of art therapists who are members of the AATA report that they specialize in treatment of grief and bereavement issues (Elkins & Deaver, 2015). Grief is one of the “top” 10 specialties in the field of art therapy (Lister, Pushkar, & Connolly, 2008). Despite this prevalence of references to grief, there is a lack of published research that examines art therapy as a treatment for CG. It appears that art therapists, even when licensed and credentialed, do not necessarily receive exposure to CG in their professional education and training. Because there are no training requirements for art therapy relating to grief or CG, art therapists may confront issues relating to grief for the first time when they encounter a client situation.

Developing recommendations for training, such as identifying and working with clients with CG, may be beneficial to both therapists and their clients. Including a curriculum unit or module on CG in graduate art therapy courses to educate art therapists could ideally include recommendations for treatment as well as contraindications. Such a
module would include exposure to various diagnoses, such as CG, major depression (MD), and posttraumatic stress disorder (PTSD), as well as learning about research-based art therapy protocols that may aid in the treatment of CG. A module might include a review of current literature on CG as well as an introduction to the Complicated Grief Inventory, the assessment tool most practitioners use to screen for CG. Research that examines the use of existing art protocols with clients screened for CG, using the Complicated Grief Inventory, might be helpful in determining which approaches offer the most promise in the use of art therapy as a treatment for individuals with CG.

Use of art therapy in the treatment of CG may help the griever to integrate his or her experience of loss and to resume normative life engagement. Art therapy has assisted people by treating posttraumatic symptoms (Gantt & Tinnin, 2009), increasing self-esteem and positive self-image (Ponteri, 2001), reducing stress (Salzano, Lindemann, & Tronsky, 2013), alleviating or containing anxiety or fear (Johnson, 1987), identifying and coping with the pain they experience in grief (Forrest & Thomas, 1991; Graves-Alcorn, 1994; Simon, 1981). There is ample room for additional research that examines the methods and processes of art therapy in the field of CG.
CHAPTER 2

Literature Review

A growing number of clinicians have examined grief that is acute, persistent, and prolonged. They now call it CG. CG is different than normal grief, which is a state that manifests when people “are deeply saddened by the death of an attachment figure during a period of weeks or months of acute grief” (K. Shear & Shair, 2005, p. 253). Despite the individuality of the typical grief experience, and the varied responses of bereaved individuals, the yearnings, thoughts, and divergent emotions of normal or typical grief do not persist. CG, by contrast, is an acute period of grief that is more than a year in duration.

CG has generated much discussion, treatment, research, and the development of new therapeutic techniques. Prolonged acute grief has generated the clinical term CG (Cruz et al., 2007; K. Shear, Frank, Houck, & Reynolds, 2005; M. K. Shear, 2006, 2012), also known as prolonged grief disorder (Craig, 2010; A. H. Jordan & Litz, 2014; Prigerson et al., 2009), and the mental-health insurance system often supports treatments (Lichtenthal, Cruess, & Prigerson, 2004; Prigerson et al., 2009; M. K. Shear, 2011).

Many clinicians supported the inclusion of CG as a diagnosis in the most recent publication of the American Psychiatric Association’s (2013) Diagnostic and Statistical Manual of Mental Disorder (DSM-5; Lichtenthal et al., 2004; Pies, 2012; Prigerson et al., 2009; Prigerson, Vanderwerker, & Maciejewski, 2008; M. K. Shear, 2011). While CG did not receive diagnostic status in this manual, the American Psychiatric Association acknowledged it as a life situation that might affect a person’s functioning, and thus it
received a “V” code (Cooper, 2013; Wakefield, 2013; Zisook & Shear, 2009). This important recognition makes CG an appropriate topic of further study.

There has been an uptick in the amount of art therapy literature that addresses working with people experiencing pervasive and intense grief (DiSunno, Linton, & Bowes, 2011; Finn, 2003; Griffith, 2003; O’Callaghan, McDermott, Hudson, & Zalcberg, 2013; Safrai, 2013; Schimmel & Kornreich, 1993; Turetsky & Hays, 2003; Webb, 2003; Webb-Ferebee, 2001). Despite this, there still is a lack of literature specifically addressing CG within the professional art-therapy community, including possible art-therapy treatment options for CG.

In this chapter, I include information about CG, including markers, causes, and prevalence, and then I discuss diagnostic issues of CG and tools for measuring CG. I include CG interventions and prevention of CG, and I discuss grief theories that influence and inform CG. Finally in this literature review, I discuss creative approaches to addressing grief in therapy.

**Theories that Influence Grief Research**

**Grief Work Perspectives**

In the first half of the 20th century, Freud (1917) pioneered theoretical writing about death. He maintained that the fear of death fuels all humans. He suggested that grief was a necessary and natural reaction to the loss of a loved one. According to Freud, the client should grieve until he or she is free of attachment and has severed emotional ties with the deceased (Earle, Komaromy, & Bartholomew, 2009).

However, there are a couple of shortcomings with this theory. For one, Freud’s philosophical assumptions about death were largely unsubstantiated. He identified fear
of death as polyvalent and omnipresent, and he hypothesized that the human mind cannot imagine its own demise. Second, Freud posited that if one has never experienced death personally, one could not actually fear death: he argued that people lack the ability to conceive of their own death because the unconscious does not register how much time one has left in life. He suggested instead that what people experience as a fear of death masks other concerns (Kastenbaum, 2009). In the Freudian tradition, those who express fears relating to death are actually trying to deal with unresolved conflicts from early life, but for some reason they are unable to come to terms with emotions relating to that conflict (Kastenbaum, 2009; Mallon, 2008). This insight can seem to undermine Freud’s position on a universal fear of death.

Feifel (1959) was a proponent of the psychological exploration of death and grief. Deeply influenced by the death of his mother and by watching men die during his service in World War II, his subsequent writings gave rise to the field now known as thanatology. Feifel (1963) developed Freud’s theme of the general fear of death and posited that increased education about death could help to counter the fear of death (Feifel & Branscomb, 1973; Feifel & Nagy, 1981).

Worden (1991) developed a task theory around death, predicated on the belief that there are certain tasks in mourning that an individual must accomplish to move beyond acute grief. Worden defined these tasks as (a) accepting the reality of death, (b) experiencing and learning to cope with the pain of loss, (c) adjusting to life without the deceased, and (d) investing in new relationships as part of moving on with life. In this theory, the first two tasks are about a new reality in life and facing the pain that comes
with loss, while the second two tasks entail the acceptance of and adjustment to new roles, responsibilities, and opportunities.

Neimeyer’s (2000a, 2000b, 2001) meaning making theory posits that the main goal of bereavement is to make meaning out of a loss so that the bereaved can then move on with life. This constructivist process presents a highly subjective experience based on the griever’s reworking of his or her world. The bereaved person must construct a new world of meaning as a result of and based on the experience of loss (Neimeyer, Baldwin, & Gillies, 2006; Wortman & Silver, 2001).

Beder (2005), like Neimeyer, examined the loss of what she calls “the assumptive world” in the face of losing one’s object of attachment. When death and the realization of mortality violate this relationship, it calls everything a person has assumed is true into question. Beder made recommendations for practitioners working with survivors of loss to help them to reconstruct their lives, knowing that survivors will never be the same after having lost a fundamental attachment. Building from the idea that adult grief resonates with early experiences of separation, grief therapy approached from this perspective tries to explain adult loss by understanding its connection to early life attachment experiences.

**Attachment Theory**

Bowlby (1963) built on Freud’s ideas by exploring loss, a key component in his psychodynamic theory of attachment, which he likened to the grief the bereaved experience. Since he was primarily interested in the attachment of the developing child to the primary caregiver, his ideas about grief and what constitutes pathological mourning mostly centered on children (Bowlby, 1961a, 1961b, 1963, 1980).
Bowlby’s (1961b) attachment theory, the belief that the strong emotional and physical attachment to and learning to let go of at least one primary caregiver in early life helps to shape individual development, and the psycho-social amplifications of Colin Murray Parkes (1972) suggest psychological models of bereavement that allow predictions regarding the outcome of an individual’s bereavement process (Madison, 2005; Parkes, 1988). Bowlby’s theory suggests a cause-and-effect relationship between early attachment patterns and later grief responses (Fraley & Shaver, 1999). Parkes (1988) supported Bowlby’s theory and added an emphasis on the importance of the psychosocial transitions necessary during the grief response and after bereavement. These transitions depend largely on the relationship between the deceased and the bereaved (Parkes, 1988).

Spurring much popular interest in the topic, Kübler-Ross (1969) adapted Bowlby’s phases into a five-stage theory, which she first presented as delineating the emotional experience of a dying person and later appropriated to represent the experience of a griever (Kübler-Ross, 1975). Stages included denial and isolation, anger, bargaining, depression, and ultimately acceptance. A stagnant response at any stage impeded a griever’s movement to the next stage, and thus obstructed resolution of grief.

Kübler-Ross’s (1975) theory of death and grief has become as controversial as it was influential (Konigsberg, 2011). In popular culture it is still often cited as fact, despite having little support from academic research (Kastenbaum, 2009). While some authors and clinicians have found her stages a helpful guide, others regard them as a limiting paradigm of grief that may incite feelings of grieving incorrectly or inappropriately (Downe-Wamboldt & Tamlyn, 1997). Many authors suggested that there
is likely more individual variation in grief than Kübler-Ross’s theory allows (Doka & Tucci, 2011; Kastenbaum, 2009; Maciejewski, Zhang, Block, & Prigerson, 2007).

Modern interpretations of this theory may allow for a more individualized grief response, but “the process of ‘resolving’ [the] bereavement is based upon a predictable template” (Madison, 2005, p. 339).

Klass, Silverman, and Nickman (1996) advanced the theory of continuing bonds, which contrasts sharply with theories that suggest grief is a task to complete or something to move past. This theory contends that bereaved persons do not need to sever bonds with the deceased, but only to transform those bonds. This theory holds that maintaining bonds with the deceased is not inherently harmful, and it may also be beneficial (Field, 2006; Schut, Stroebe, Boelen, & Zijerveld, 2006). This theory may align with some religious and spiritual belief systems (Klass et al., 1996). These authors also posit that grief is a process based in negotiating and renegotiating the loss over time. While a death may be permanent, the process of adjusting to the death and loss is not. The purpose of grieving in this perspective is “to maintain the presence of the deceased in the web of family and social relationships by establishing a continuing role for them within the lives of the bereaved” (Madison, 2005, p. 340).

**Dual-Process Model**

The dual-process theory proposed by Stroebe and Schut (2005-06) suggests that multiple simultaneous processes take place during grief. The two processes this theory describes are loss-oriented and restoration-oriented, such that a person experiencing bereavement constantly vacillates between these two types of stress. Loss orientation involves activities of mourning, such as missing and longing for the deceased, feeling
sad, reminiscing, and experiencing a sense of denial, as if the loss cannot possibly be true. Restoration orientation is defined by activities that promote a renewed engagement in life after having integrated the loss. According to the dual-process theory, a person can embrace the grieving process and confront the loss, and at other times he or she may avoid facing the loss. This theory holds that adaptive coping skills result from a combination of confrontation and avoidance of the loss. The model also addresses the concept of “dosage” in grieving – the idea that bereaved persons need some respite from each type of stress experienced while in grief.

Doka (2016) posited that grief may be more of a journey than an illness. To this end, his work fits in well with the dual-process model, or the idea that there is both active grief and reprieve as a griever rebuilds life. His work is designed to help individuals to understand and address the nature of their grief by identifying it as sourced in gender (Doka & Martin, 2010), age and stage of life (Doka & Tucci, 2014), dementia (Doka, 2015), chronic or terminal illness (Doka & Tucci, 2010, 2013), unacknowledged relationships (Doka, 2002), and the sequence of death and decline (Doka, 2007). For example, he discussed anticipatory grief, or the concept that when dealing with a loved one who has terminal illness, the grief process may in fact start before the loved one has died (Doka, 2007). Doka (2002) discussed disenfranchised grief, which he identified as the grief one feels over the loss of a person with whom society does not acknowledge the relationship, as with a divorced spouse or former lover, an unborn child, or a therapist or other caregiver.
Growing Literature

A large and growing body of grief-counseling literature has emerged (Bonanno & Lilienfeld, 2008; Clements-Cortés, 2010; Cooper, 2013; James & Friedman, 2009; Kacel, Gao, & Prigerson, 2011; Kissane, Lichtenthal, & Zaider, 2007; Krueger, 2006; Larson & Hoyt, 2007; Mallon, 2008; Roberts, 2013; Robinson & Marwit, 2006; Rosner, Pfho, & Kotoucova, 2011; Worden, 2009). Researchers and therapists have also attempted to qualify and categorize types of grief to improve treatment (J. T. Brown & Stoudemire, 1983; Jacobs, 1993; Prigerson & Jacobs, 2001; Prigerson et al., 2008; Sanders, Mauger, & Strong, 1985; M. K. Shear, 2011). While grief is a typical process after loss, and it usually progresses without the need for therapeutic intervention, in some circumstances professional help is necessary and griefers seek it. In some cases, the grief process becomes “pathologically delayed or distorted, with serious consequences for the survivor’s emotional and physical health” (J. T. Brown & Stoudemire, 1983, p. 378), and this is when consulting literature on grief may be helpful to clinicians. Creative approaches to grief counseling may also serve as part of the solution.

Complicated Grief

CG Markers, Causes, and Prevalence

CG often involves pervasive feelings of yearning and longing for the lost loved one, and sadness over the death; these feelings are like those of typical acute grief; however, CG also often involves a period of acute grief that is longer than expected, or than cultural norms typically sanction (M. K. Shear, 2015). In American culture, this means longer than one year.
CG may affect a person psychologically, emotionally, physiologically, and behaviorally, especially when untreated (Cruz et al., 2007). Symptoms may include anger, sadness, anxiety (M. K. Shear & Skritskaya, 2012), depression (Boelen & van den Bout, 2005; Zisook & Kendler, 2007), increases in heart rate or blood pressure, changes in immune response (Buckley, Sunari, Marshall, Bartrop, & McKinley, 2012), increases in cortisol levels (O’Connor, Wellisch, Stanton, Olmstead & Irwin, 2012), and sleep disturbances (Boelen & Lancee, 2013; McDermott et al., 1997).

CG affects about 7% of bereaved people (M. K. Shear et al., 2016), and up to 3.7% of the general population, although this rate may be higher in certain groups with higher risk factors such as female gender, lower income, older age, or cancer as the cause of death (Kersting, Brahler, Glaesmer, & Wagner, 2011). Rates of occurrence may be as high as 20% after the death of a romantic partner (M. K. Shear, 2015), and even higher among parents mourning the death of a child (Meert et al., 2011). Rates of prevalence also vary based on deaths that are sudden or violent (Mitchell, Kim, Prigerson, & Mortimer, 2005; Nakajima, Ito, Shirai, & Konishi, 2012).

Causes of CG are unknown; however, research suggests that there are many factors involved. Persons who may be at a higher risk of CG include those with a history of anxiety, mood disorders, and substance abuse problems; or those who have experienced multiple losses (M. K. Shear, 2015).

Recovery from CG involves the process of adapting to loss, which therapy can accelerate. Treatments for CG can assist the bereaved in understanding the intensity of the loss, accepting the finality and consequences (e.g., how the loss affects hopes and plans), and ultimately, revising future goals. For example, psychotherapy can benefit
individuals with CG, specifically a short-term approach called complicated grief
treatment (CGT; K. Shear et al., 2005; M. K. Shear, 2015).

CGT is a structured, 16-week protocol that involves both a focus on restoration of
functioning for the bereaved and a focus on the loss and the integration of the loss into
the life of the bereaved. CGT is more effective than a less structured interpersonal
psychotherapy in the treatment of CG (M. K. Shear, 2015). To date, CGT is the most
studied treatment for CG (M. K. Shear, 2015). Before looking further at CG treatment
options, including CGT and creative approaches, I examine CG from a diagnostic
perspective.

**Diagnostic Issues of CG**

Clinicians of all kinds, including art therapists, may encounter clients with CG,
whether or not they can identify it. Some clients themselves are unaware that they have
CG, and they seek treatment for other ailments with similar or shared symptoms.
Distinguishing CG from a diagnosis such as MD can help patients to receive effective
treatment (Boelen & van den Bout, 2005; Cooper, 2013; Guerin et al., 2009; Lichtenthal
et al., 2004; Pies, 2012; Prigerson, Frank, et al., 1995; Rosner et al., 2011; K. Shear et al.,
2005).

The medicalization of bereavement has been a topic of renewed debate. Since the
publication of the *DSM-III* (American Psychiatric Association, 1980) bereavement has
been an exclusion criterion in the diagnosis of MD. The newest publication of the *DSM*
(i.e., *DSM-5*; American Psychiatric Association, 2013) removed the bereavement
exclusion from the diagnostic criteria for MD – a change that may increase the number of
MD diagnoses and possibly increase the number of people with CG issues who receive
pharmaceutical interventions (Bandini, 2015). This may also increase the need for clinicians to understand clients’ traditional and cultural methods of grieving better (Bandini, 2015), as well as to recognize better how to address a differential diagnosis of CG (M. K. Shear, 2015).

Some researchers have attempted to create a body of empirical data that could support the creation of CG as a distinct clinical diagnosis (M. K. Shear, 2015). This has led to an academic debate about the extent to which clinicians can view and treat CG as a unique clinical imperative, in contrast to the diagnoses of MD, generalized anxiety disorder, and PTSD, as well as the distinction from normal or uncomplicated grief (Hogan, Worden, & Schmidt, 2004).

Researchers at the Langley Porter Psychiatric Institute from the University of California, San Francisco, established criteria for a disorder of CG based on structured interviews and self-report rating scales that examined the experiences of 70 subjects’ bereavement in increments of six and 14 months after the deaths of their spouses (Horowitz et al., 1997). After identifying 30 questions that related to possible CG symptoms, they analyzed their data using latent variables, a method that assesses the relationships between the measured and conceptual variables (Stangor, 2007). Their CG criteria established a minimum bereavement time frame of 14 months, as well as signs and symptoms criteria that fell under the categories of either intrusive symptoms or signs of avoidance and failure to adapt (Horowitz et al., 1997).

