

Topical Manuscript

Strengthening Rehabilitation Professional Identities: Including Grief Education as a Psychosocial Aspect of Disability

Xiaolei Tang^{1 a}, David A. Rosenthal²

¹ University of Illinois Urbana-Champaign, ² University of Wisconsin-Madison

Keywords: grief support education, rehabilitation counselor education

<https://doi.org/10.52017/001c.38666>

Rehabilitation Counselors and Educators Journal

Vol. 11, Issue 3, 2022

The primary objective of this paper is to call attention to rehabilitation counseling educators and leaders to include grief support as part of the rehabilitation counseling training curriculum. Disability and chronic illness have long been associated with loss, death anxiety, and chronic sorrow. The prevailing model of psychosocial adaptation to chronic illness and disability emanated from grief theories and has been well conceptualized and applied in both understanding disability experiences and providing effective services. However, rehabilitation counselors have expressed a lack of competency and confidence in understanding grief as a psychosocial concept and providing grief support for people with chronic illness and disabilities. Too often, pervasive understanding of grief and loss has been associated with pathology and prescriptive notions, which have been criticized by clinicians and scholars in bereavement research and practice. To address this concern, this paper proposes including grief support education in rehabilitation counselor training curricula. In addition, several suggestions are made for program design and implementation within the context of CACREP curricula requirements.

The profession of rehabilitation counseling has evolved in interesting and unexpected ways. We are presently experiencing the inclusion of mental health curricula resulting from the merger of the Council for Accreditation of Counseling and Related Educational Programs (CACREP) and Council on Rehabilitation Education (CORE). There are challenges and struggles. Foremost among the curricula change is the sense that psychosocial aspects of disability is being infused into other mental health counseling courses and it is felt that there is lack of specificity regarding this important topical area in the new CACREP standards, seemingly pulling the discipline away from our strong psychosocial professional identity. We must embrace our historical roots in psychosocial aspects of disability, as we simultaneously fulfill the new curricula requirements and ensure marketability for future rehabilitation counseling graduates. It is imperative that we stay flexible yet assertive and confident as we seek new opportunities in advancing and strengthening our professional identity.

One missing piece in the new CACREP curricula requirement across all of the counseling specialties is grief education. Not only it is missing in the language within CACREP standards, but also has seldom been included in programs' counseling curricula (CACREP, 2015; Humphrey, 1993). Grief issues, both death-related and non-death related, are

a natural part of counseling. Moreover, rehabilitation counselors frequently work with individuals with disabilities and chronic illness, who are often accompanied by unresolved grieving issues after the loss of body functions, social identity, sense of control over life, and employment, all of which are considered integral components to psychosocial aspects of disability. However, these grieving experiences are not often recognized, and most rehabilitation professionals have limited knowledge of the nature, prevalence, and scope of grief in the context of disability and chronic illness.

Grief issues and clinical implications have evolved from pathological perspectives, but scientists are increasingly seeing grief as an important part of the coping process (e.g., Lazarus & Folkman, 1984; Stroebe & Schutt, 1999), and in need of validation and understanding as opposed to clinical interventions (Ossefort-Russell, 2013; Siegel, 2012). This contemporary viewpoint of grief is compatible with the spirit of rehabilitation counseling—we seek functionality, emphasizing resilience rather than pathology and deficiency. As many of the value- and functionality-laden beliefs of adaptation and adjustment to disability and chronic illness indicate, a psychosocial perspective of grief has important meaning beyond diagnostic markers and our capacity for accurate measurement (Dunn & Elliott, 2005; Livneh

& Martz, 2016; Wright, 1983). In this sense, this paper intentionally employs the terms “grief support” and “grief education” instead of “grief counseling” and “grief counseling education” (with some exceptions in the discussion of existing grief counseling programs), emphasizing the psychosocial and non-pathological implications.

Therefore, the purpose of this paper is to raise awareness among rehabilitation professionals—that we are responsible for recognizing and acknowledging disenfranchised grief while serving people with disabilities. Ultimately, we argue that rehabilitation counselors can be instrumental in assisting consumers to “enfranchise” their disenfranchised grief.