Researchers at Yale University also developed criteria for CG, after first developing the Inventory of Complicated Grief (ICG) in 1995 (Prigerson, Maciejewski, et al., 1995). A series of studies demonstrated the specificity, reliability, validity and
predictability of scores on the ICG (Prigerson, Bierhals, Kasl, et al., 1996; Prigerson, Bierhals, & Zonarich, 1996; Prigerson, Frank, et al., 1995), and consensus criteria for CG eventually emerged based on this tool (Prigerson & Jacobs, 2001).

Prigerson et al. (2008) made a case for including prolonged grief disorder in the DSM-5. Researchers now consider prolonged grief disorder and CG as the same. Prigerson et al.’s (2009) criteria for prolonged grief disorder stipulated that bereavement is due to death, as opposed to other forms of loss, and that a key symptom is that of separation distress. Other symptoms of bereavement that may fluctuate in frequency and intensity include trouble accepting the death, inability to trust others, excessive bitterness or anger related to the death, difficulty moving on in life, numbness or detachment, feeling that life is empty or meaningless without the deceased, visualizing a bleak future, and agitation. Persistent impairment in functioning and duration lasting at least two months from the time of onset are also pertinent to Prigerson et al.’s (2009) CG criteria. Despite the proposal of criteria for the DSM-5, the American Psychiatric Association did not include CG as a distinct diagnosis, but clinicians continue to research and treat it.

**Measuring CG**

There are several measures that quantify the subjective experience of grief. The short review here lists assessments, provides short descriptions, and offers some information on the validity, reliability, and practical considerations of the various tools.

**Texas Revised Inventory of Grief.** The Texas Revised Inventory of Grief is a 21-item scale that measures pathological grief symptoms, as distinguished from normal grief. This measure evaluates thoughts, feelings, and behaviors based in the past, or shortly after the loss by death, as well as in the present, or during the data collection.
Two subscales are structured as five-point Likert-type scales, and they sum to produce one total score (Faschingbauer, 1981).

One criticism of this tool is the retrospective nature of the questions in the first subscale that allow for memories to influence the current state. This instrument underwent expansion to measure 58 items that showed more variability in the grief response (Zisook, DeVaul, & Click, 1982); however, there is a lack of data to support the validity and reliability of the revised tool.

**Hogan Grief Reaction Checklist.** The Hogan Grief Reaction Checklist is a 61-item Likert-type questionnaire that developed based on interviews with bereaved adults. Six categories emerged from interview content analysis, namely despair, panic behavior, blame and anger, disorganization, detachment, and personal growth. Researchers reduced an original 100-item questionnaire to these 61 items after piloting with four purposively selected focus groups (Hogan, Greenfield, & Schmidt, 2001). In the Hogan Grief Reaction Checklist, respondents identify thoughts or feelings from a list that they may have experienced in the prior two weeks since the loss of their loved ones.

The Hogan Grief Reaction Checklist appears to have sound psychometric support. As Hogan et al. (2001) reported:

Additional data are provided that support reliability and validity of the HGRC as well as its ability to discriminate variability in the grieving process as a function of cause of death and time elapsed since death. Empirical support is also provided for Personal Growth as an integral component of the bereavement process. (p. 1)
The Hogan Grief Reaction Checklist does not produce one total score, and each subscale appears to measure different aspects of a grief response. However, it is not clear from research or design whether the Hogan Grief Reaction Checklist is measuring CG, or normal grief, making this tool difficult to recommend as a measure of CG.

**Grief Evaluation Measure.** This self-report tool can “screen for the development of a complicated mourning response in a bereaved adult” (J. R. Jordan, Baker, Matteis, Rosenthal, & Ware, 2005, p. 301). The Grief Evaluation Measure provides an assessment of risk factors to evaluate the subjective grief experience and symptoms of each subject. Several factors relate to the specific loss, including circumstances of death, medical history of the bereaved, and coping resources. This test does not depend on any specific theory, but rather the variables the members of the research team observe in the client’s complicated mourning responses. The research team comprised practicing clinicians who do much work in grief counseling response (Jordan et al., 2005).

The test has seven sections that ask personal demographic and socio-economic questions, questions about the respondents’ history of loss and use of healthcare services, questions about personal relationships, questions about the circumstances of the death, and 91 questions pertaining to the respondents’ experience of grief. There is also a section in which each respondent has the chance to write an open-ended narrative, consisting of other information that he or she wants to share, or thinks might help the clinician. The reliability testing for this tool involved a very small sample, and thus, it warrants further testing. There is a suggestion that this tool may be able to discriminate
between respondents based on the severity of their grief response (Jordan et al., 2005). The length of the instrument may also disallow practical use in clinical practice.

**Core Bereavement Item.** The Core Bereavement Item is a 17-item tool derived from grief literature and investigators’ clinical experience. The basis of the tool is data from a longitudinal study that examined the grief responses of bereaved spouses, bereaved parents, and bereaved adult children (Middleton, Raphael, Martinek, & Burnett, 1997). The Core Bereavement Item is a measure made up of three subscales that comprise phenomena frequently experienced by the bereaved: images and thoughts, acute separation, and grief. This tool has high internal consistency reliability (Cronbach’s alpha coefficient of 0.91; Stangor, 2007).

**Inventory of Complicated Grief- Revised (ICG-R).** This 19-item inventory developed by Prigerson, Maciejewski, et al. (1995) originally underwent testing with 97 elderly bereaved men and women. This tool assesses symptoms that predict long-term dysfunction (Prigerson & Jacobs, 2001), and distinguishes CG from other related diagnostic issues, such as anxiety and depression (Prigerson, Maciejewski, et al., 1995). Factor analysis showed that the ICG-R measured the single underlying construct of CG, and researchers obtained both high internal consistency (Cronbach’s alpha coefficients of 0.92-0.94) and test-retest reliability estimates (0.80). This inventory is easy to administer, and thus it seems a most effective tool for assessing CG. Researchers have called for longitudinal research to determine the capacity of the ICG-R to predict CG responses.

**Revised Grief Experience Inventory.** Parkes’s (1972) framework of bereavement is the basis for this 22-item, six-point scale. The tool measures framework
levels of depression, physical distress, existential distress and tension/guilt. There were mixed results for correlations between the Revised Grief Experience Inventory results and elapsed time since loss and length of illness (Lev, Munro, & McCorkle, 1993). It is also not clear whether this tool can detect a CG response. Further testing with this instrument may be necessary if severity of grief response over time is a useful indexing tool for CG reactions.

**Bereavement Risk Index.** Parkes proposed the original Bereavement Risk Index in 1988 and more recent tests have used a modified 4-item version that goes by the same name. This modified version has undergone testing to study the validity, reliability, and feasibility in an Australian home hospice care setting (Kristjanson, Cousins, Smith, & Lewin, 2005). One hundred and fifty bereaved family members classified as high, medium, or low risk of CG participated in a structured bereavement support protocol based on their Bereavement Risk Index measured risk levels. In this study, nurses could implement the instrument with minimal training and adhere to a bereavement support protocol (Kristjanson et al., 2005).

**Grief measures of specific context.** Several instruments can assess grief in specific contexts. The Grief Experience Questionnaire is a 55-item questionnaire that examines specific grief elements in survivors of suicide. Relevant grief response symptoms include physical reactions, general grief reactions, searching for explanation, loss of social support, stigmatization, guilt, responsibility, shame, rejection, self-destructive behavior, and reactions to unexpected death (Barrett & Scott, 1989). The Grief Experience Questionnaire may have the potential to differentiate the grief reactions
of survivors of suicide from those of survivors of accidental or unexpected death. Factor analysis has not yet confirmed the dimensions of this tool.

The Perinatal Grief Scale measures the intensity of grief response symptoms following the loss of a baby (Toedter, Laser, & Alhadeff, 1998). Shorter versions of this scale exist, and researchers have explored them for validity to ensure concurrence with symptom checklists, depression scales, and measures of parental distress.

**Summary of grief measures.** Several measurement tools are available, and many aim to identify a more acute CG response or the risk of the development of a CG response. Many recommend that clinicians who are assessing individuals for CG use the criteria specified by Prigerson and colleagues in the ICG-R (Prigerson & Jacobs, 2001). Primary care health professionals should screen bereaved individuals for possible CG if they present with symptoms that are persistent (six months or more post-death) or severe (intensity or frequency of symptoms that present daily) (Kristjanson, Lobb, Aoun, & Monterosso, 2006).

In addition, most of the measures listed above do not consider tools that more broadly assess psychiatric symptoms of emotional distress. Neimeyer and Hogan (2001) indexed all-purpose measures of symptomology that may fit into bereavement studies, such as the Brief Symptom Inventory. Many recommend that bereavement studies researchers consider measures of psychiatric symptoms to differentiate CG better from diagnoses with similar symptoms, such as MD and PTSD.

**CG Interventions**

Researchers have attempted to uncover the most effective treatments for CG. Some have also assessed the efficacy of treatment interventions for diagnoses that show
symptoms similar to those of CG. Typical interventions for depression and standard grief counseling have been ineffective in relieving symptoms associated with CG (K. Shear et al., 2005; M. K. Shear, 2010).

K. Shear et al. (2005) designed a targeted new treatment for CG that draws on techniques and concepts from interpersonal therapy, motivational interviewing, positive psychology, and cognitive-behavioral therapy. They called it CGT. CGT can help a grieving person to make the adaptations necessary in life to allow the intensity of his or her grief to subside, to accept the reality of loss, and ultimately to feel satisfaction in life again. CGT assumes a natural capacity to adapt after the experience of loss, and the treatment builds on this by encouraging clients to focus on grief and loss in each session. Practitioners first encourage clients to revisit the initial period of loss, and then help them to move their thinking into the future. CGT emphasizes personal strengths, resources, and relationships with others, as well as maintaining bonds to the deceased (M. K. Shear, 2010).

K. Shear et al. (2005) explored CGT using a randomized controlled trial. They stratified participants according to the manner of death of a loved one and the treatment site. They recruited a total of 95 men and women aged 18 to 85 years who met the criteria for CG via professional referrals, self-referrals, and media announcements. They randomly assigned participants to either 16 sessions of standard interpersonal psychotherapy treatment ($n = 46$) or to a similar number of CGT sessions ($n = 49$). Both treatments were effective in reducing grief symptoms. The CGT group, however, showed significantly greater improvement, and researchers concluded that CGT is a more
effective treatment than interpersonal psychotherapy, because it showed higher response rates and faster response times.

Current research in CGT looks at efficacy in certain populations. M. K. Shear et al. (2016) attempted to confirm the efficacy of CGT on CG and the effects of citalopram in elderly persons. Citalopram is a selective serotonin reuptake inhibitor that is useful to treat depression. M. K. Shear et al. divided 395 bereaved adults showing symptoms of MD into four groups in four metropolitan areas. One group received the medication Citalopram \((n = 101)\), a second group received a placebo medication \((n = 99)\), a third group received CGT with Citalopram \((n = 99)\), and the fourth group received CGT with a placebo medication \((n = 96)\). Independent evaluators assessed each study participant in each group for 20 weeks, and they compared responses under the intention-to-treat principle, meaning that once randomized, they included each participant’s treatment in the analysis to help to counter the effects of crossover and dropout. This study found that CGT was the current optimal treatment of choice, and that the addition of Citalopram helped to address co-occurring depressive symptoms. While there have been studies that compare the effectiveness of various pharmacological agents that improve depression and grief intensity symptoms, current pharmacotherapy research on CG seems to focus on the collaborative effect of medications and psychotherapy approaches (M. K. Shear et al., 2016).

A form of treatment for CG that is quite common, but typically non-clinical in nature, is a grief support group. Support groups exist in the realm of many diagnostic and situational life issues, and their basis is the concept of perceived similarity; while there is little empirical research, there is some anecdotal backing (DeSpelder & Strickland, 1987).
However, many individuals with chronic bereavement issues or CG report not finding support groups helpful in alleviating their grief symptoms (Strouse, 2013). These groups tend to be unstructured or semi-structured, and many are peer-based, rather than having therapists or researchers leading them. Survivor support groups vary in their emphasis, approach, and methodology (DeSpelder & Strickland, 1987).

Bartone, Bartone, Violanti, and Gileno (2017) conducted a systematic review of peer support groups and investigated best practices in peer support for bereaved survivors (Bartone, Bartone, Gileno, and Violanti, 2018). Their findings, after reviewing 32 studies, suggested that most studies showed evidence that peer support helped bereaved survivors in part by reducing grief symptoms, and increasing well-being and personal growth. There was even evidence of benefit from Internet-based support groups, which were helpful in part due to their ease of accessibility. Survivors of suicide especially benefited from peer support, perhaps due to a real or perceived stigma that may relate to suicide (Bartone et al., 2017). It is unclear how many subjects may have met the criteria for CG; there was no distinction between bereaved survivors and survivors with CG in terms of their benefit from peer support groups.

In a follow-up study, these same researchers (Bartone et al., 2018) examined the important elements in effective peer support programs to understand better why bereaved survivors are achieving benefit. Findings from their investigation into best practices indicated that peer support programs that are effective are easily accessible, confidential, provide a safe environment, utilize carefully chosen peer supporters with similar experience who have training, and partner with professional mental healthcare providers or institutions (Bartone et al., 2018). One published study (Graham & Sontag, 2001)
looked at the use of art as an evaluative tool for children in grief support groups, although it did not specify CG, and nor did it suggest that art making was art therapy. It was a pilot study that attempted to address the limited literature indicating efficacy of grief support groups. This pilot study used art making to allow children to express their experience of a grief support group. The authors wrote that the results support the use of art as an effective qualitative tool for evaluating children’s grief groups (Graham & Sontag, 2001).

Psychotherapy interventions for CG are often group-based, and they may vary in theoretical approach, including cognitive-behavioral therapy, psychodynamic therapy, behavioral therapy, or interpersonal therapy. A Canadian study examined group therapy as an intervention for clients with CG (Ogrodniczuk et al., 2003). The researchers selected participants for an interpretative or supportive psychotherapy group using a stratified random process, matching for personality characteristics, gender, and age. The goal of the interpretative therapy was to increase the patient’s insight regarding repetitive trauma and conflicts associated with the loss. These personal conflicts could serve as obstacles to normative mourning, and resolution could improve the patient’s adaptive response to loss. Supportive therapy, in contrast, could improve the patient’s immediate ability to adjust to his or her loss. In both cases, patients met weekly for 90 minutes across 12 weeks (Ogrodniczuk et al., 2003). The results indicated that there are different dimensions of CG. These might indicate different types of grief reactions. This study suggested that both therapies were effective, perhaps with people with different grief reactions. The authors also differentiated between CG and MD, and they suggested that clinicians should not rule out CG in the absence of MD (Ogrodniczuk et al., 2003).
Subsequent studies drew on Ogrodniczuk et al.’s (2003) study, examining how various patient characteristics, as well as group processes, interacted to influence treatment outcomes (K. Shear et al., 2001, K. Shear et al., 2005). Most of the follow-up studies showed some benefit of psychotherapy, although the lack of a control group was often a limitation.

K. Shear et al. (2001) and K. Shear et al. (2005) conducted psychotherapy-based interventions for CG that used individual, not group therapy. They tested the efficacy of a traumatic grief treatment protocol, which they later called CGT, which involved a revisiting of the death experience, examination of avoided activities and situations including possible exposure, and interpersonal therapy (K. Shear et al., 2001). They found that the CG scores decreased significantly for both subjects who completed the treatment and those with intent to treat, as compared to subjects who experienced only interpersonal therapy. Later, K. Shear et al. (2005) compared the efficacy of CGT with standard interpersonal psychotherapy using a randomized controlled clinical trial. In this study, both treatments produced improvement in CG symptoms, although the CGT showed more significant improvement than interpersonal psychotherapy (K. Shear et al., 2005). K. Shear et al. (2005) measured improvement by independent evaluator-rated Clinical Global Improvement scores, or as 20-point or better increases on the self-report ICG. Since a high proportion of patients in this study were using psychotropic medications, controlling for this has been a topic of interest in other studies.

Saltzman, Pynoos, Layne, Steinberg, and Aisenberg (2001) evaluated a school-based screening and group treatment protocol specifically for adolescents who underwent exposure to community violence and traumatic loss. They initially assessed the grief
experience of 26 adolescents the Grief Screening Scale and the UCLA Trauma-Grief Screening Interview. They used a pre- and posttest design, and their results suggested an association between participation in group therapy and improvement in CG symptoms, including posttraumatic stress, as well as academic performance (Saltzman et al., 2001). The small sample size in this study, the lack of a control group, and the limited reliable measures make treatment outcomes difficult to assess or generalize.

There are limited studies of CG treatment that fall under the category of other therapeutic approaches. Kempson (2000-2001) considered the effect of touch therapy for one group (n = 31), to that of a control group (n = 34) of grieving mothers whose children had died within the last 6-60 months. Kempson found statistically significant improvement in favor of touch therapy on the scales of despair ($F = 8.290, p = 0.006$), depersonalization ($F = 4.904, p = 0.031$), and somatization ($F = 6.833, p = 0.012$), as measured by the GEI (Kempson, 2000-2001). Unfortunately, Kempson did not measure the actual effect of the touch therapy intervention on CG. Limitations included the absence of a specific instrument to measure the experience of touch and a non-verbal measure to assess the efficacy of the non-verbal intervention.

Sprang (2001) attempted to compare the effects of eye movement desensitization and reprocessing (n = 23) with guided mourning (n = 27) on traumatic stress and CG. Sprang measured grief with the Texas Revised Inventory of Grief, and clients completed pre- and posttreatment measures, as well as a follow-up nine months later. The results indicated that intensity of grief decreased significantly over the nine-month period for both groups, and there was no significant difference by treatment group. The lack of a
non-treatment control group and of random assignment made it almost impossible to distinguish the effects of treatment from a natural mourning process.

Layne et al. (2001) investigated whether participation in trauma- and grief-focused group psychotherapy showed a correlation with a reduction in posttraumatic stress, depressive symptoms, and CG. Fifty-five war-traumatized school students in Bosnia completed pre- and postgroup measures of posttraumatic stress, depression, and grief symptoms; Layne et al. (2001) measured CG with the Grief Screening Scale. The results were promising in that half of the students showed improvements in primary outcome measures and grief scores (Layne et al., 2001). Limitations included the lack of a control group, random assignment to treatment groups, and a reliance on self-report measures. A follow-up study examined 127 students, who Layne et al. (2008) randomly assigned to one of two experimental treatment groups. They evaluated program effectiveness based on symptom reduction of PTSD, depression, and maladaptive grief assessed via pretreatment and posttreatment comparisons (Layne et al., 2008). A limitation in this follow-up study was the lack of a control group. Also, it is unclear whether there is a distinction between maladaptive grief, the term they used in the study, and CG.

In a study investigating the use of five cognitive-behavioral strategies for adjustment to bereavement, Powers and Wampold (1994) identified factors that increase the likelihood of positive outcomes of grief counseling. They found that (a) having social supports, (b) engaging in health-promoting behaviors, (c) identifying themes of grief that cause distress, (d) attributing personal meaning to loss, (e) maintaining a connection to the deceased, and (f) allowing oneself to experience the emotions that come with grief
and to reinvest in normal life activities supported an improved bereavement outcome (Powers & Wampold, 1994).

Cognitive-behavioral interventions have shown some efficacy in the treatment of CG (Boelen, de Keijser, van den Hout, & van den Bout, 2011). One preliminary study examined data from 43 patients with CG who were randomly assigned to cognitive-behavioral therapy. Researchers found that greater effectiveness of treatment seemed to be associated with higher education level, stronger motivation for treatment, and completion of the treatment. The researchers speculate that some CG patients may need a longer cognitive behavioral treatment, and that there may be benefit in increasing patient motivation and adherence to treatment (Boelen et al., 2011).

While the studies above represent important advances in the treatment of CG, there is room for improvement in future research. Clinical fields could benefit from research that examines the links between assessment, intervention, and outcomes. Researched interventions should go to well-defined patient populations at clearly defined phases of bereavement. Future research on interventions should also consider the amount of practitioner training and the role that that may play in treatment efficacy (Kristjanson et al., 2006).

**Preventing CG Through Preventative Treatment**

Kissane et al. (2006) conducted a randomized, controlled trial ($N = 81$) with families of patients dying from cancer. They screened the families using the Family Relationships Index, and they identified families at risk of poor psychosocial outcomes during the palliative care of terminally ill patients, and afterwards during bereavement. They assigned two thirds of the families to family-focused grief therapy, and the
remainder formed a control group. Through periodic assessments using the Brief Symptom Inventory, Beck Depression Inventory, and Social Adjustment Scale, Kissane et al. evaluated the treatment group families’ progress, and they found a reduction in distress after 13 months. They noted that while global family functioning did not change, some families in the treatment group experienced improvement, and those individuals with high baseline inventory scores experienced significant improvement in distress and depression (Kissane et al., 2006). This finding suggests that family-focused grief therapy during the palliative care of terminally ill patients and into the bereavement period might prevent a CG response.

Cultural Differences in CG

Grief and CG are a deeply personal part of a person’s social and emotional experience, and are highly influenced by their cultural affiliations. People everywhere experience grief and become bereaved in the wake of losing a loved one to death but the manner in which we experience, identify, express, ritualize, commemorate and make sense of our grief can differ dramatically by culture, and even within cultures and subcultures (Rosenblatt, 2008). Expressions of grief can be affected and influenced by gender (Chen et al., 1999; Doka & Martin, 2010), race (Collins & Doolittle, 2006; Smith, 2002), ethnicity (Burton et al., 2012; Fujisawa et al., 2010; Ghaffari-Nejad et al., 2007; Langner, & Maercker, 2005; Momartin, Silove, Manicavasagar, & Steel, 2004; Spiwak et al., 2012), socio-economic income and education level (Newson et al., 2011), spirituality or religious affiliation (Becker et al., 2007; Mantala-Bozos, 2003; Smith, 2002; Walsh et al., 2002), social role such as caregiver (Chiu et al., 2010; Ghesquiere, Marti Haidar, & Shear, 2011), and possibly more. Even the language we use to discuss grief and the
measures we use to identify CG may be experienced as bias, uninformed and ineffective in some cultures.

Cruz et al. (2007) examined whether ethnic differences were evident in CG patients and whether treatment approaches were effective across ethnic lines. They developed a study that “contrasted the clinical presentation, treatment alliance, and rates of treatment completion and responses” (p. 700) for randomly assigned African American and Caucasian patients with CG as identified by use of the ICG. Participants received either 16 sessions of standard interpersonal psychotherapy or 16 sessions of psychotherapy augmented by focused CG components. Cruz et al. found that African American and Caucasian participants did not differ in their clinical presentation, treatment, or outcomes. Goldsmith, Morrison, Vanderwerker, and Prigerson, (2008) explored the prevalence of CG (called Prolonged Grief Disorder in their study) in African Americans, and found significantly higher rates than in Whites. This team discussed the need to identify individuals at high risk for CG, refer them to therapy, and to ensure that CG is addressed in culturally sensitive approaches to treatment (Goldsmith et al., 2008). There is other literature that examines various aspects of the CG experience in the African American population, including as pertains to religion (Smith, 2002) funeral rites and rituals (Collins & Doolittle, 2006).

Spiwak et al. (2012) wrote about the potential increased risks from trauma and loss that may befall Aboriginal individuals and challenged researchers to create more studies that would look at this sub-culture, and do so in a way that cooperates with Aboriginal communities to help identify risk factors for CG. Ghaffari-Nejad et al. (2007) interviewed 400 Iranian survivors of a devastating earthquake that destroyed the city of
Bam, Iran. Researchers here were seeking to identify the prevalence of CG as well as its correlations with various demographic factors including gender, educational level, presence in the city during the traumatic event, loss of home, and loss of first degree relatives. They found the presence of CG in 76% of respondents (Ghaffari-Nejad et al., 2007). A study of prolonged grief disorder and depression in widows due to the Rwandan genocide found such a strong correlation between these two conditions, that researchers are not sure that CG is a distinct nosological entity, and that it may be a facet of depression (Schaal, Elbert, & Neuner, 2009). Through these studies we see instances of CG in Aboriginal, Iranian, and Rawandan cultures, and we may begin to understand some of the cultural differences in CG and the human nuance in the grief experience. These studies also may encourage more research that examines the relationship between CG and trauma.

Research culled from various cultures can be used to establish expectations of CG or related phenomena which are culturally specific, as well as addressing best practices in treatment. One study aimed to establish norms for CG among the Japanese population, and found such a high prevalence of sub-threshold CG among participants that researchers concluded that routine screening for CG could better identify those in need of help (Fujisawa et al., 2010). Another study looked at the comparison in CG and coping between American and Chinese populations (Burton et al., 2012). Studies like this might begin to help understand the impact of culture on grieving rituals and rites, as well as what is considered CG or pathological grief within various cultures, and how to best help individuals with CG from any given culture.
Grief in Art Therapy and Creative Approaches

As I stated earlier, there has been an increase over the last 20 years in the amount of art therapy literature that addresses working with people experiencing pervasive and intense grief (DiSunno et al., 2011; Finn, 2003; Griffith, 2003; O’Callaghan et al., 2013; Safrai, 2013; Schimmel & Kornreich, 1993; Turetsky & Hays, 2003; Webb, 2003; Webb-Ferebee, 2003). Despite this, there are few studies specifically addressing CG within the art therapy profession, including possible art therapy treatments for patients with CG. Many art therapists work with grieving clients or those suffering with CG. Some grief counselors employ arts-based techniques in their work. Tools and techniques are available to support creative explorations of grief.

One of the first art therapists to publish a workbook on grief was Graves-Alcorn (1994). Her text allows for a wide spectrum of grief sources and explains some of the physical, social, emotional, intellectual, and spiritual processes involved in grieving. Graves-Alcorn engaged her readers in directed creative activities and asked questions to guide them towards understanding their losses as part of developing a new identity. This book deals with the process of grief as developmental milestones and with making a range of emotions (e.g., mad, sad, glad, and scared) functional for healing. This workbook is a tool derived from many years of clinical practice.

Dying, Bereavement and the Healing Arts, edited by Gillie Bolton (2007), is a collection of essays by practitioners discussing their use of the arts in bereavement and at the end of life. These artists, many of whom are also clinicians, use their media for expression, for communication, and for processing their experience, always toward some sense of healing. The authors in this collection share an examination of their own
experience with grief to inform and assist their clients who are wrestling with emotional pain.

Art therapists Leeuwenburgh and Goldring (2008) collaborated on a resource for young people to process their grief at age-appropriate levels. Their book, Why Did You Die?: Activities to Help Children Cope with Grief and Loss, offers exercises and practical tools to help grieving children to understand death better, and to cope better with low grades, sleep problems, moodiness, behavior issues, and concentration deficiencies stemming from unresolved grief. This book uses creative approaches to help kids to learn to express their feelings and to develop self-care skills. The art therapist-designed workbook The Grief Bubble (DeBay, 2007) similarly leads kids ages six and older through creative activities to educate and help them to process deep thoughts and emotions.

Letter writing is an art form many pursue as a way of communicating with the deceased (Scofield, 2015). Writing can be healing for bereaved persons, in part because it can put them into direct and unmediated communication with their loved ones. Multiple creative techniques are involved in grief expression, including poetry (Young, 2010), songwriting (Heath & Lings, 2012; Roberts & McFerran, 2013), and prose (Hardy, 2013). There is a wealth of literature on written communication with the dead (Bolton, 2007; Lander & Graham-Pole, 2009; Rogers, 2007; Scofield, 2015; Seftel, 2006), but the topic is largely unexplored in grief-counseling research.

Feen-Calligan, McIntyre, and Sands-Goldstein (2009) used doll making in art therapy to help with bereavement. Through the case study of a 16-year-old client who was grieving her sister’s death, the authors examined dolls as therapeutic media in a
clinical setting. They found that dolls can provide a tool to communicate with the deceased. Since clients can often interact with them as characters, dolls can provide an opportunity for the therapist to work on relationships, including ones that have ended through loss (Feen-Calligan et al., 2009). Other creative approaches include Kohut (2011), who used scrapbooking with bereaved clients, helping them to collect photographs and mementos to create a memory book that honors the legacy of the deceased. Rutenberg (2008) also created casts of the dying person’s hands as a grief project and a way of leaving a legacy to survivors.

Several authors discussed art therapy in relation to a variety of specialized populations experiencing grief. In most of these articles, the emphasis is on the inclusion of art-making in therapy (Bardot, 2008; Farrell Fenton, 2008; Graham-Pole & Lander, 2009; Turetsky & Hays, 2003), including certain media (Kohut, 2011; Rutenberg, 2008), and on the unique attributes of the populations, such as children (Chilcote, 2007; Graham & Sontag, 2001; Raymer & Betker McIntyre, 1987), survivors of natural disasters (Chilcote, 2007; Suk Mun Law, 2012), inmates (Ferszt, Hayes, DeFedele, & Horn, 2004; Hanes, 2008), and parents who have lost children (Seftel, 2001; Speert, 1992).

Turetsky and Hays (2003) discussed the development of an art-psychotherapy model for the prevention and treatment of unresolved grief. Their model focused on the adaptive mourning needs of mid-life adults and the pursuit of active grief, while simultaneously awakening creativity through art exploration. They posited that the dual process allows for “a more effective transition through the mid-life period” (p. 148), a perspective supported by the dual-process theory of grief (Stroebe & Schut, 2005-06).
There are art therapists whose journey into grief work arose from their own experience with loss. Strouse (2013) wrote of the decade of grief she experienced following the suicide of her 17-year-old daughter. She used her own artistic process of making collages as a tool in helping her process her grief, and now she uses a similar method in her clinical social work practice that largely centers on helping other bereaved parents mourn their children. She is a proponent of collage as a medium, and she uses it as a reparative tool that lets the bereaved actually piece together a new visual reality from given scraps, a process she describes as transformative (Strouse, 2013). Another art therapist, Seftel (2006) wrote about grief and loss after her own experience of having a miscarriage. This author then went on to use art as a clinical intervention with others who are grieving pre- and postnatal deaths.

Psychologists K. Hill and Lineweaver (2016) conducted a study that evaluated the change in 54 grieving children after individually making art, as compared to collaborative art making, and individual or collaborative puzzle assembling. While findings suggested that the creative and expressive aspects of art making are effective for improving mood in children coping with grief, this study did little to inform on the use of art materials or art therapy techniques. Children received canvas, oil pastels, and watercolors and instructions to “Create a happy person” (p. 93), or in the case of group work, to “Work together to create a happy person” (p. 93). The researchers stated that participants “were at different stages in the grieving process” (p. 93), but they did not further define what the process or stages were, or categorize the participants in any way. The authors stated that they wanted to evoke positive emotion, which was important in prior research, and cited studies that aimed to reduce stress, confront sadness, and improve mood through art
making (Curl, 2008; Dalebroux, Goldstein, & Winner, 2008; Drake & Winner, 2012; Pizarro, 2004; Smolarski, Leone, & Robbins, 2015). K. Hill and Lineweaver (2016) had all participants complete a modified version of the Positive and Negative Affect Schedule, a measure of current affect, at both the beginning and end of the session.

Schut, de Keijser, van den Bout, and Stroebe (1996) wrote about a new grief treatment program that they termed cross-modality grief therapy. They developed this approach as a time-limited, inpatient, group treatment protocol that integrated behavioral and art therapy. The authors implemented a pre-, post-, and follow-up assessment that measured symptoms and compared the levels with participants in a more traditional program. These researchers found advantages in incorporating art therapy into the treatment. One case client who could hardly talk in behavioral therapy thrived in art therapy, where she could convey her grieving process visually.

Her art works not only reflected where she was in terms of her grieving process (e.g., her preoccupations, anxieties, and so on), but they also revealed her ongoing, active, effort to cope with grief during—even by means of—their actual creation. (Schut et al., 1996, p. 362)

Art therapy with these clients utilized a variety of techniques, including symbolic and metaphorical representation, confrontation of emotions, and music-guided visualization. Researchers felt that the use of art therapy in conjunction with behavioral therapy made for a more successful treatment protocol due in part to the structured approach that came with the art therapy, and the use of art therapy in a group context (Schut et al., 1996).

Sas and Coman (2016) wrote about the value of developing personal grief rituals, including the making of personal symbols through craft. These authors interviewed 10
therapists with expertise in grief therapy and grief rituals to improve their understanding of the value of hand-crafted personal symbols that might help in clients’ processes of honoring, memorializing, letting go, and experiencing self-transformation that can accompany loss. Sas and Coman discussed the value of making, handling, and showcasing symbols for use in grief rituals, or those that can themselves become grief rituals.

There are a few modern books that look at the use of the creative arts therapies for use with clients in grief. Brooke and Miraglia (2015) compiled a volume that includes examples of art, play, music, dance/movement, drama, and animal-assisted techniques in therapy. Most chapters come from credentialed professionals within the named specialty. Each chapter looks at creative techniques for facing grief, sometimes with a specific case study or type of client (Brooke & Miraglia, 2015). Thompson and Neimeyer (2014) also created a volume for a diverse clinical audience that examined the use of varied art forms and techniques in a series of chapters by some well-known creative arts therapists. They discussed the use of the arts as a staple intervention in hospices, in grief camps, among survivors of suicide, and in trauma programs, and they provided case studies to accompany the various techniques they discussed. These editors also addressed the issue of when to use what approach, and they proposed that creative techniques are a natural fit for a modern and evolved understanding of grief therapy that includes a highly individuated experience (Thompson & Neimeyer, 2014).

Rogers (2007) included a volume of creative approaches for working with those in grief, based on the foundation that the talking cure does not always work, and that clinicians can benefit from using creative arts approaches. This book includes pictures
and detailed instructions for an eight-session curriculum for use in a grief support group (Rogers, 2007). In his 2012 volume on *Creative Practices for Counseling the Bereaved*, Neimeyer included more than just the arts; he interpreted creativity in counseling to include techniques that are embodied, that use behavioral and cognitive approaches, that deal with clients who exhibit resistance, and that include the writing of narratives, consolidating memories, accessing existing resources, and renewing the bond with the deceased. Each chapter author included notes on what clients each given technique is appropriate for, as well as recommendations for further study pertaining to theory, research, and practice associated with each technique. This volume was designed for a clinician who sees lots of clients with bereavement issues and understands how diverse these issues can be (Neimeyer, 2012).

Art Therapist MacWilliam (2017) edited a book that proposed eight-week art therapy curricula for use with clients suffering from CG. This is the first book that directly addresses the use of art therapy with CG, and its authors promoted approaches they drew from attachment theory, research in mindfulness, dialectical behavioral therapy, and art therapy relational neuroscience. While the curricula in this book lack published research, they begin to address a void that existed in the art therapy literature promoting an understanding of CG and the value of visual-art based approaches with CG.

There is still a paucity of literature based in research that examines creative interventions or approaches with CG. At this time, there is no research literature in art therapy that compares or contrasts art media, techniques, or projects useful with clients experiencing grief, or that looks at creative interventions used across populations (Lister et al., 2008).
Grief and the Arts

Grief Expression in Art

Artists have been turning to creative expression to cope with grief for a long time. Similarly, those in grief have turned to the arts for solace and relief, even if they do not identify as artists. The world of art in the expression of grief is rich, and I provide here just a small sample of examples.

In Figure 1, Artist Joseph Wright (1790) explored the complex emotions in loss through a depiction of a scene in the tomb, from the play *Romeo and Juliet*, by William Shakespeare. Similarly drawing on history and literature, Figure 2 showcases the *Pietà* (Neue Photograpische Gesellschaft AG, 1894-1948), a sculpture completed by Michelangelo in 1499. In this piece, we see a solemn Mary mourning the loss of her son Jesus, after his crucifixion.
Figure 1. Romeo and Juliet: The Tomb Scene by Joseph Wright. This figure illustrates the fatal scene where Juliet awakens to see that her lover is dead, and she is filled with grief.
Figure 2. Mary cradles her dead son Jesus in this marble Pietà by Michelangelo.

Artist Jean-Michel Basquiat (1987) created Gravestone, the piece of art depicted in Figure 3, out of acrylic and crayon on three hinged doors. This piece, created on salvaged material, was Basquiat’s memorial and homage to his friend Andy Warhol, who died that year.
Figure 3. *Gravestone*, by Basquiat, is an art piece memorializing the artist’s friend, Andy Warhol.