The CORE-CACREP merger presents us with challenges and opportunities. As suggested by Patterson (2009), we can look to the past, examine the present, and inspire the future as a way to unify and decrease disharmony in our discipline. Embracing our roots, and thus the importance of psychosocial emphases, can be a catalyst for reflection while strengthening our professional identities. With a strong belief and conviction emphasizing psychosocial aspects of disability as the essence of our professional identity, this paper takes a closer look at grief as a psychosocial concept and calls for the inclusion of grief education in rehabilitation counseling curricula.

Understanding Grief

Different theories and models have evolved in understanding loss and grief over the past century. Implications abound, starting from the classic psychoanalytic view (Freud, 1917/2018) to the more recent interpersonal neurobiological perspective of grief (Siegel, 2012). Historically, clinicians and theorists have tended to either set specified norms for grievers and/or pathologize grief, suggesting prescriptive grief work, while emphasizing symptoms reduction. Yet, it is also important to note that diverse grieving experiences resulting from different types of loss are being recognized and validated, with considerable contributions from efforts in the fields of hospice and thanatology. In rehabilitation counseling, loss and grief are by no means new themes: Beatrice Wright posited the term “psychosocial approach” as early as 1960, which was further developed by Livneh (1997) in *Psychosocial Adaptation to Chronic Illness and Disability*. The staying power and continuous implications of psychosocial aspects of disability cannot be fully understood in practice, teaching, and research without a comprehensive and in-depth understanding of grief and loss. This section first reviews classic theories and models of grief, embedded in both myths and facts. Then it further reflects upon the interdisciplinary dialogs about pathological and non-pathological grief, as well as the implications for mental health counselors and rehabilitation counselors. It closes with a review of up-to-date literature on grief in the context of chronic illness and disability.

Prevailing Grief Theories and Models

In the early 1900s, Freud (1917/2018) posited that the “work of mourning” after the loss of a loved one involves

painful and intense emotional reactions. From this viewpoint, the grieving process could only be completed by withdrawing ties to the attached figure who is no longer present and investing in new relationships. Although Freud was one of the first individuals to focus on grief and mourning construction in modern Western culture, his psychoanalytical perspective on the grieving process has recently come under question as being too broad and lacking in clarification (Stroebe & Schutt, 1999; Wortman & Silver, 1989). Later, Erich Lindemann, the then psychiatrist-in-chief of Massachusetts General Hospital, conducted the first systematic survey of grief on 101 bereaved patients at the Harvard Medical Center who were families and survivors of the Coconut Grove Fire of 1942. After his landmark work with bereaved individuals during World War II, Lindemann (1963) refined and further conceptualized *grief work* as “emancipation from the bondage of the deceased, readjustment to the environment in which the deceased is missing, and the formation of new relationships” (p. 8).

Another dominant theoretical framework construing the origin of grief is John Bowlby’s (1961, 1969, 1972) attachment theory. From a social psychology perspective, attachment theory explains and decodes the attachment behaviors presented by grievers, such as seeking the attached figure, crying, or angry protest (Wortman & Boerner, 2011). These behaviors are explained as deriving from the absence of the attached figure and the perceived threat to the affectional bond resulting from the loss. In contrast to Freud’s *work of mourning*, Bowlby contended that grievers seek out a reunion with their loved one, rather than withdrawing from the bond, and intense physical and emotional manifestations arise because of the opposing force (the fact of the loss). While Bowlby’s grief research emphasized the “urge to recover the lost object” (Bowlby, 1961, p. 330) as the initial reaction, Glick and colleagues (1974) later pointed out that “numbness” should arise prior to “searching.” This contribution was acknowledged by Bowlby, and the two researchers outlined a four-stage model of grieving: (a) *numbness*, which is often presented as denial of the loss; (b) *yearning and searching*—the behaviors activated by the absence of the attached figure or object, often accompanied by anger, guilt, and a tendency to keep the memory of the loved one as clear as possible; (c) *disorganization and despair*, which appear when the griever gives up searching, often accompanied by feelings of depression and hopelessness; and (4) *reorganization*—which as the last stage signals the acceptance of loss and presents in establishing a new normal (Rando, 1984).