In Figure 4, we see the Albert Memorial (Scott, 1972) located in Kensington Gardens in London, which Queen Victoria commissioned in 1872 to memorialize her beloved husband Albert, who died of typhoid in 1861. The work incorporates several types of stone, and it has a Gothic revival style canopy with an ornate bronze statue of Albert underneath. This example showcases how even nonartists turn to art as a vehicle to remember those loved and lost. It may also suggest a phenomenon whereby a griever benefits from publicly proclaiming his or her grief and love. Similarly, the Taj Mahal (Lahauri, 1653), shown in Figure 5, is a larger-than-life mausoleum in Agra, India, that the Mughal emperor Shah Jahan commissioned in memory of his beloved third wife. This enormous white marble testament to love and grief took over 20 years to complete, and it has inspired its own architectural style.
Figure 4. Queen Victoria commissioned Sir George Gilbert Scott to design and build this Albert Memorial in honor and memory of her deceased husband.
Figure 5. Lahauri designed the white marble Taj Mahal, in Agra, India as a mausoleum to house the tomb of Mumtaz Mahal, favorite wife of Emperor Shah Jahan.

The final example here of grief depicted in art is Figure 6, an oil painting called *To My Wife*, by Marc Chagall (1944). Chagall was famously in love with his wife, writer Bella Rosenfeld, who served as his creative muse throughout his life and appeared in many of his paintings (Jamieson, 2016). Bella died of a viral infection in 1944, and her husband spent the rest of his life expressing his grief over her loss in his artwork.
Figure 6. *To My Wife*, an oil painting by Marc Chagall, is just one of many paintings that honor his deceased first wife Bella and the love that they shared.

Somewhere between the world of artists who make their own art and art therapists who help to facilitate the making of client art, there is a wealth of coloring books. Artists often make coloring books to help people to make art. A recent rise in the popularity of coloring books (Alter, 2015; Berl, 2015; Blackburn & Chamley, 2016; Eglash, 2015) has seen a wealth of coloring books that deal with various personal and psychological issues, including grief (Derman, 2016; Diehl, 2016; Grace, 2016; Lightfoot, 2012; Manning, 2009; Nakamura & DeNami, 2017; Stickney, 2009). In many cases, these artists create images first to help process their own grief, and they then market them in the service of helping others in grief to access their creativity, as Barton (2017) did with her coloring book about death and grief. Barton created her book as a tool to combat her own grief at
a time when she lost several loved ones. In this written and illustrated coloring book, Barton tackled topics as diverse as funeral rites and rituals to decay, and from coffin design to feelings associated with one’s own death.

**Textile Collage and Altered Books**

Literature exists on the use of textile collage (Collier, 2011; Garlock, 2016) and altered books (Chilton, 2007; Harrison, 2002) with the bereaved. Both media have links to transformation, however, a primary goal in helping clients with CG to integrate their experience of grief (Joffrion & Douglas, 1994; Romanoff & Terenzio, 1998).

Harrison (2002) described the process of altering books as both playful and naughty, and she suggested forgetting any learned rules. She discussed the comfort of creating on a page that is not blank, and incorporated techniques like stitching in objects, layering, and using themes and materials to express a mood or meaning. With examples from children’s literature and historic texts, Harrison used the art form as a method of transformation that imposed her new meaning on a canvas that formerly had a different meaning. Sometimes there is a connection between the new and old meaning; often there is not. Chilton (2007) wrote that when “creating an altered book, the emphasis is on the significant alteration and transformation of another’s work into one’s own” (p. 61).

Brazelton (2004) wrote of her love of recycling and of the transformation that comes from giving new meaning and value to something old.

Chilton (2013) used altered book making as an arts-based research technique that traced her learning about arts-based research. She discussed her “transformative learning” (p. 457), which stemmed from a 10-week independent study course that was part of her doctoral program, and the resulting “transformation-through-the-arts
paradigm” (p. 467). For Chilton (2013), both the making of her altered book art and the communicating about it are transformative experiences that can contribute to personal, social, and cultural change. Chilton (2007) also wrote about using altered books clinically in art therapy with adolescents. She recommended altered book making as an option for art therapists who wish to promote creativity while also providing clients with a means of containing their emotions and experience (Chilton, 2007).

In altered books, the art object acts as a metaphor for how our lives are altered by experiences. Our own core text—that blend of culture, childhood experiences, and inner spirit—can also be transformed by the material life presents us, (p. 63) wrote Chilton (2007), who concluded that, “the art concretizes a life transformed” (p. 63).

Cobb and Negash (2010) wrote about using altered book-making in art therapy as a means of allowing clients to gain insight, harness control, face obstacles, and narrate their own story. Rewriting a book in the context of therapy, as one would do in creating an altered book, “symbolizes the parallel possibilities that clients have to reauthor their own lives” (Cobb & Negash, 2010, p. 54).

Huntley (2015) conducted research and wrote a master’s thesis on the topic of using altered book-making in art therapy with children and adolescents who were affected by traumatic loss. Huntley hypothesized that art therapy would be effective with this population, and that altered book making would lessen the traumatic grief symptoms of children and adolescents. She employed a pre- and posttest for the group, as well as open-ended post research surveys after conducting six sessions of an art therapy group. The research group included four children and teens who had lost family members to death by traumatic means, such as homicide or suicide; the loss had occurred within five
years. Participants reported an increase in their understanding of grief responses, emotional identification, and self-reflection. Through the altered book-making intervention, study participants reported a decrease in anger, dissociation, and trauma symptoms (Huntley, 2015). Huntley (2015) suggested that altered book-making might be especially useful since it encourages clients who likely feel out of control to take control of a found object (a book) and to use it to create a new story.

While the book itself provides the grounding foundation for the art piece, the client is encouraged to assert [his or her] personal choices within the pages. In addition, clients are given the control to open and close the book, protecting or revealing their artwork, when they choose. (Huntley, 2015, p. 80)

Eco-artist Attara (2012), who uses reclaimed materials in her art, created an altered book from a novel as a way of memorializing her mother and the experience of that loss. “When I page through this book, as I do several times a year, I love how as the book comes to a close” she wrote. “I can see the process itself that helped heal me as I tried to make sense of my mother’s pain and passing” (Attara, 2012, p. 139). After documenting her experience in creation and sharing several meaning pages and passages of her work, Attara made some recommendations for those interested in using altered books as means of honoring a loved one.

Textile and fiber arts have a rich legacy as a craft that is specific to women, and many consider it women’s work (Chansky, 2010; Collier, 2011; Nelson, LaBat, & Williams, 2005; United Nations Population Fund, 2012). There is ample support that textile and fiber arts are valuable forms of recording stories, memories, and record keeping, in good times (Rickerl, 1996), but also in times of struggle (Agosin, 1996, 2014;
Cohen, 2013; Fry, 1990; Moya-Raggio, 1984; F. Reynolds, 2004). Rickerl (1996) referenced quilting bees, where many artisans work together in a group to create a quilt. Collier (2011) surveyed 821 textile handcrafters and reported that some of the most important reasons women gave for engaging in textile making were to feel grounded and to cope with or change difficult moods.

In a qualitative study, F. Reynolds (2000) explored the individual meanings people project onto needlecraft fiber arts, and the way that 39 women used this art form to manage their depressive symptoms. The women reported feeling more relaxed, both mentally and physically, and feeling an increase in self-esteem associated with creative mastery, productivity, ability to change their social status, ability to accept praise from others, and ability to make creative choices (F. Reynolds, 2000). Homer (2015) wrote about the use of fabric collage as an approach to treating trauma. Demonstrating her consideration for neurodevelopmental factors in developing art therapy interventions for trauma, Homer wrote that “treatment that offers relational, relevant, repetitive, rewarding, and rhythmic activities may help ameliorate trauma by activating the limbic system” and stimulating the midbrain (p. 20). A National Endowment for the Arts survey of public participation in the arts suggested that craft-based practices, such as fabric and textile arts, are so prevalent in the United States that some art therapists suggest the use of this media in art therapy (Kaimal, Gonzaga, & Schwachter, 2017).

Garlock (2016) uses what she calls narrative textile in therapeutic work. “Art therapists and other mental health practitioners are increasingly using sewing as a medium, particularly in places where it is culturally relevant, to help people tell their stories graphically” (Garlock, 2016, p. 58). There is a growing body of literature that
attests to the use of textiles and fabric work with survivors of trauma (Agosin, 1996, 2014; Cohen, 2013; Fry, 1990; Homer, 2015). Garlock helps her clients to make story cloths in community groups that provide them with connections and help them to cope with traumatic events. Artist Allie Alden (2000) created fabric pieces drawn from her own grief; Alden suffered a miscarriage and as part of her healing sewed a small baby fetus the size of the one she had lost. She wore it inside of her bra, to keep it close to the spot where she would have nurtured it, and then eventually put it in a grief bag she had made for it that was modeled after a uterus. She wrote of how it helped her to have an object to hold and look at and to focus on in her grief, and so she began creating grief bags for other women who had lost unborn children (Alden, 2000). The aim of the Stiches Doll Project was to help women and girls who are living with HIV/AIDS to create a doll that could speak for them. In this initiative, community groups gather for support, education, and connection, and through the textile arts, women transform their personhood and voice into fabric beings (Lewis & Gerus-Darbison, 2014).

There is a tradition prevalent in many Latin American countries for women to create arpilleras, or cloth stories, which are a kind of woven, sewn, and embroidered tapestry (Comas-Díaz & Jansen, 1995). Arpilleras are frequently means of recording community and personal trauma, including violence against women, and they occur extensively in Chilean culture (Mujica, 1997). Arpilleras are also a form of protest against dictators or political regimes, and a way of documenting acts of war. Variations exist in many cultures (Charland, 2011). For many arpilleras (women who create arpilleras), these textile tapestries were a tool to help them contain, express, and placate
their grief. Eventually these arpilleras have come to represent the history of a nation, and they helped to build the platform for the human rights movement in Chile (Strauss, 2015).

Grief counselor and critical care nurse Jennie Wright-Parker (n.d.) runs the website called Recovering from Grief (https://www.recover-from-grief.com/creativity-grief.html), and she talks about the benefits of healing arts. She even recommends memorial quilts when individuals are coping with grief, and she makes suggestions for how to personalize them, for example by using the old clothing of the deceased (Wright-Parker, n.d.). Lauren Muscarella (n.d.) founded an organization called Trauma to Art in memory of her deceased mother. The mission of Trauma to Art is to help people with the initial stages of grief, by helping them to find therapists, recommending resources, and encouraging creative expression as a means of coping with grief. Muscarella does not recommend specific art as much as she shares her experience, and those of others, as examples of what she has learned (Muscarella, n.d.).

Since the creation of the AIDS Memorial Quilt in June 1987, memorial panels have become a common way for the bereaved to honor and remember loved ones who died as a result from AIDS (NAMES Project, 1988; Rickerl, 1996). The AIDS Memorial Quilt is one tool in our culture that has created a public space for grief (Power, 2009). One study reported a relationship between depression and self-transcendence among bereaved individuals who created AIDS memorial quilt panels; self-transcendence is the process that helps an individual to reestablish well-being after a significant loss. In this study, emergent themes included that quilting helped grieverers to accept loss, provided validation and a community of survivors, and created a living memory of the deceased (Kausch & Amer, 2007). There have been similar memorial quilt projects by the
bereaved in honor of other losses (Carocci, 2010), such as by the loved ones of victims killed in the World Trade Center attacks on September 11, 2001 (Megna, 2001), or the Columbine quilt (Fast, 2003). Romanoff and Terenzio (1998) wrote about rituals as being inherently transformative and discussed the use of objects as tools in ritual for transformation such as planting a tree, establishing a memorial fund, building a memory box, or creating a fabric quilt. Robertson (2009) examined the properties of quilting, including fabric, pattern, piecing, and binding, to examine their relevance to healing.

Both altered book projects (Brazelton, 2004; Chilton, 2007; Harrison, 2002) and textile collage have the capacity to help to create transformation (Garlock, 2016; Homer, 2015; Romanoff & Terenzio, 1998), both in physical materials and metaphorically in the client artists who create them. Effective resolution of CG requires that individuals transform their grief experience, their relationship with the deceased (Klass et al., 1996; M. K. Shear, 2015), and their own identity in light of their experienced loss (Schut et al., 2006; M. K. Shear, 2015; Stroebe & Schut, 2005-06). Altered book projects and textile collages seem to be media that could assist clients with CG in this transformative process. Using altered books and textile collage to express, contain, convey, and work through grief could provide creative and therapeutic opportunities for art therapists and the clients with CG with whom they work.

In summary, there is little published research that examines creative interventions or approaches for clients with CG. At this time, there are no known research studies that discuss art therapy, or media and projects for clients experiencing CG, and nor are there any studies that compare or contrast art media, techniques, or projects for clients experiencing grief (Lister et al., 2008).
Art Therapist Preparation for Clients with Grief

Part of what inspired the work this study describes, including the creation of a unit of study on CG for art therapists and the desire to elicit recommendations from seasoned art therapy practitioners who have seen clients facing grief and CG, is a distinct lack of preparation in grief for clinicians in the field. A pilot study formulated as a systematic review of graduate art therapy programs accredited by the American Art Therapy Association (AATA) as well as standards put forth by accrediting bodies, the Council for Accreditation of Counseling and Related Educational Programs (CACREP), the Commission on Accreditation of Allied Health Education Programs (CAAHEP), and TRICARE took place. The aim of this review was to help to assess art therapist preparedness in grief and CG and to inform the discussion of training recommendations.

CACREP

Today many graduate programs in art therapy have or seek accreditation with CACREP. CACREP (2016) provides a system of standards first developed cooperatively in 1981 by the Association for Counselor Education and Supervision and the American Personnel and Guidance Association. Recognized by the Council for Higher Education Accreditation, CACREP awards accreditation to qualified graduate-level and degree-granting programs in the professional counseling fields. CACREP accreditation includes the following entry-level specialty areas: addiction and career counseling, clinical mental health counseling, college counseling and student affairs, marriage and couple counseling, family counseling, and school counseling.

CACREP (2016) accreditation specifies the following eight common core areas of the counseling curriculum: professional counseling orientation and ethical practice, social
and cultural diversity, human growth and development, career development, counseling and helping relationships, group counseling and group work, assessment and testing, and research and program evaluation. Programs in art therapy may qualify for accreditation because they fulfill clinical mental-health counseling and training requirements. In accordance with CACREP policies, programs must use titles that accurately reflect the counseling area for which accreditation is conferred. The most recent CACREP standards were published in 2016.

The eight core areas covered by CACREP (2016) include 385 standards that pertain to master’s level education. The CACREP standards do not include any of the following terms: death, dying, grief, grieving, bereavement, bereaved, mourning, or loss. The CACREP standards document has no mandate that counselors have training in grief counseling, grief therapy, or working with clients who are bereaved.

**CAAHEP**

In 2016, the AATA adopted new standards and guidelines for art therapy programs set by an outside accreditation body. That is how CAAHEP standards came to be a new benchmark for art therapy programs. As with other similar bodies, CAAHEP sets standards for learning for art therapy programs, including curriculum, student evaluation, and outcomes reporting. The CAAHEP (2016) standards document does not include any of the following terms: death, dying, grief, grieving, bereavement, bereaved, or mourning. The word loss is included in the description of the profession, and it is used in the phrase “loss of brain function” (CAAHEP, 2016, p. 2). The CAAHEP standards document has no mandate that art therapists have training in grief counseling, grief therapy, or working with clients who are bereaved.
TRICARE

TRICARE (2014) is a healthcare program and rule formed by the U.S. Department of Defense. One of its regulations specifies that mental-health counselors may deliver services to certain government employees, including members of the armed services. The rule allows certain licensed or certified mental-health counselors (CMHCs) to provide care to persons insured by TRICARE and to receive financial compensation for such care. This rule phased out a previously required physician referral and supervision process, making it possible for CMHCs to practice independently under TRICARE – a change that resulted from a report that the former regulations created barriers to service delivery.

TRICARE relies on existing state systems’ requirements that CMHCs must have licenses in the jurisdictions in which they are practicing. In addition, TRICARE CMHCs must have passed the National Clinical Mental Health Counselor Examination or an identified substitute, have at least a master’s degree from a CACREP-accredited mental-health counseling program, and have a minimum of two years of supervised post-master’s work experience in mental-health counseling (TRICARE, 2014).

The relevant stipulations in TRICARE, are for hospice programs that must provide “bereavement counseling for the immediate family or terminally ill individuals.” The TRICARE requirements define bereavement counseling as “counseling services provided to the individual’s family after the individual’s death” (TRICARE, 2014). However, this definition does not stipulate the kind of counseling services (e.g., group versus individual counseling, or modalities such as art therapy), the duration, or the frequency.
Counseling services “for the purpose of helping the individual and those caring for him or her to adjust to the individual’s approaching death” (TRICARE, 2014) are a requirement in hospices, but there is no such requirement in any other context. The word death occurs 56 times in the TRICARE document. None of these references pertain to directives in treatment, theoretical approaches, grief-counseling education, or continuing professional development. They all appear in the context of the insurance coverage of survivors or the changing family composition of beneficiaries (Siegel, 2011). There is no mention of competency, training, or knowledge requirements for CMHCs that pertain to death, dying, grief, grieving, bereavement, or loss.

The aim of TRICARE was to allow more members of the armed forces returning from war overseas with PTSD to access the services they needed. At this time, TRICARE does not specifically address the bereavement needs of returning veterans or ongoing needs to receive grief counseling or treatment for CG. It also does not stipulate that CMHCs have any specific knowledge or training in grief or CG.

**Grief Counseling in Art Therapy Training Programs**

A systematic review revealed that few art therapy programs in the United States offer courses in grief counseling to art therapy students (Brandoff, 2017). There are currently no statistics on the number of art therapy students who study CG within specialized grief courses. A review of art therapy programs that have offered training in grief or CG may inform the discussion by approximating how likely it was that art therapy students would have had exposure to and opportunity to study CG in their programs.
At the time of the review, there were 35 accredited art therapy master’s programs in the United States, and I examined each of these for current and prior course offerings both within the department and throughout the larger college or university. I investigated each graduate art therapy program via the school’s website. I examined course curricula for each program, including both the title and course description as published in each school’s web-based course catalog. For each program, the data I systematically reviewed included program requirements, course names, course descriptions, program electives, and available elective courses at the college or university that focused on grief or bereavement. I scanned each program’s courses, electives and college electives for the following terms: death, dying, grief, grieving, bereaved, bereavement, CG, thanatology, and loss. I reviewed courses on human development, the aging process, elderly and medical populations carefully to assess the expectation of death and grief as potential course topics. The relevant information from this systematic review (P. A. Brown et al., 2012) is in Table 1.
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<td>Elective Courses Including Grief Training</td>
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* Concordia University in Montreal, Quebec, Canada is in this list of U.S. Art Therapy Graduate Programs because it is accredited by the AATA, the national body that accredits U.S.-based art therapy programs.
None of the AATA-accredited master’s art therapy programs mandates any grief-counseling training (Brandoff, 2017). Of the 35 graduate art therapy programs that the AATA accredited in 2015, only one program provided a grief course within the art therapy program. This program was at Marylhurst University (2017) in Oregon, and it is notable that the course in question was offered as an elective.

Ten graduate programs offered elective courses that featured grief and bereavement, either within the art therapy program or within the greater university environment accessible to students in the art therapy program. These 10 programs in alphabetical order were Antioch University – Seattle, Caldwell College, the College of New Rochelle, Florida State University, George Washington University, Marylhurst University, Naropa University, New York University, Southwestern College, and Ursuline College.

Grief-specific education is not a requirement or a part of the standard education of most art therapists in the United States. Some students may have access to grief courses during their programs at their schools, but many do not. The education of any clinician, including art therapists, should continue after the master’s training program, and CG could be an appropriate subject for continuing education study, although the AATA does not currently recommend this. The AATA recommends continuing education, and it offers a roster of courses on various topics. The Art Therapy Credentials Board requires continuing education for board-certified art therapists, and it lists seven content areas into which coursework must fall. Those content areas are psychological and psychotherapeutic theories and practice, art therapy assessment, art therapy theory and practice, client populations and multicultural competence, art therapy and media,
professional issues (e.g., supervision, building private practice, social action), and ethics
(minimum of six continuing education credits per recertification cycle).

This systematic review has many inherent limitations. This review only examined
accredited programs, and it only included the discipline of art therapy. This means that it
did not include art therapy master’s programs that are unaccredited or not yet accredited;
nor did it include undergraduate or PhD programs in art therapy.

A complicating factor of online systematic reviews is the uneven and
unpredictable rates of change in educational policy, school programs, and website
updates. Systematic reviews are often out of date by the time of publication due in part to
rapid changes in fields pertaining to healthcare (Shojania et al., 2007). In the case of this
review, it is unclear when each school made changes to its program, when it updated its
website, or how closely the web information reflects what is actually occurring in the
program. It is possible that art therapy master’s programs do offer education on
bereavement and grief counseling, but that the institution has not published this on its
website, or that listed courses that offer education on such topics do not use the search
terms of this study, which included death, dying, grief, grieving, bereaved, bereavement,
CG, thanatology, and loss.

This literature points to changing theoretical understandings of grief. There is a
paradigm shift in place whereby society is more willing to acknowledge grief (Devine,
2017; Hanlon, Guerin, & Kiernan, 2018; Soffer & Birkner, 2018), and more willing to
accept that it is a highly individualized process. Traditional grief work and task-based
theories have ceded some ground towards understanding the role of attachment theory,
continuing bonds, and the dual-process model of grief. Grief is universal, but a
prolonged and persistent grief can be pathological. CG can warrant treatment, and clients will benefit from studies that look at the efficacy of treatments, both as individual phenomena and in comparison to other treatments. Some treatments may be most beneficial when used in conjunction with others.

Since studies show that CG is prevalent (M. K. Shear et al., 2016), produces adverse health effects (Boelen & Lancee, 2013; Boelen & van den Bout, 2005; Buckley et al., 2012; Cruz et al., 2007; McDermott et al., 1997; O’Connor et al., 2012; M. K. Shear & Skritskaya, 2012; Zisook & Kendler, 2007) and may be preventable (Kissane et al., 2006; M. K. Shear, 2015), and since art therapists claim grief as a specialty in clinical practice (Elkins & Deaver, 2015; Lister et al., 2008) but lack any formal training in CG during their master’s education, competency in the area of grief and CG warrants examination. This study is an attempt to consider how to prepare art therapists to work effectively with clients with CG.
CHAPTER 3

Method

For this research study, I developed a CG training module, which I presented in a workshop format. The training module started with the assertion that education on CG might help art therapists who work with clients with CG. I presented this training module in the didactic portion of a workshop to professionals who voluntarily attended the free, three-and-a-half-hour workshop. I invited attendees to ask questions throughout the presentation as needed.

Design

This research study used a phenomenological method, appropriate to this topic of exploring CG training in art therapy, which had little prior research (Creswell & Poth, 2017; Davidsen, 2013; Giorgi, 2009; Moustakas, 1994). I asked participants who attended the workshop on CG to describe their experience and provided them with methods to reflect on the content of the workshop; “A description of the essence of the experience of the phenomenon becomes a phenomenology” (Creswell & Poth, 2017, p. 105). The goal of the workshop was to provide professional art therapists with an educational and creative opportunity to understand CG better, and then to elicit their thoughts and feelings and to formulate recommendations for addressing this topic with art therapists in training. My hope was also that participating art therapists would draw on their professional experience in working with clients in grief in responding to the workshop.

The workshop included a didactic module, art making, free writing, an individual questionnaire, a focus group, and an individual follow-up interview. The workshop ran
for a total of three and a half hours, starting with a didactic presentation on grief and CG. The didactic presentation ran for one hour and 15 minutes. This presentation (see Appendix A) included an overview of theories of grief that have influenced psychotherapy and grief counseling; I discussed grief work and task theories, stage-based theories, attachment and continuing bonds theories, and dual-process model theory. The presentation included viewing six pieces of art inspired by grief; they are included in the literature review (Chapter 2). The module also contained a review of current literature on CG including definition, symptoms, prevalence, diagnostic issues, measures, treatment protocols and information on the use of art therapy with grief and CG.

After the lecture, participants had one hour and a wide array of art materials (see Appendix B) to construct one art project; participants choose one of two options: either a textile collage or an altered book. In addition to the discussion of these media in Chapter 2, both media have associations with transformation, and they may have potential in integrating grief. Brief descriptions of the projects are in Appendix C. The purpose of the art making, as presented to the participants, was to help them to connect to and reflect on the topic and the didactic material of the workshop. Bridging their experience from the didactic unit on CG to the focus group discussion, the aim of the art making was to assist participants in synthesizing their own thoughts and ideas about how they have worked with grieving clients, and what sort of knowledge and training may be useful in doing that work.

After one hour of art making time, attendees engaged in a free writing exercise for three minutes. Free writing is a creative technique whereby a person writes continuously for a set period without regard to spelling, grammar, or content. This technique can
loosen the thought process, access authentic emotion, help to solidify learning, and help to overcome obstacles to creativity such as self-criticism, anxiety, resistance, fear of failure, or judgment (Elbow, 1989; Li, 2007). After the free writing, participants responded to a brief questionnaire (see Appendix D) about the art making for approximately 10 minutes.

Finally, participants engaged in a focus group discussion about CG and their experience in the workshop for one hour; this discussion included a statement of the preset themes and an invitation to participants to comment on or discuss if and how these themes were relevant to their experience. Preset themes (see full explanation below) emerged during the formation of the literature review, and included (a) feelings, (b) intention of art, (c) benefits, (d) surprises, (e) triggers, (f) difficulty in engagement, and (g) need for art therapy. Participants also had the opportunity to discuss thoughts or issues that did not pertain to any of the preset themes. Emergent themes (see full explanation below) included (a) education, (b) recommendations, (c) universality, and (d) emerging (i.e., it always comes up).

I asked the participants on their consent forms (see Appendix E) if they were willing to engage in a follow-up interview, seven to 10 days after the workshop. All participants consented, and most provided a phone number for postworkshop contact.

**Participants**

Participants learned about the workshop through public announcements via social media sites, Facebook.com and LinkedIn.com (see Appendix F), and through the e-mail newsletter of the professional art therapy association’s local chapter. Additionally, flyers were available at a September workshop hosted by the local professional organization.
Eight attendees responded via e-mail to state that they planned to attend; two attendees came with friends or colleagues who had preregistered. One potential participant who had preregistered did not show up.

**Data Sources and Analysis**

I initially analyzed the data from this research separately; that is, I analyzed artwork, questionnaires, focus group discussion notes, and interview notes separately, and I analyzed them with the intention of describing the essence of participants’ experiences and knowledge (Creswell & Poth, 2017). Later, I contrasted data analyzed from different collection methods as a way of confirming findings and verifying meaning.

**Artwork**

As I described above, I invited participants to create a piece of art to assist in reflecting on the didactic portion of the workshop. Thus, I did not analyze the artwork per se, but I used it as a catalyst. However, participants had the opportunity to show and make a statement about the artwork, and the statements and the artwork are in the results. Half the participants created altered books, while the other half created textile collages.

**Questionnaires**

Each participant filled out an individual questionnaire about the experience of the artwork after working for one hour on his or her art project. The questions (see Appendix D) invited attendees to reflect on their experience in the didactic CG unit, and on creating art inspired by grief and CG. The goal of presenting the questionnaire in advance of the focus group was to prime the participants in accessing their emotions and thoughts, their experience of learning and art making, and their consideration of how they might
understand these experiences and harness them as a way of informing recommendations on CG training for art therapists.

I coded the questionnaires based on the preset themes, and then again using emergent themes. The preset themes included *feelings, intention of art, benefits, surprises, triggers, difficulty in engagement*, and *need for art therapy*. As I stated above, the preset themes drew on the literature review findings that suggest that discussion about grief can act as a trigger, can elicit feelings, and may be surprising (Bartone et al., 2017; DeSpelder & Strickland, 1987; Schimmel & Kornreich, 1993). Literature on the use of art making as a vehicle to channel or process grief suggested that participants can reap benefits (Baker, 1991; Davis, 1989; Feen-Calligan et al., 2009; Irwin, 1991), can name an intention such as memorializing the dead that they can realize through artwork (Graves, 1994; Junge, 1985), and can experience difficulty in making art or translating their grief into a creative and visual medium (Barton, 2017; Bolton, 2007; Kohut, 2011; Lander & Graham-Pole, 2009; Rogers, 2007; Seftel, 2006). I also coded the questionnaires with emergent themes I chose based on repeated mention or intensity in the questionnaires, discussion group, and interview. Emergent themes included *education, recommendations, universality*, and *emergence*.

**Focus Group Discussion**

I documented the focus group discussion with notes on large posters and real-time participant checking. I wrote each preset theme at the top of a poster-size piece of paper and hung it up on the board in the room where the workshop and focus group took place. Attendees could see all the preset themes simultaneously. Attendees contributed to the focus group discussion, and frequently identified the preset theme to which they thought
their statement pertained. In some cases, attendees did not seem to know where their thought fitted in, but other attendees helped them to identify a theme that fitted. I recorded statements during this focus group session and wrote them under a preset theme. In this way, I coded each statement as data; “a phenomenology may use significant statements as the organizing structure for reporting how the phenomenon was experienced” (Creswell & Poth, 2017, p. 106).

After the workshop, I carefully transcribed the focus group session notes, examined them, and read through them 10 times to detect any emergent themes that I had not initially named. I also transcribed individual questionnaires, which participants wrote by hand during the workshop, and read them through 10 times to detect and confirm emergent themes. I derived emergent themes from transcribed focus group notes and questionnaires based on recurrent ideas or ideas that received heavy emphasis in discussion. In addition to identifying emergent themes, I examined focus group discussion notes to see if statements fit in more than one preset theme, or if I had erroneously assigned them to a preset thematic category that did not seem to fit. I subjected transcribed focus group notes and individual questionnaires to the same thematic analysis using preset and emergent themes (Braun & Clark, 2006)

**Interview**

During the interview, I took notes and I later analyzed them, first by reading through the notes, and then by coding. I coded the interview notes using the same preset and emergent themes. I read the interview notes three times before coding, and then 10 times through while coding to check for specific mentions of or references to themes, and to extract statements that may link to multiple themes. An example of this is when one
interviewee stated that greater education in the area of CG could have helped her, and could possibly help others, in their work. This statement pertains to the theme of education as well as the theme of recommendations. It also speaks to the preset theme of benefits, since the interviewee was speaking to the benefit of preparedness in clinical work.

While every participant signed a consent form stating that he or she was willing to participate after the workshop, ultimately only one post-workshop interview took place. This was because I could only reach one participant. I called each of the consenting participants twice on the phone during the month following the workshop, in an attempt to conduct follow-up interviews. I left messages when there was a voice mail box option, and I left call return information. No one returned the calls. I e-mailed participants who put their e-mail on their consent forms in an attempt to conduct follow-up interviews; however, I did not receive any responses. Only one participant was reachable for the follow-up interview.

The follow-up interview was largely open-ended, starting with three prompted questions. The first question was, “Since the CG workshop, have any new thoughts or feelings arisen for you pertaining to CG or CG and art therapy?” The second question was, “Do you have any thoughts or feelings about your current state of preparedness to deal with CG in a professional setting?” The third question was, “Do you have any recommendations about what CG education should be required of art therapists?” The follow-up interview was casual and conversational in nature, and the interviewee shared the relevance of CG to her professional work and the attempts she had made to get greater training in grief and bereavement. The interviewee was eager to share the
resources that she had pursued on this topic, which she said had helped her in her work.

The interview lasted for 23 minutes.
CHAPTER 4

Results

Ten people attended the CG workshop, held on Saturday, October 7, 2017, in Philadelphia, Pennsylvania. Of the attendees, three were professional art therapists, with one year, nine years, and 20 years of experience in the field. Two attendees were master’s art therapy students, one attendee was a high-school student interested in pursuing art therapy, and the remaining four attendees were master’s counseling students. All participants signed consent forms, and all participants consented to photography of their artwork and its inclusion as data in this study. Additionally, all participants remained for the entire workshop, and each person contributed at least once during the focus group discussion. Attendees were nine women and one man; six of the attendees, including all the art therapists and art therapy students, were Caucasian, while all four counseling students in attendance were Asian.

Images of CG Workshop Attendee Art Projects

Half the workshop attendees choose to make an altered book art project and half chose to make a textile collage. The images of the art projects follow with the brief information the participants shared on each project (Figures 7-16). Of the 10 participants, eight used their art making to explore a personal loss. One participant did not use the art making to explore a personal loss, and one participant did not indicate if the art making process or product explored a personal loss. Seven out of 10 participants stated that they planned to continue working on their art projects after the workshop.
Figure 7. Textile collage project. Materials: fabric, paper, glue, oil pastels, chalk pastels, pencil. Approximate size: 12 x 12 inches; project ongoing; artist shared: it was the beginning of a personal exploration that was important and necessary.

Figure 8. Textile collage project. Materials: fabric, yarn, glue. Approximate size: 13 x 13 inches; project ongoing; artist shared: piece pertains to personal loss.
Figure 9. Textile collage project. Materials: fabric, yarn, feathers, beads, glue.

Approximate size: 8 x 13 inches; project finished; artist shared: memorialized important personal loss of beloved pet.
Figure 10. Altered book project. Materials: book, colored pencils. Approximate size: 10 x 10 inches; page finished, unsure about project; artist shared: enjoyed the process of using the materials.
Figure 11. Altered book project. Materials: book, paper, pen, colored pencils, fabric, glue. Approximate size: 5 x 8 inches; project ongoing; artist shared: this helped to begin to process an important and difficult loss, and it validated that it is okay still to think of the lost person and not to have finished grieving.
Figure 12. Textile collage project. Materials: fabric, puzzle pieces, glue. Approximate size: 12 x 13 inches; unsure if project finished; artist shared: used art to process important personal loss.
Figure 13. Textile collage project. Materials: fabric, glue. Approximate size: 4 x 3 feet; project ongoing; artist shared: memorialized and helped to process an important loss in her life that she thinks of often.

Approximate size: 7.5 x 10 inches; page finished, project ongoing; artist shared: used artwork to process what she learned in the didactic portion of the workshop.
Figure 15. Altered book project. Materials: book, string, paper, glue. Approximate size: 5 x 8 inches; page finished, project ongoing; artist shared: explored important personal loss that she often comes back to in her artwork.
Figure 16. Altered book project. Materials: book, fabric, yarn, paper, rhinestones, puzzle pieces, glue. Approximate size: 10 x 20 inches; page finished, project ongoing; artist shared: piece is a reflection of artist’s personal grief and about using multiple lenses for viewing the same phenomenon.

Information about art projects that pertain to the artists’ intentions is in Table 2.
### Table 2

**Coded Artwork**

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<th>Exploration of Client’s Loss</th>
<th>Exploration of Working with Clients in Grief</th>
<th>Exploration of Grief Learned in Workshop Lesson</th>
<th>Is the Work (Collage or Book Page) Finished?</th>
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At least eight out of 10 participants used their art making to explore a personal loss.

At least seven out of 10 participants incorporated some of what they learned in the CG workshop into their art making.

At least seven out of 10 participants plan to continue working on their art pieces after the workshop.

**Totals:** 5 AB projects, 5 TC projects

* Blanks indicate information not known.
Of the 10 participants, none stated that they used their art making to explore a client’s loss. Two out of 10 participants stated that they used the art making to explore the possibility of working with clients in grief; one participant did not answer this question. When asked if they incorporated any of what they learned in the CG workshop into their art making, seven out of 10 participants said yes; two participants said no, and one participant declined to answer. Seven out of 10 participants stated that they planned to continue working on their art pieces after the workshop was over; one participant would not work further on their piece, and two participants did not answer.