A generation after Lindemann’s initial postulations, while working with families in Boston, Elizabeth Kübler-Ross, a Swiss-American psychiatrist who later became the “Death and Dying Lady” (Kübler-Ross, 1997, p. 15), brought a five-stage model of grief to light. This highly influential model was developed to explain the reactions of dying persons to their own impending death, with a progression of denial, anger, bargaining, depression, and acceptance (Kübler-Ross, 1969/2011). The five-stage model had great impact on the hospice movement in the United States and was the first that offered a way to medically manage dying

(Doka, 2016). It was also criticized extensively. One of the major weaknesses identified was the linearity of the model, given research evidence supported a more individualized experience of death and dying (Archer, 2001). The criticism was acknowledged and appreciated by Kübler-Ross herself; late in her life, following the death of her ex-husband, she noted in her book *On Grief and Grieving*, "I now know that the purpose of my life is more than these stages...And so are you" (Kübler-Ross & Kessler, 2005, p. 216).

Non-Death Losses and Disenfranchised Grief

The biography of *disenfranchised grief* should start with the conversation in 1980s between Kenneth Doka and one of his students about grieving the death of her ex-spouse (Doka, 2020). Doka realized that in some situations of loss, grief is silenced by social norms. Within a social context, Doka defined disenfranchised grief as "the grief that results when a person experiences a significant loss where the resultant grief is not openly acknowledged, socially validated, or publicly mourned" (p. 25). Empirical studies on disenfranchised grief of non-death losses emerged, including the loss of cultural identity experienced by immigrants (Rosenzweig, 2010), the loss of romantic relationships (Kaczmarek & Backlund, 1991), and grief experiences in older age (Moss & Moss, 2003). Furthermore, research also began to explore the bereavement experiences among individuals with AIDS (Hornjatkevyc & Alderson, 2011), as well as elements of disenfranchised grief among caregivers for loved ones with dementia (Dempsey & Baago, 1998).

Doka (2020) further proposed that disenfranchised grief may be experienced when (a) the relationship is not acknowledged (e.g., the loss of a non kin-based figure); (b) the loss is not validated (e.g., the loss of health or grief of anticipatory death after receiving a diagnosis of life-threatening illness); (c) the individual who is grieving is excluded due to socially defined cognitive limitations that lead to the incapacity to mourn (e.g., grief experiences among people with intellectual disabilities); (d) the circumstances of loss, may be associated with increased level of fear, stigma, and anxiety from the social environment (e.g., a loss due to suicide); and (e) only certain ways of grief are expressed, which is associated with the cultural differences surrounding the expressions of grief. Within the disenfranchised grief frameworks, it is asserted that all types of losses deserve validation, and each grief experience is acknowledged.

Grief as A Non-Pathological Term

The delineation between normal and pathological grief is controversial and has long been debated. There is no doubt that grief as the emotional reaction to loss encompasses intense personal anguish and is associated with increased risk for a variety of psychological and somatic ailments (Middleton et al., 1993). However, there is no simple answer to the question of whether or not some grieving reactions should be considered pathological. Nonetheless, it is sobering to review and reflect on arguments offered in the development of grief theories across disciplines. From

psychoanalytical to the more recent interpersonal neurobiological viewpoints, changes in the understanding of grief have occurred in terms of the grief continuum.

Freud (1917/2018) and Parkes (1965) asserted that forms of grieving can be considered either normal or pathological. Parkes and Prigerson (1972/2013) once stated that grief, as the reaction to loss, is the "only one functional psychiatric disorder whose cause is known, whose features are distinctive, and whose course is usually predictable" (p. 26). Bowlby (1980) also proposed that there are disordered forms of grieving; he was followed by Raphael (1994), who described several "morbid or pathological patterns of grief" (p. 59). All these assertions were attempts to delineate "normal grief" from what is not normal. As increasing number of medicalized terms were added to different presentations of grief; a separate diagnostic category for pathological grief was first proposed by two groups of researchers led by Horowitz and Prigerson (Horowitz et al., 1997; Prigerson et al., 1995). The diagnostic category has been referred to as *pathological, complicated*, and more recently, *prolonged grief disorder* in the Diagnostic and Statistical Manual for Mental Disorders (DSM) system (Boelen & Prigerson, 2013).