**Questionnaires**

In the first question, I asked participants to “Describe how this experience (CG workshop – didactic lesson and art making) was for you.” Participant 1 responded, “It’s good. Very new and interesting knowledge which I have never known. Get a lot of resonance.” Participant 2 said, “Interesting learning about different theories.” Participant 3 said, “Very interesting to learn about textile art and grief.” Participant 4 said, “It was great learning the history of art therapy.” Participant 5 said, “Refreshing, thought provoking.” Participant 6 said, “It was very informal and also nostalgic of my own experience with loss. The art making was fun and soothing.” Participant 7 said, “I learned a lot from this experience. I liked both parts of it. Information was good.” Participant 8 said, “Wish there was more time for art.” Participant 9 said, “This experience was beneficial for me for educational + personal reasons. I can use this info. To inform my personal practice and explore my own experiences with grief + loss.” Participant 10 said, “This experience was very educational. I learned so much in the lesson and enjoyed the art-making.”
In the second question, I asked the participants to “Describe your artwork and experience working with these art materials (textile collage or altered book).” Participant 1 answered, “It’s interesting and creative. I did not know it can be that creative. Can be applied to some kinds of population such as children.” Participant 2 said, “I love working with textures, so textiles were great! It’s about repetition and patterns that don’t seem to have an end.” Participant 3 said, “It helped me think about different symbols and meanings representing each piece of textile.” Participant 4 said, “[I] added some color to a b/w photo from WWI.” Participant 5 said, “I had a few difficulties on cutting out the exact shape, size paper for the cover. I enjoyed altering the book by adding my personal elements in it.” Participant 6 said, “My art work depicts the contrast in life from when you have a loved one vs. when they are gone. I enjoyed the selection of materials, I really took to the fabric.” Participant 7 said, “I love textile and don’t get the time to work with it besides small knitting projects.” Participant 8 said, “I enjoy altered books.” Participant 9 said, “I chose to do the altered book project, using construction paper, string, and glue. I enjoyed using these materials and will employ them for future projects.” Participant 10 said, “I chose to do the altered book project and chose materials I don’t normally work with.”

In the third question, I asked participants, “How do you feel about your art piece at this time?” Participant 1 answered, “Still kind of wondering what I should cover, as I have never done this before.” Participant 2 stated, “I feel good about the piece: it may need more to it, but overall good.” Participant 3 said, “It recreates the memories that I have of my pet.” Participant 4 said, “Pretty good, added some life to pix.” Participant 5 said, “Incomplete, but personally related.” Participant 6 said, “I feel it holds a lot of
symbolism and color contrast to help establish the mood it is trying to portray.”
Participant 7 said, “I like it a lot. It has a lot of meaning for me. I want to finish it.”
Participant 8 said, “It’s not finished, so I don’t like it.” Participant 9 said, “I am pleased
with the outcome of my piece, thought I feel it is unfinished and warrants further work.”
Participant 10 said, “I am happy about my art piece. On one page I depicted something I
learned in the lesson and one the other page I depicted something that expressed my
emotional connection with a loved one I’ve lost.”

The fourth question asked participants to describe any rules or parameters, beyond
the given instruction, they incorporated into their art project. Participant 1 answered, “I
used some traditional cultural elements into my work which I’m very interested in and
also reflects our philosophy on death and grief.” Participant 2 stated, “None.”
Participant 3 said, “I was trying to create a picture that can be understood by others.”
Participant 4 said, “No new rules.” Participant 5 said, “I decided to use cloth as my
primary material on altering the book. I think the material connects me to my personal
experience more compare[d] to regular colored papers.” Participant 6 said, “I decided to
apply a personal touch to the piece, while also portraying complicated grief.” Participant
7 said, “It was pretty free besides the time constraints.” Participant 8 left this question
blank. Participant 9 said, “I chose to stay within the boundaries of the book page
[because] I thought I might have trouble transporting [and] storing [with] pieces sticking
out.” Participant 10 said, “I wanted to make sure to depict the educational aspect and a
personal aspect.”

The fifth question asked participants to “Describe any value you derived from
making your art project (during or after creation).” Participant 1 answered, “I kind of
accept any current state of grief when making it, as it’s natural and common for human beings, and also acceptable for me. I can talk about it and move forward with it.” Participant 2 stated, “Valuable to conceptualize Complicated Grief.” Participant 3 said, “It gave me a valuable time to spend with my old pet and relive the memories that I have with her.” Participant 4 said, “It was interesting, imaging myself there.” Participant 5 said, “I decided to use cloth as my primary material on altering the book. I think the material connects me to my personal experience more compare[d] to regular colored papers.” Participant 6 said, “I decided to apply a personal touch to the piece, while also portraying complicated grief.” Participant 7 said, “It helped me to process some aspects of my mother’s death that have recently came up to the surface.” Participant 8 said, “After experiencing a recent loss, it was good for me to express my own grief.” Participant 9 said, “I think my artistic identity was enhanced through this project and feel prided in the piece I created.” Participant 10 said, “I feel value in my piece after creation.”

In the sixth question, I asked participants if they “had any difficulty engaging in the art?” and “If so, why do you think that is? Describe any difficulty that you may have had with engaging in the art.” Participant 1 answered, “Yes. I think personally I’m not very good at art creating especially drawing. I tried to use what I’m good at like calligraphy, but it looks a little bit odd since I’ve never done this before.” Participant 2 said, “No.” Participant 3 said, “No.” Participant 4 said, “No.” Participant 5 said, “I did have a little difficulty on cutting out the exact shape, size of the paper for the cover page because of myself being a perfectionist. Other than that, I am pretty satisfied with the experience of experimenting different art materials.” Participant 6 said, “Yes. I find that
my thoughts come together in the last minute. I couldn’t decide whether or not I wanted to make it a personal piece or strictly about complicated grief.” Participant 7 said, “No.” Participant 8 said, “Yes. Because of my recent loss.” Participant 9 said, “Yes. I did experience some difficulty with the glue, often the string wouldn’t fully stick or the string would stick to my fingers instead of the paper, but ultimately I was successful in my endeavors.” Participant 10 said, “No.”

The seventh question asked participants “What are any complications you could foresee in using this art intervention with an actual client experiencing CG?” Participant 1 answered, “Like me, they might be a little confused on what it looks like and what they can do. If they’re not very interested in art making, it will be a little hard to carry out.” Participant 2 stated, “People having difficulty engaging with the Art materials.” Participant 3 said, “It could recreate past trauma, as client is expecting quiet time focusing on the deceased.” Participant 4 said, “No.” Participant 5 said, “[Clients] may have difficulties engaging the art supplies because they are unfamiliar with the materials. Or, they may be reluctant to make art because they are often graded when they are younger.” Participant 6 said, “[Clients] might have issues using the materials or figuring out how to express themselves through art.” Participant 7 said, “I think it would be helpful – but a client may become overwhelmed with emotion which could have to be addressed in an empathetic and gentle way.” Participant 8 said, “I would maybe ask them to pay attention to what feelings come up during the process.” Participant 9 said, “Clients may experience intense emotion while exploring their grief, also may become frustrated w/ materials.” Participant 10 said, “Clients may feel too overwhelmed by grief and feel unable to complete a project.”
In the eighth question, I asked participants, “Is there anything in the direction that you would change if you were going to use this art intervention with a client with CG? Is there anything that you would do differently? Bring more attention to?” Participant 1 answered, “I would ask if they’re interested in any kind of creating.” Participant 2 stated, “‘describe how your grief feels to you.’” Participant 3 said, “Maybe inform client what is the purpose of art intervention.” Participant 4 said, “No.” Participant 5 said, “I would like to try giving out specific instructions and techniques when using art intervention with a CG client. For instance, when [altering] a book, I could show the client that he/she can make his/her own cover page cut out ho[l]es b/w pages to personalize the book.” Participant 6 said, “I would maybe make it a piece that they work on over time and see how their stages and thoughts of grief change over time, and take pictures along the way.” Participant 7 said, “I might say think of a specific loss you have had and maybe would like to process here. Maybe that’s what you said but I was already thinking and distracted!” Participant 8 said, “I would maybe ask them to pay attention to what feelings come up during the process.” Participant 9 said, “Depending on the specific issue the client had sought therapy for, I might offer more specific direction for the project.” Participant 10 said, “I would allow more time for the piece to be created.”

In the ninth question, I asked participants to describe any objective(s) they had for their artwork that specifically applied to grief (e.g., using it as a transitional object, using it to communicate with the deceased, memorializing one who is lost, understanding grief theory, etc. Participant 1 answered, “Communicating with and memorializing the lost and self-talk.” Participant 2 stated, “Understanding grief theory.” Participant 3 said,
“Memorializing one who’s lost.” Participant 4 said, “Make it therapeutic.” Participant 5 said, “I am connecting my work to my recent family member’s illness and potential loss.” Participant 6 said, “My objective was mostly honoring the emotions of grief and how loss can impact our lives. I also added personal components that memorialized my mother.” Participant 7 said, “I think for me it was memorializing the loss of my mother to me 35 years ago and creating something tangible from the memory.” Participant 8 said, “Communicating feelings of grief.” Participant 9 said, “Depending on the specific issue the client had sought therapy for, I might offer more specific direction for the project.” Participant 10 said, “Understanding grief theory and memorializing one who is lost.”

In Question 10, I asked participants to “describe how the unit on CG and/or the subsequent art project may have triggered thoughts of or connection to your own experience with loss, either professionally or personally.” Participant 1 answered, “Kind of changed my mind on my own grief after hearing some of the theories, which make me start to think about accepting and moving further.” Participant 2 stated, “Thought about two losses and also have been thinking of facilitating a grief group @ work; this may give me places to do some more research to help me with that. Grief work is something I’m interested in. I found Art Therapy through my own grief when my mother died.”

Participant 3 said, “When trying to draw my late pet, I was really trying hard to recall how she looked like because it’s been 10 years since she passed.” Participant 4 said, “Time heals most wounds.” Participant 5 said, “The art making component has been a trigger to my personal connection to grief.” Participant 6 said, “Personally, grief has a huge impact on my life from such a young age. I found the whole art lesson and art
making to be very nostalgic of my experience.” Participant 7 said, “I think you would have to be devoid of all emotion not to have thoughts come up for each instance described. My daughter had two miscarriages and those thoughts came up as well.” Participant 8 said, “I’m grieving my own loss + have realized I never really gave myself an opportunity to process past losses.” Participant 9 said, “I felt a deep connection with this unit and project because I am currently in therapy working on exploring and processing the death of my father almost nine years ago.” Participant 10 said, “It personally triggered thoughts because after certain points were made, I thought of specific people.”

In Question 11, I asked participants to “describe how your socio-cultural background may have affected your learning and experience of this didactic lesson and/or the art making portion of this workshop.” Participant 1 answered, “I kind of used some cultural elements such as calligraphy and ancient Chinese poems which I’m interested [in]. They are basically implicit which is appreciated in our culture.” Participant 2 stated, “Not affected.” Participant 3 said, “From a traditional counseling background it prompted me to look at grief from a different/creative aspect.” Participant 4 said, “I didn’t draw much growing up so that was interesting.” Participant 5 said, “In my culture, grief can be a prolonged process when a family decides to [grieve] over a family member loss by not eating meat/wearing black for a year to memor[ial]ize him.” Participant 6 said, “As a current art therapy student, I found the process to be quite familiar, whereas others may have not.” Participant 7 said,

Being old and from a middle-class family I was exposed to more ways to deal with grief – funerals, church, catholic school. We were slightly obsessed with
funerary rituals. I went to my first (Irish) funeral at 12 years of age and the body was in the living room of this unfamiliar relative!

Participant 8 said, “It didn’t affect me personally — but I can see how a person’s belief in what happens after death could impact the experience.” Participant 9 said, “As a white + privileged female I felt little difficulty with learning and art making during this workshop.” Participant 10 said, “Growing up in different backgrounds affects how often someone deals with loss and grief.”

In Question 12, I asked participants to “write any other comments that you have, or any information that you wish to share.” Participant 1 answered, “I feel it’s a good and interesting way which I have never tried before. Hope I know more and [someday] apply it in my counseling work.” Participant 2 did not comment. Participant 3 also did not comment. Participant 4 said, “Great experience!” Participant 5 said, “Thank you for the workshop!” Participant 6 said, “I really enjoyed the experience! Thank you.” Participant 7 said, “Thank you for conducting this workshop – Good luck w/ your dissertation!” Participant 8 left no comment here. Participant 9 also did not comment here. Participant 10 said, “This has been a great experience! Thank you! I’ve learned so much.”

A further discussion of how I analyzed questionnaire responses into themes follows in a section detailing coding by theme. When I asked the participants to describe their art-making experience, nine described it favorably, using terms like interesting ($n = 3$), good ($n = 2$), great ($n = 2$), refreshing, thought provoking, fun, soothing, beneficial, educational. One participant stated that she wished she had had more time for the art making.
Focus Group Discussion

I coded the focus group discussion notes for the number of mentions that pertained to the preselected themes, and then again for the emergent themes. The focus group discussion notes showed four mentions of feelings, nine mentions of intention in art, one mention of benefit, five mentions of surprises, four mentions of triggers, one mention of difficulty in engagement, and three mentions of the need for art therapy. I examined the focus group discussion notes for emergent themes, and found one mention of education, one mention of universality, one mention of recommendations, and zero mentions of the emergent nature of grief. Specifics notes from the focus group discussion are in the thematic breakdown below.

Interview

Only one workshop attendee participated in a follow-up interview, despite many saying they were willing. The follow up interview took place two weeks after the workshop, and I took notes during the interview. I later coded the interview notes in accordance with the same preset and emergent themes.

I asked the interviewee three questions, and the interview lasted for 23 minutes. The first question was, “Since the CG workshop, have any new thoughts or feelings arisen for you pertaining to CG or CG and art therapy?” The interviewee spoke conversationally at length and seemed to value the opportunity to speak on the subject. She frequently reiterated how grief is always coming up in her work, and she shared some anecdotes that reflected this. Her answer to the question of new thoughts or feelings on the topic prompted mention of current new clients that she had started working with since the workshop. She described one family in which the mother had
recently died from cancer, the father is utilizing drop-in services to cope with grief and has started dating, and the 18-year-old daughter is angry about her father dating so quickly after the loss of her mother. This new client family has prompted thoughts about grief theory that she learned in the workshop, and about potential arts-based interventions that could help the father and daughter both to identify and to process their grief.

The second question was, “Do you have any thoughts or feelings about your current state of preparedness to deal with CG in a professional setting?” The interviewee spoke about the benefits she felt in preparedness, and how she had taken it upon herself to get further training in grief so she could help her clients better. She described a lack of support from her employer. She also spoke of the benefit of education in grief for one who is helping clients who are coping with grief. The interviewee shared the relevance of CG to her professional work, and the attempts she had made to get greater training in grief and bereavement.

The third question was, “Do you have any recommendations about what CG education should be required of art therapists?” She had several recommendations, both general, which supported grief education for clinicians, and specific, which involved mention of books that she had found helpful, detailed below.

In terms of preset themes, the interview subject made mention five times each of feelings and of intention in art. Three times in the interview she made mention of benefits, and one time she mentioned a trigger, specifically that her work triggered feelings of needing more preparedness in grief counseling and theory. There were zero mentions of surprises or of difficulty in engagement, and one mention of a solidified need for art therapy.
Conversationally, some of these categories overlapped. Some poignant statements that the interviewee made were about how grief and CG are “always coming up” and that she has to “deal with [grief] every day for work.” This interviewee made many references to dealing with grief in the context of her work with clients in a healthcare setting who face major medical illnesses. She discussed the benefits of preparedness in feeling competent to help to hold and guide a client in grief. The interviewee made mention of continuing education initiatives (e.g., eye movement desensitization and reprocessing certification, certification in grief and bereavement, webinar recordings by various art therapy authors) that she has sought on her own, despite having worked in the field for years. The interviewee reported that when she told her non-art-therapist clinical supervisor that she was seeking a certification in grief and bereavement, her supervisor asked her why. The supervisor did not seem to understand or care about the value of continuing education, and the interviewee felt that her employer was not supporting her continuing education in any way.

In terms of emergent themes, this interviewee made mention six times of education or things learned and six times made mention of recommendations. She also made mention once of the universality of grief, and she made five mentions about the emergent or always relevant nature of grief. This interviewee stated that initially, she thought and felt that she could not do the work that she does, by virtue of the fact that helping people to grieve and to die is emotionally difficult work. She started working with this population as an intern in graduate school, and she was unsure if she wanted to work with this population. She was subsequently hired by her internship site after
graduating, and she has now worked there for approximately 10 years. She quickly decided that if she was going to help others, this was a valuable way.

The interviewee finds value in art since it is a way to process the surreal, and because facing death or living with grief can be a surreal experience; she brings this intention to her art making. She believes that learning about grief is so immense and intense that it is helpful to break it up and engage a little at a time. She also states that when working with people who have had a loss, grief is always coming up, and for this reason she recommends that clinicians do their own work and process their own losses. This was one of the benefits that this interviewee saw in this workshop; it gave participants the chance to process their own loss or losses as needed.

This interviewee stated that she would like to see more education for art therapists around grief and CG, and that it would help to have it embedded earlier in a clinician’s career. She also felt that this learning should be an ongoing endeavor throughout one’s career, since this topic is vast and one’s understanding of and perspective on grief can shift over time.

This interviewee felt strongly that she would have benefited from a course on grief earlier in her career. She talked about the benefits she has reaped from feeling more prepared to approach grief and to use art making to process grief and relationships with deceased loved ones. She also articulated the necessity of engaging in regular self-care as a way of fortifying oneself to be able to deal with grief better when it inevitably arises.

In the CG workshop, this interviewee made an altered book, and she incorporated fabric into her work. She spoke about the possible value of this type of art for a clinician who works in her type of work setting and regularly loses clients to death. She could
dedicate a book page for each client who passed away as a way of honoring and remembering the clients. This interviewee spoke about her lost clients and the difficulty of working with clients who die. She told a story about a time years ago when she felt internal debate about going to a funeral. She recalled how her education impressed on her the importance of maintaining strict boundaries with client relationships and keeping oneself emotionally separate. She stated that in all the years that she has worked with clients who were sick and later died, she has only attended a funeral three times, and it was something she did with great consideration, thoughtfulness and internal debate.

The interviewee spoke highly of a grief counseling certification program that she has pursued via the American Institute of Healthcare Professionals (n.d.), where she has taken several courses online. She recommended four books that she learned about through her American Institute of Healthcare Professionals program and has enjoyed. They are *Death, Society and Human Experience* by Kastenbaum (2009), *Grief Counseling and Grief Therapy: A Handbook for the Mental Health Practitioner*, by Worden (2009), *Talking with Children About Loss*, by Trozzi (1999), and *Grief and Loss: Theories and Skills for Helping Professions*, by Walsh-Burke (2012).