Increasingly, since the mid-1990s, the inclusion of the grief syndrome in mental health diagnostic systems has been debated among researchers and clinicians. Several issues arose and were judged to need further clarification, including the definition of pathological grief, the distinction of pathological from normal grief, their relationship with other disorders, and the criteria for pathological grief (Stroebe et al., 2000). For example, in the revision discussion for the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association, 2013), it was suggested that complicated grief (from the DSM, 4th edition) should be included: (a) alongside post-traumatic stress disorder (PTSD; Horowitz, 2006); (b) in the category of attachment disorders (Prigerson & Vanderwerker, 2006); (c) within personality disorders (Parkes, 2006); and (d) in the system, but only within an appendix as a disorder proposed for further study (Goodkin et al., 2006). The current DSM-5 has adopted the suggestion within the fourth edition and included complicated grief in "Section III - Emerging Measure and Models" as one of the conditions for further study. In the DSM-5, complicated grief is now refined as *persistent complex bereavement disorder* (APA, 2013).

Standing in stark contrast to "medicalized grief," the concept of non-pathological grief emphasizes the individualized grief experience and a myriad of variables that affect and influence individual grief experience. For example, as indicated in the typologies of disenfranchised grief, the circumstances of the loss vary, such as whether the loss is anticipated, traumatic, or sometimes liberating. In addition, the characteristics of the grieving individual also play an important role in coping strategies and cognitive styles utilized (Doka, 2020). Rando (1984) and Kübler-Ross (1993) also once viewed grief as a process of adjusting and making accommodations, rather than a process of fixing deficits. In addition, Rando conceptualized grief as a process that implies a natural reaction to the experience of loss based on

individualistic perceptions. She believed that, based on the unique perception by each individual griever, grief happens without necessarily being validated or recognized by others as a natural biological evolution.

While important progress has been made by clinicians and researchers in psychology and psychiatry, endeavors made in interpersonal neurobiology are worth noting. Siegel (1999, 2012) argues that the awareness of danger and safety starts below the level of consciousness, and the mirror neurons cause individuals to mutually influence each other's neural firing and autonomic activation, allowing people to empathize. Consequently, clinician perceptions of individuals' emotional experiences greatly impact their ways to relate, empathize, and establish therapeutic relationships. From this perspective, if counselors perceive grief as pathological, even implicitly, their clients' feelings of isolation, shame, and distress may increase. Interpersonal neurobiology helps us understand grief from both an individualized and relational perspective, and it is suggested that the most important clinical pursuit for grief support is to be present and non-judgmental (Ossefort-Russell, 2013).

Near the end of his life, Freud—considered the first modern grief researcher—was reported to have said to a woman, who had become depressed following the death of her husband, “madam, you do not have a neurosis, you have a misfortune” (Wahl, 1970, p. 137). While the endeavor for effective grief support continues, there is one common thread: grief should be viewed in light of a multitude of influential factors, rather than along the dichotomy of normal and pathological grief.

Grief Re-Conceptualized: A Psychosocial Concept

Grief and Disability

While disenfranchised grief encompasses grief experiences in the context of chronic illness and disability as often out of the social range of acknowledgement and support (Doka, 2016, 2020), rehabilitation research on the psychological accounts of adjustment to life with chronic illness and disability involve expectations of grief (e.g., Berger, 1988; Lewis, 1983; Livneh & Antonak, 1997). In the past half century, contemporary conversations about disability experiences, in debates and resonances, have informed this present paper. The following selected messages conveyed from multiple practitioners and researchers have enriched the psychosocial understandings of disability, loss, and grief.

From a nurse's perspective, Lewis (1983) outlined the common losses experienced by people with chronic illness and disability, including (a) sense of control of life, (b) sexual function, and (c) productivity. She contended that the individual's chronic health condition and/or the loss of body function are “in attendance at their own small dyings” (p. 9). For example, as Lewis illustrated, the fact of taking medications can symbolize one is giving over part of the control of the body and/or emotions to the drugs. Similarly, a grieving cycle may evolve when sexual function is impacted or false-belief of sexual dysfunction arises,

which may greatly impact the person's self-esteem and relational bond. Loss of productivity entails both vocational and avocational implications. This discussion, emanating from clinical observations, has brought the multifaceted feature of disability, loss, and grief into light, from which grief may be viewed in the context of chronic illness and disability as just as complex and messy as grief in bereavement.