**Coding Themes**

I coded questionnaires, focus group discussion notes, and the interview in accordance with preset themes, which I established in advance of the CG workshop and I named in Chapter 3. Additionally, I coded questionnaires, focus group discussion notes, and the interview by emergent themes, which I named in Chapter 3. A discussion of the coding results in Tables 3 and 4 below, follows.
### Table 3

*Coded Questionnaires and Focus Group Discussion – Preset Themes*

<table>
<thead>
<tr>
<th>Preset Themes</th>
<th>Feelings</th>
<th>Intention of Art</th>
<th>Benefits</th>
<th>Surprises</th>
<th>Triggers</th>
<th>Difficulty in Engagement</th>
<th>Solidified Need for Art Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of mentions in focus group discussions</td>
<td>4</td>
<td>9</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>1</td>
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<tr>
<td>Number of participants who mentioned theme in individual questionnaire</td>
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<td>10</td>
<td>4</td>
<td>1</td>
<td>10</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Total number of mentions in all individual questionnaires</td>
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<td>12</td>
<td>5</td>
<td>1</td>
<td>10</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Total number of mentions in individual interview (two weeks after workshop)</td>
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<td>5</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
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</tbody>
</table>

**Words/phrases examined in coding within questionnaires**
- Feeling, emotion, intuition, hunch, sentiment, belief, notion, inkling, view, opinion
- Intention, intent, intentionality, deliberateness, design, calculation, meaning, objective, goal, forethought, planning
- Benefit, beneficial, healthy, wellness, good, positive
- Surprise, unexpected, shock, astonish, amaze, astound, wonder, stun
- Trigger, precipitate, prompt, elicit, provoke, launch, generate, initiate, begin, start
- Difficulty, challenge, strain, struggle, trouble, problem, obstacle, hurdle, barrier, hassle, stress, plight, dilemma, quandary
- Need, require, necessity, demand, call, requirement, should

**Total Questionnaires: 10**
### Table 4

**Coded Questionnaires and Focus Group Discussion – Emergent Themes**

<table>
<thead>
<tr>
<th>Emergent Themes</th>
<th>Education (e.g., Things Learned)</th>
<th>Recommendations</th>
<th>Universal</th>
<th>Emerge</th>
</tr>
</thead>
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<td>Number of participants who mentioned theme in individual questionnaire</td>
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<td>1</td>
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<td>Total number of mentions in all individual questionnaires</td>
<td>7</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total number of mentions in individual interview (two weeks after workshop)</td>
<td>6</td>
<td>6</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Words/phrases examined in coding within questionnaires</td>
<td>Education, learn, study, teach, taught, train, school</td>
<td>Recommend, should</td>
<td>Universal, universality, common, broad, comprehensive, extensive, ubiquitous, regular, customary, normal, typical, familiar, prevalent, natural</td>
<td>Emerge, emergent, develop, rise, dawn, come up, crop up, occur, turn up</td>
</tr>
</tbody>
</table>

**Total Questionnaires: 10**
Feelings

Feelings occurred nine times in questionnaires, four times in the focus group discussion notes, and five times in the interview. In the focus group discussion, participants mentioned feelings or issues pertaining to feelings repeatedly, and they included statements about how art allowed for the examination of complex emotions and the examination of subjective experience of grief, as well as a mention by one participant that she doubted her feelings in light of an invalidated grief theory. Another participant shared her feelings of nostalgia due to her familiarity in working with textiles.

Intention of Art

Participants mentioned intention in art 12 times in questionnaires, nine times in the focus group discussion notes, and five times in the interview. Intention of art ranged from comments such as, “Communicating with and memorializing the lost” to “honoring the emotions of grief and how loss can impact our lives.” Most responses spoke to the issues of communicating feelings or memorializing personal losses.

In the focus group discussion, participants mainly discussed what their preferred art medium was and why they chose it. One participant chose to do an altered book due to being inspired by the material. Another felt that the altered book provided distance, and still another stated that the altered book provided structure. One participant described the fabric as unlimited, which helped to fulfill her intention of art. One participant stated that the altered book project allowed for a journey, and then another participant asserted feeling that the textile collage allowed for a journey, and she described how she told a story in fabric. One participant felt that the altered book projects were overwhelming and thus contraindicated, given their intention in art.
Another participant felt that the altered book project lent itself well to the idea of creating coloring pages. Two participants discussed intention of art that was irrelevant to materials; their goals were to record feelings and to have a place to engage in reflection on a deceased loved one.

**Benefits**

Participants mentioned benefits five times in questionnaires, once in the focus group discussion notes, and three times in the interview. I expected coding for benefits to produce responses that pertained to the benefits of education on CG, or the benefits of art making inspired by CG. One participant wrote in her questionnaire, “This experience was beneficial for me for educational and personal reasons. I can use this info to inform my personal practice and explore my own experiences with grief and loss.” In this example, the participant found benefit and suggested that it will impact both personal and professional domains.

One participant mentioned a benefit during the focus group and stated that having learned about the dual-process model of grief felt healthy and useful. Participants later suggested that a benefit of this workshop may be allowing those not familiar with CG to learn about it.

**Surprises**

Surprises came up once in the questionnaires, five times in the focus group discussion notes, and zero times in the interview. The one participant who wrote about a surprise in the questionnaire was commenting on the art making process and “still kind of wondering” what to do in the artwork, since that participant had no experience of making art in this way. In the focus group, several participants expressed feelings of surprise for
a variety of reasons, including (a) that they ended up dealing with personal loss issues, (b) that in facing a snowball of losses, those losses produced different feelings from each other, (c) the variety of therapies available, (d) that people gravitate towards art, and (e) the structure of a product that makes sense despite an unstructured approach in art making.

**Triggers**

Participants mentioned triggers 10 times in questionnaires, four times in the focus group discussion notes, and once in the interview. I asked participants directly in their questionnaires how the unit on CG and/or the subsequent art project may have triggered thoughts of or connection to their own experience with loss (professionally or personally). Answers seemed to center around the fact that learning about issues of grief and CG unavoidably make one consider one’s own experience with grief. One participant wrote, “Kind of changed my mind on my own grief after hearing some of the theories, which make me start to think about accepting and moving further.” Another participant wrote,

Thought about two losses and also have been thinking of facilitating a grief group [at] work; this may give me places to do some more research to help me with that. Grief work is something I’m interested in. I found Art Therapy through my own grief when my mother died.

One participant seemed to imply that the didactic unit on CG may not have been personally triggering in the same way that the art was; the participant wrote, “The art-making component has been a trigger to my personal connection to grief.” But for another participant, the didactic unit was triggering: “It personally triggered thoughts
because after certain points were made, I thought of specific people.” Two other notable responses included, “Personally, grief has a huge impact on my life from such a young age. I found the whole art lesson and art making to be very nostalgic of my experience,” and “I think you would have to be devoid of all emotion not to have thoughts come up for each instance described. My daughter had two miscarriages and those thoughts came up as well.” One participant was triggered to grieve for her lack of grieving, stating: “I’m grieving my own loss and have realized I never really gave myself an opportunity to process past losses.”

**Difficulty in Engagement**

Participants mentioned difficulty in engagement five times in questionnaires, once in the focus group discussion notes, and zero times in the interview. In the questionnaire, I asked participants directly, “Did you have any difficulty engaging in the art? If so, why do you think that is? Describe any difficulty that you may have had with engaging in the art.” Five participants stated that they did not have any difficulty in engaging, while the other five cited difficulty. Difficulty engaging the art seemed to center around lack of experience, insecurity in ability, and self-judgment. Others reported technical difficulties with art materials that they subsequently worked through, such as “cutting out the exact shape, size of the paper for the cover page,” or “difficulty with the glue.” One person reported difficulty engaging due to the freshness of the loss, and another reported that the inability to decide whether to make the art piece personal made it difficult to engage fully until the very last minute.

There was one mention of difficulty in engagement during the focus group discussion, and it pertained to trying to focus on or channel thoughts towards the CG
information learned in the didactic portion of the workshop as opposed to focusing on the personal aspects of grief and loss.

**Need for Art Therapy**

Participants mentioned need for art therapy zero times in questionnaires, three times in the focus group discussion notes, and once in the interview. Within the focus group discussion, participants discussed a solidified need for art therapy in several ways. One participant talked about how her desire and need to process her grief is what led her to art therapy. Another participant mentioned that the universality of loss makes education on CG necessary for art therapists or solidifies a need for art therapy. Last, a participant mentioned that art therapists should have some experience with or knowledge of CG, which that participant linked to solidifying a need for art therapy.

**Education**

Participants mentioned education seven times in questionnaires, once in the focus group discussion notes, and six times in the interview. Comments pertaining to education included the following: “I learned a lot from this experience. I liked both parts of it. Information was good,” “This experience was very educational. I learned so much in the lesson and enjoyed the art-making,” and “This experience was beneficial for me for educational and personal reasons. I can use this info.” Another participant wrote, “I am happy about my art piece. On one page I depicted something I learned in the lesson and one the other page I depicted something that expressed my emotional connection with a loved one I’ve lost.”


**Recommendations**

Participants mentioned recommendations zero times in questionnaires, once in the focus group discussion notes, and six times in the interview. The one mention in the focus group discussion was a statement of expectation that art therapists should have some knowledge of or exposure to CG. The interviewee mentioned various recommendations, such as suggested reading, along with the general idea that recommendations should and could exist. I chose recommendations as an emerging theme since it related to the motivation for the study, and thus was an attempt to identify any specific recommendations that participants wanted to make.

**Universality**

Universality as a theme pertained to the idea that all people have experienced or will experience grief; that it is a typical and expected human experience. Participants mentioned universality once in questionnaires, once in the focus group discussion notes, and once in the interview. In the questionnaire, one participant mentioned the universality of grief, stating, “I kind of accept any current state of grief when making it, as it’s natural [and] common for human beings, [and] also acceptable for me. I can talk about it and move forward with it.”

It should be noted that while being bereaved in the wake of losing a loved one seems to be a universal human experience, the form and expression that a person’s grief takes can be highly individualized, and influenced in part by culture, family, life experience (Rosenblatt, 2008).
Emerging

Emerging or emergence pertained to the idea of grief as “always coming up” or always arising. Participants mentioned emerging once in questionnaires, zero times in the focus group discussion notes, and five times in the interview. The interviewee mentioned the emergent nature of grief, and implied that it is unavoidable for feelings pertaining to grief to rise when discussing and learning about it.

**Recommendations Gleaned from the Data**

Ten participants took part in an art therapy workshop on CG in fall 2017, and appreciated the opportunity to consider and process grief, whether their own, their clients’, or potential future clients’. There they learned about grief theory and CG, a brief history of the use of art as a means of processing, containing, or expressive grief, and an overview of the use of art therapy to address grief.

There are several important recommendations that I make based on the data that has emerged from this research. These recommendations are (a) teach art therapists about grief and CG during their master’s programs, (b) have art therapists make art about grief and CG, (c) include studies that describe the influence of culture on grief, and the variations of grief expression between cultures, and (d) teach grief and CG to art therapists in a group setting.

Art therapists should learn about CG during their master’s education. Incorporating a module on CG and grief theory into master’s art therapy programs would ensure that art therapists would have this knowledge and experience from the outset of their careers. The interviewee in this study regretted that she had not received education
on CG or grief theory “earlier in her career,” noting that it would have been a great benefit.

Art therapists should make art about grief and CG. I also recommend that art therapists learning about CG and grief theory have an opportunity to process their learning and the affect aroused by it through art making. In the CG workshop featured in this study, participants made art after the didactic module on CG and indicated that the mix of didactic lesson and art making opportunity in this workshop allowed them to assimilate new information and to synthesize it through a creative process. Making art can help a person to accommodate new information into old schemas, augment knowledge (Allen, 1995; P. London, 1989; Schwartz, 2015; Sutherland & Acord, 2007), and “help them express their values and understandings” (Campisano, 2016, para. 1). Art therapists know this, as they frequently employ art making with clients for discovery, confirmation of ideas and self-expression, and personal growth (Hass-Cohen & Findlay, 2015; Hieb, 2005; Stepney, 2010). In this study, eight out of 10 participants using the art-making component to explore grief pertaining to a personal loss supports the value of self-expression in the interest of personal growth (Allen, 1995; Hieb, 2005).

Exposing art therapists to CG and grief theory might help them to manage and address their own grief and loss issues effectively; this would be very helpful in identifying countertransference issues in treatment. Understanding of and sensitivity to their own grief experiences and responses might assist practicing art therapists in more readily identifying CG when present in clients, assist them in distinguishing CG from diagnoses with similar symptomology, and make them better prepared to help guide clients in their highly individualized grief processes. The desire for better preparation
and the benefits of preparation in this area of learning came up in both the focus group discussion and the interview. I especially chose the art making I offered to participants for its transformative properties as documented in the literature. That transformative element needs emphasis for working with both students and clients. Clients need the transformative property for obvious reasons. Students need the transformative property of specific art making to assist in the learning process. Using art making may be important for processing the information on CG, but it also triggered memories of loss along with the didactic content in workshop participants. Thus, in addition to providing carefully selected, transformative art-making experiences, educators should take care in presenting the topic of CG in master’s education by preparing students for the range of responses that may trigger emotionally laden material.

Art therapists should learn about grief and CG with the inclusion of studies that describe the influence of culture on grief, and the variations of grief expression between cultures. The impact of culture on grief, both research-based and anecdotal, should be included in a CG module incorporated into art therapy education. This was not something that I did during the CG workshop. Addressing CG and the grief process as highly individualized somehow seemed sufficient. In continuing my literature research following the workshop however, I realized that there is a growing amount of research that examines CG in various ethnic, racial, spiritual, gender, and other identity cultures. This research and literature is exceptionally useful to clinicians trying to understand the life experience of their clients. Knowledge of this research and exposure to some of it could help art therapists to be more culturally aware and sensitive to the specific needs of their grieving clients.
CG should be taught to art therapists in a group setting or class. The focus group discussion in this CG workshop seemed to take the place of an interpersonal and therapeutic sharing component that would likely occur in an art therapy workshop or class. While participants intended to contribute to the research project and not necessarily to each other’s experience, there may in fact be benefit in engaging learning on CG in a community atmosphere. It can be helpful for students to learn about emotionally triggering material with the support of a compassionate peer group (Champe, Okech, & Rubel, 2013; Curșeu, Pluut, Boroș, & Meslec, 2015).

Based on this study, I recommend that art therapists learn about CG during their master’s program, in a group format, with the inclusion of art making and specific attention given to cultural distinctions in grief practices and presentations.
CHAPTER 5

Discussion

The purpose of this project was to gather the opinions, ideas, and experiences of art therapists on the topic of grief and CG, with the intention of assessing the need for guidelines and making recommendations for art therapy training on these topics. To collect these data, I held a workshop to sensitize the attendees to the topic and then to probe their ideas via a focus group.

Coding participant responses in questionnaires, focus group discussion notes, and an interview, I utilized both preset and emergent themes. The preset themes drew in part on expectations informed by the literature on CG and from clinical art therapy practice. The preset themes included **feelings, intention of art, benefits, surprises, triggers, difficulty in engagement, and need for art therapy**. Learning about grief and CG can inspire significant, and in some cases unprecedented, personal introspection (O’Rourke, 2011), which is why I used feelings as a preset theme. Learning about grief can also be triggering, and surprising (Frankl, 1959; Soffer & Birkner, 2018). I wanted any potential benefits of learning about CG, and any difficulty in engaging with the process, to be easily identifiable. Intention of art is an elemental part of the cumulative experience of art (E. H. London, 2011), including appreciation of that art (Conrad, 2016).

I also applied emergent themes to all sources of data, and the included **education, recommendations, universality, and emergence**. I identified the emergent themes as recurrent or heavily emphasized topics in questionnaires, focus group discussion, and interview notes.
Summary

Findings from the artwork made by workshop participants as a part of their workshop on CG showed that many of them referenced their personal losses. Giving art therapists the opportunity to learn about grief, including art making about grief, may deepen their understanding of grief, the resolution of grief, or the grief processing experience. “Art making, by nature of its two-step process of expression and reflection, allows both the isolation of internal focus and the connection with others” (Hill, 2008, para. 77), and thus it is an important part of the process of learning about grief. For art therapists, the art-making process contributes to and affirms the learning (Allen, 1995), as well as enhancing empathic connection with others (Hill, 2008). The findings here suggested that participants found a way to utilize the art-making component however they needed to. One participant stated that her “objective was mostly honoring the emotions of grief and how loss can impact our lives” but that she “also added personal components that memorialized my mother.” Similarly, another participant stated that her intention was for “understanding grief theory and memorializing one who is lost.”

Most participants found value in the CG workshop, including the didactic lesson and the art making, as well as the follow-up focus group discussion. Many participants commented in their questionnaires or in the discussion that they benefited from the experience, despite some challenges, which included negotiating art materials, deciding to pursue or ignore personal losses in an academic environment, and the nature of grief itself, including the difficult emotions that one might encounter. It may be best to explore grief theory and CG in a group workshop format, as opposed to solely individual reading or self-study, due to the benefit of increased “reflective surfaces” as participants
“contain and mirror each individual’s experience of loss” (Hill, 2008, para. 66).

Additionally, they can hone their skills in working effectively with others around issues pertaining to grief (Bennett & Gadlin, 2012).

A curriculum on CG could benefit art therapists in training or those at other stages in their career who feel that exploration of grief issues, grief theory, and art making around the topic of CG would benefit their client base. Findings from the individual questionnaires show a benefit in learning about grief, and a benefit in exploring one’s own grief. One participant wrote, “This experience was very educational. I learned so much in the lesson and enjoyed the art-making.” Another attendee expressed a similar sentiment: “I learned a lot from this experience. I liked both parts of it. Information was good.” Participant feedback indicated that participants can even work through obstacles with materials, as one participant stated, “I did experience some difficulty with the glue, often the string wouldn’t fully stick or the string would stick to my fingers instead of the paper, but ultimately I was successful in my endeavors.” Many participants expressed gratitude for the opportunity to explore grief in general. The findings suggest that given the opportunity to explore a difficult topic, in this case CG, then art therapists will take it.

Findings from the focus group discussion notes show that participants valued the chance to make art about grief. Some connected it to the didactic module and what they may have learned there. There was rich discussion about participants’ intentions in art and the benefits of both textile collage for some or for others, in altered books as a format. The literature supports that both textile collage (Charland, 2011; Cohen, 2013; Collier, 2011; Comas-Díaz & Jansen, 1995; Fry, 1990; Garlock, 2016; Homer, 2015; Kausch & Amer, 2007; Moya-Raggio, 1984; Power, 2009; F. Reynolds, 2004) and
altered books (Brazelton, 2004; Chilton, 2007; Cobb & Negash, 2010; Harrison, 2002; Huntley, 2015) can be powerful art forms for expression and transformation. Focus group findings also spoke to the mystique and power of art and supported the education and exploration of grief at least in part through art making. Focus group discussion included statements about the way that people gravitate towards art, the way that art provides a forum for healthy expression, and that art allows for examination of complex emotion (Cole, 2014; Kramer & Schehr, 2000; Lowenfeld & Brittain, 1987).

Findings from the post-workshop interview notes indicated that the clinician interviewee felt unprepared coming out of her master’s art therapy training to work with clients in grief. In fact, after years of working with clients with chronic medical conditions facing death, and in a hospice with bereaved families, this clinician still felt underprepared for the specific challenges that accompany grief work. So much so that she independently sought out continuing education opportunities to expand her knowledge base about grief, grief theory, complicated grief and how to work most effectively with clients dealing with grief. This interviewee specified that earlier exposure in her career to grief theory and CG could have helped her sooner, and she emphatically recommended that for other art therapists and clinicians.

Findings from the continued literature review conducted after the workshop revealed the importance of learning about the grief responses and rituals of different cultures, which vary significantly. A limited discussion of this can starts on page 30. In this paper I address the universality of grief as a human experience, as well as the variation in grief responses between individuals. Noting cultural norms and distinctions
in all areas is important to the work that art therapists do, and this is also apparent with grief.

These findings, extrapolated from all data sources, can inform education on CG in art therapy. Recommendations for art therapists include a module on CG, ideally delivered during master’s training or shortly thereafter. I recommend that a module on CG include a history of grief theory, grief counseling, a definition of CG, causes, symptoms, prevalence, measures, interventions, current research, art therapy and creative approaches to grief, and a history of art as an outlet for and expression of grief. The delivery of this module on CG should be in concert with an art making opportunity that would allow art therapists to address issues of grief, both academic and personal, in art, and then to explore them as necessary in a group format. So much of what art therapists learn in their training uses this format, and there could be great benefit of exploring grief in this format as well. However, findings especially for the preset themes of feelings, intention of art, benefits, surprises, triggers, and difficulty in engagement indicate that learners should be ready for the potential of CG and grief curricular content and art making to differ from other subject matter. The connections to personal experiences with loss are inevitable, but they are valuable for preparing therapists to deliver quality services to clients.

**Limitations**

This study has several limitations. The original target of the workshop was professional art therapists, with the goal of extracting and deducing what could inform the field of art therapy, and more specifically of education within the field of art therapy. As it turned out, only three of the 10 workshop participants were professional art
therapists. However, the other seven participants in the study were either art therapy students or counseling master’s students.

Another limitation was the lack of participation in the follow-up interviews. The one interview that took place seemed to contribute useful and relevant data, and perhaps more interviews would have helped to support the current recommendations. While all participants indicated on the consent form that they would be willing to have follow-up interviews, they were not responsive to contact after the workshop. It might be possible that participants changed their mind about participating due to a negative or adverse experience following the workshop. Perhaps participants were simply busy in their work and lives, but with a lack of contact, there was no confirmation about why follow-up interviews did not happen. Since these could have generated more useful data, this is a limitation of the study.

Another factor affecting the difficulty with gathering interview data may have been the personal nature of grief. Several participants touched on the fact that it was difficult to separate the personal from the professional in dealing with grief. Participants created art that drew on academic knowledge they gleaned from the didactic lesson in the workshop, but they also thought about their own experiences with loss and made art that memorialized their loved ones. This inherent nature of this topic might itself be a limitation, or it might be a phenomenon that explains why people might be unlikely to participate in a follow-up interview.

**Implications for the Field**

While this study had limitations, it may have useful implications for the field; the first is presenting CG as a relevant and important topic of study for art therapists. This
may inspire change in accreditation standards as pertains to art therapy education on
grief, or more likely might inspire CG workshops in art therapy programs, or lectures or
training on CG and grief which academic institutions and professional associations could
support and offer to students, graduates, and professionals. There is real benefit in
having clinicians who feel a sense of preparedness in their work (Brueilly, Gravano,
Kroll, & Nelson, 2009) and in having art therapists who know what CG is and who have
explored issues pertaining to CG, as well as to their own losses, and to the use of art with
grief. There is room for research that would better explain the effect of early learning on
student art therapists’ self-perceived level of clinical preparedness in the areas of CG and
grief. This study might invite further inquiry into CG and preparedness among art
therapists for working with clients coping with grief.

**Recommendations for Further Study**

There are many ways that further study in art therapy and CG could be useful to
the field of art therapy, and also to the greater community of clinicians in healthcare and
mental health. Some recommendations for future research with CG are for studies on (a)
specific art therapy protocols, (b) creative techniques, (c) art therapy with certain
populations, (d) specific art materials, and (e) broader classifications or types of art
materials.

Future research on art therapy and CG should investigate the efficacy of art
therapy protocols and creative techniques that are useful in treatment with grief or CG.
Research that compares and contrasts art media, techniques or projects with clients
experiencing grief could be useful to the field. An examination of creative interventions
across populations, including data about what creative interventions might be
contraindicated and when, would serve art therapists well. Last, research that extracts more on the personal and professional grief experiences of art therapists might be useful. This could include recommended texts, directives, and self-care or decompression methods. There is so little literature on CG and art therapy, and currently no efficacy studies that support the use of art therapy with CG. There is room for research that might suggest that art therapy is a useful prescriptive treatment.

Closing

I started research on grief eight years ago as a means of coping with my own CG. What I have found in my literary exploration of CG and grief, my continued clinical art therapy practice that often involved working with clients with CG, my teaching art therapists about grief, and my own exploration of grief through visual art, is that grief is extremely humbling. Having clients and students share their own grief stories with me has been one of the greatest honors of my professional work. The journey into and exploration of grief on a personal level allows for an unparalleled intimacy that could stand as a metaphor for all that therapy can be. My hope is to invite further academic discussion on art therapy and CG.
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*World Psychiatry, 8*(2), 67-74.
APPENDIX A: Outline of CG Workshop

I. Didactic Lecture (75 minutes)
   A. Introduction
      1. Grief inspires artwork
      2. Background on research and research questions
   B. Grief
      1. Artwork inspired by grief *(Figures 1-6)*
   C. Complicated grief (CG)
      1. Definition
      2. Symptoms
      3. Prevalence
      4. Diagnostic issues
         a. To diagnose or not; when is grief a pathology
         b. DSM V inclusion (as a V code)
         c. Differential diagnosis – distinguishing CG
      5. Measures
      6. Treatments
   D. Art and Grief
      1. Grief and CG in art Therapy
         a. No training mandates
         b. Lots of art therapists are treating grief and CG
         c. Literature on how art therapists are treating grief and CG
      2. Other creative approaches in therapy
      3. Art projects and mediums that explore grief

II. Art Making (60 minutes)
   A. Participants choose between altered book or textile collage project
   B. Photograph art piece

III. Free Writing (5 minutes)

IV. Questionnaire (10 minutes)

V. Focus Group Discussion (60 minutes)
   A. Introduction to preset themes
   B. Invitation to share experience in workshop
   C. Invitation to share artwork made in workshop
   D. Discussion leading prompts
      1. Impactful educational experiences that help clinical work with grief/CG
      2. Educational recommendations
      3. Response to content presented in lecture
APPENDIX B: Art Projects & Supplies available at CG Workshop

Art Projects at CG Workshop (Participants each chose one)
- Altered Books
- Textile Collage

Art Supplies at CG Workshop (Participants used whatever they like)

Altered Books
- Books
- Magazines
- Paper collage materials
- Decorative papers
- Construction paper
- Tissue paper

Textile Collage
- Fabric scraps
- String/yarn
- Needle and thread
- Trim and notions
- Fabric markers

General
- Markers
- Crayons
- Colored pencils
- Oil and chalk pastels
- Glue sticks
- Tacky glue
- Glitter glue
- Rubber cement
- Clear tape
- Masking tape
- Hole and decorative punches
- Stamps and inkpads
- Puzzle pieces
- Beads
- Sequins
- Popsicle sticks
- Scissors
- Utility knives
- Acrylic paint
- Watercolor paint
- Paintbrushes
APPENDIX C: Definitions of Terms

The following terms are used throughout this manuscript.

**Altered book.** Chilton (2007) described an altered book as any preexisting book that someone has changed into a new work of art. The alteration process itself utilizes a wide variety of artistic approaches, taking on the notion of “no rules” within the actual creation.

**Art therapy.** The American Art Therapy Association (2017) defined art therapy as “an integrative mental health and human services profession that enriches the lives of individuals, families, and communities through active art-making, creative process, applied psychological theory, and human experience within a psychotherapeutic relationship. Art Therapy, facilitated by a professional art therapist, effectively supports personal and relational treatment goals as well as community concerns. Art therapy is used to improve cognitive and sensorimotor functions, foster self-esteem and self-awareness, cultivate emotional resilience, promote insight, enhance social skills, reduce and resolve conflicts and distress, and advance societal and ecological change.”

**Complicated grief.** Grief that is persistent and prolonged, lasting longer than a year, and interrupting the normative ability to adapt to the loss of a loved one from death.

**Free writing.** This is a creative technique whereby a person writes continuously for a set period without regard to spelling, grammar, or content. This technique can loosen the thought process, access authentic emotion, and help to overcome obstacles to creativity such as self-criticism, anxiety, resistance, fear of failure, or judgment.

**Textile collage.** This is a piece of art that is primarily made of fabric and other materials typically used in sewing or textile work, such as yarn, string, thread, trim, and notions. A textile collage may involve sewing, knitting, weaving, applique, or other methods typically associated with fabric and textile work; however, it is not limited to these processes. Textile collage may also involve painting or drawing on fabric.
APPENDIX D: Individual Questionnaire

The following were the questions for workshop participants after their experience in the didactic and art making portions of the CG workshop. Participants answered the questionnaire on paper with pen. Each question allowed for a write-in response whereby participants could elaborate on their answer as much as they liked.

1. Describe how this experience (CG Workshop – didactic lesson & art making) was for you.
2. Describe your artwork and experience working with these art materials (textile collage or altered book).
3. How do you feel about your art piece at this time?
4. Describe any rules or parameters, beyond the given instruction, that you incorporated into your art project(s).
5. Describe any value you derived from making your art project (during or after creation).
6. Did you have any difficulty engaging in the art? If so, why do you think that is? Describe any difficulty that you may have had with engaging in the art.
7. What are any complications you could foresee in using this art intervention with an actual client experiencing CG?
8. Is there anything in the direction that you would change if you were going to use this art intervention with a client with CG? Is there anything that you would do differently? Bring more attention to?
9. Describe any objective(s) for your artwork that specifically applied to grief (e.g., using it as a transitional object, communicating with the deceased, memorializing one who is lost, understanding grief theory, etc.).
10. Describe how the unit on CG and/or the subsequent art project may have triggered thoughts of or connection to your own experience with loss (professionally or personally).
11. Describe how your socio-cultural background may have affected your learning and experience of this didactic lesson and/or the art-making portion of this workshop.
12. Please write any other comments that you have, or any information that you wish to share.
APPENDIX E: Informed Consent Form for CG Workshop

PROJECT TITLE:
Creations from the Classroom: Recommendations for Art Therapy Drawn from a Professional Workshop on Complicated Grief

INTRODUCTION
As part of this workshop, Art Therapy & Complicated Grief, you are invited to participate in a research study. This study aims to draw on the professional experiences and workshop/focus group experiences of art therapists to develop education recommendations for the field pertaining to complicated grief (CG). Participation in this research study is completely voluntary, and not a required part of this workshop. You may participate in this workshop and choose not to participate in this research study without consequence.

WHAT IS INVOLVED IN THE STUDY?
The workshop will consist of approximately the first hour and forty-five minutes of the presentation. The research study will also consist of approximately an hour and forty-five minutes. You are invited to participate in both the workshop and the research study, and your participation in both components of this event is completely voluntary. You are not required to participate in the research study as a consequence of your workshop attendance. If you decide to participate in the research study, you may stop participating at any time, or withdraw participation from any part of this event.

If you decide to participate, you are invited to stay for the entire 3.5-hour workshop and research study; however, this is voluntary. This event is designed for professional art therapists, and it will involve the following: a didactic workshop, personal art making, reflective free writing, a questionnaire, and a focus group discussion.

For the personal art making, you will be given a choice of two art projects that you can make, and you will be asked to choose one. After the art making, you will be invited to do some reflective free writing, and then to answer a questionnaire. The reflective free writing exercise is designed to help you to organize your thoughts and experiences before answering questions about your experience. The questionnaire will ask about demographic information, your clinical practice and training, and your experience in the workshop. You may answer as many questions as you like, and you can skip any questions that you do not wish to answer. There will no penalty for skipping questions, and you may stop the questionnaire at any point. After the questionnaire, you are invited to participate in the focus group discussion.

The focus group discussion will include group brainstorming, reflection on formal training, and drawing on individual experiences from this workshop, as well as professional experiences that may inform recommendations for the field of art therapy.

You may also elect to participate in a short (5-10 minute) follow-up phone interview after the workshop.

You may withdraw your participation from any component of the workshop or study at any time. You may decline to answer any question within the questionnaire, focus group discussion, or interview without loss of benefit from the workshop. If you choose to stop participating, you will not lose any benefits or be penalized in any way. If
you wish to stop participating, simply tell me that you are terminating your participation in the study.

RISKS

There are some possible risks of stress or harm to subjects participating in this research. It is possible that subjects could experience some stress induced by the memory of traumatic loss or negative educational, clinical, or personal experiences that might be reflected upon during or after the workshop. It is recommended that participating subjects employ their skills in self-regulation, self-assessment, and self-care during and after this research project.

Subjects are invited to debrief with the primary researcher following the workshop, upon request, and will also be offered clinical referral to a practicing therapist upon request, at a cost incurred by them. Risks of stress caused by consideration of issues pertaining to grief may include grief symptoms, such as depressive thoughts, longing for those who are lost, or desire to connect with the deceased. Risk of physical injury could be caused by accidental or intentional misuse of art materials, such as scissors. There may also be other risks that I cannot predict.

BENEFITS TO TAKING PART IN THE STUDY

It is reasonable to expect the following benefits from this research: learning about grief theory and complicated grief, making art, satisfaction at having participated in research that may result in recommendations for the field. Others may benefit in the future from the information found in this study.

CONFIDENTIALITY

Information about you will be kept private by not using your name. You are invited to use your initials, pseudonym, a chosen number, or to be identified by a randomly assigned number (which you will receive on arrival). Information shared via questionnaire or during the focus group discussion or follow up interviews that pertains to participant education, clinical training, and any personal experiences shared may be included in the study, however participants’ names will be withheld, and identifying information will be anonymized (e.g., the name of an identified supervisor or instructor or university would be changed in the study write up). Data collected from the focus group discussion will be aggregated for writing purposes.

Your data will be accessed only by the primary researcher. Data including photos of artwork will be stored on a password-protected zip drive. Data including consent forms, observation notes, focus group notes, and interview notes will be stored in a locked drawer in a locked office. Last, data, including the survey questionnaire, will be administered online via SurveyMonkey. After the workshop, the questionnaires will be downloaded and stored on the password-protected zip drive, and all online and cloud-based versions will be deleted.

Data that constitutes images of artwork may be reproduced within the study. This data will not be used again in the future, and it will be destroyed after five years.
INCENTIVES
Subjects will not receive any compensation for participating. Subjects have the opportunity to participate in an educational workshop, and may learn something, at no charge.

YOUR RIGHTS AS A RESEARCH PARTICIPANT
Participation in this study is voluntary. You have the right not to participate at all or to leave the study at any time. Deciding not to participate or choosing to leave the study will not result in any penalty or loss of benefits to which you are entitled, and it will not harm your relationship with the researcher.

CONTACTS FOR QUESTIONS OR PROBLEMS
If you have questions about this research, including questions about scheduling or residual rights of participating, you may contact:

Primary Investigator
Rachel Brandoff, ATR-BC, ATCS, BCPC, LCAT
(212) 518-7077
rachelbrandoff@gmail.com

or

Faculty Advisor
Robyn Flaum Cruz, Ph.D., BC-DMT, Professor
Expressive Therapies PhD Program
Lesley University
(412) 401-1274
rcruz@lesley.edu

I agree to participate in the study.
_________________________________________________
Printed Name

_________________________________________________
Signature Date

I agree that my photographed artwork may be published as a part of this study.
_________________________________________________
Signature Date
After the completion of this workshop, I am willing to be contacted by the researcher within 7-10 days for a short follow-up phone interview, as a part of this study.

_________________________________________________
Phone number

_________________________________________________
Best contact – days/times

_________________________________________________
Signature                Date

There is a Standing Committee for Human Subjects in Research at Lesley University to which complaints or problems concerning any research project may, and should, be reported if they arise. Contact the Committee Chairperson at irb@lesley.edu
APPENDIX F: Recruitment Strategy and Announcement

Participants were recruited for the workshop via public announcement on social media, including Facebook, Twitter, and Linkedin.com. The workshop was publicized via the social media feed and an e-mail newsletter of the local professional organization, the Pennsylvania Art Therapy Association (PAATA; formerly Delaware Valley Art Therapy Association). Flyers for the CG workshop were also distributed at an educational workshop hosted by PAATA. The recruitment announcement read as is posted below.

Free Workshop for Art Therapists

**Topic:** Art Therapy & Complicated Grief  
**Date:** October 7, 2017  
**Time:** 9:00 AM-12:30 PM  
**Place:** Jefferson University, East Falls Campus  
**RSVP:** rachelbrandoff@gmail.com

This free workshop is open to Professional Art Therapists, and it will include a didactic presentation on complicated grief, art making, and reflective free writing. This workshop is a part of a larger doctoral research project on art therapy and complicated grief. Attendees are invited to participate in the workshop, and to participate in the research study. The research portion of this event includes a survey questionnaire, a focus group discussion, and an optional follow up interview.

Feel free to contact Rachel Brandoff (rachelbrandoff@gmail.com) with questions about participation, the topic, the workshop, or the research project.

Have friends or colleagues you think might be interested? Please refer them or share this announcement with them. Thank you for your interest!