In concert with the phasic models of grief, Livneh and colleagues conceptualized the process of psychosocial adaptation to chronic illness and disability, which set forth the pursuit of the psychosocial approach in rehabilitation counseling. In particular, Livneh and Antonak (1997) concluded that most stage models in grief literature identify the following reactions: (1) shock, which is perceived as the individual's initial reaction to the onset of the traumatic event; (2) anxiety, which is signified by both physical and psychological states, such as rapid heart rate and confused thinking; (3) denial, which involves “negation or minimization of the condition” due to psychological implications (p. 20); (4) depression, which is often observed among persons who have just experienced an adverse event and are upon initial realization; (5) internalized anger, which is seen as often associated with guilt or self-blame; (6) externalized hostility, which is viewed as an attempt at retaliation against imposed functional limitation caused by the injury or medical condition; (7) acknowledgement, which is considered as the first indication of acceptance of the loss or the current condition; and (8) adjustment, which is often perceived as the final stage of the adaptation process, accompanied by re-establishing self-worth and life pursuit.

In addition, Livneh also critically conceptualized *denial* in the context of disability and adaptation (Livneh, 2009; Livneh & Antonak, 1997). Particularly, when denial is manifested in the process of adaptation, evidence has shown that denial of impending functional limitations and obstacles in daily living may mitigate negative attitudes and emotions towards a more hopeful state; it may actually ward off anxiety and other emotional distress and may prevent the individual from going into the state of “emotional flooding” (postulated by Horowitz, cited by Livneh & Antonak, 1997). In a study by Olney et al. (2004), a self-identification survey answered by 12.9 million American adults with disabilities showed that 11% of participants who were in denial of their disability status reported significantly lower rates of mental health problems. Similarly, Bennett and Boothby (2007) reviewed studies on emotional adaptation to coping and heart disease and found positive emotional outcomes were consistently reported in the short-term following a cardiac event. However, according to the review, findings on the impact of denial on longer-term emotional functioning or psychosocial adaptation showed both positive and negative correlations.

Job Loss Grief

Grief in unemployment entails both tangible (e.g., income) and intangible loss (e.g., identity, sense of self-worth). Amundson and Borgen (1982) proposed a conceptual model of the unemployment cycle, which suggested

the emotional experience after job loss was similar to the grieving experience formulated by Kübler-Ross. Through their exploratory studies, they asserted the emotional and physical manifestations of grief, such as fear, distress, and numbness, are also true to the aftermath of unemployment. The dynamics of this unemployment model, coupled with the constant and alarming rate of unemployment among people with disabilities in the United States, speaks to the distress people with disabilities undergo, with many implications for rehabilitation counseling interventions.

As Wright (1983) asserts, the significance of the effects of illness and disability is usually minimized if the person's job is left intact. Similarly, Jones (1979) stated that "it is important to realize that grief over the loss of a career may be more acute than over the death of a loved one" (p. 197). While not stated explicitly in many of the early grief theories and models, the pivotal role of relationship and attachment at work is acknowledged from the perspective of meaning for engagement with the environment (Doka, 2016).

Grief Education

Despite the rich grief literature and research along both lines (pathological and non-pathological), studies and reviews highlight that grief education for health-related professionals is too often overlooked. *Grief education*, indicated here, is a broader term and is often referred as death education in medical, nursing, social work, and sometimes counseling programs. The following section uses grief education and death education interchangeably. This section reviews the development of grief education across health-related disciplines, and calls for the need of grief education in rehabilitation counseling.

Grief Education Across Disciplines

Grief Education Developments in Medical Schools

Modern grief education started in the field of thanatology (the study of death and dying). Dr. Herman Feifel, a philosopher, psychologist, and a pioneer in the field of thanatology, organized and presented a scientific symposium on "Death and Behavior" at the 1956 annual meeting of the American Psychological Association, which broke the prevailing silence on the subject of death at that time (Wass, 2004). Following Feifel's insistence of the benefits of death education and the emphasis of the multidisciplinary nature of death study (Wass, 2004), the first two university-level death education courses were led by Robert Fulton at the University of Minnesota in 1963 and Edwin Shneidman at Harvard University in 1969 (Corr, 2016). One of the main goals of these early death education courses was to alter death-related attitude, and some of the course activities are still used today, such as "Write Your Own Obituary, which was originally used by Shneidman among his college students at Harvard University (Shneidman, 1972).

As the hospice movement got underway in 1960s in the United States, considerable efforts were made in developing death education programs primarily in nursing schools

(Wass, 2004). In the following decade, criticism arose on the lack of communication between physicians and patients on death and end-of-life (EOL) issues (Klenow & Youngs, 1987; Quint, 1967). Not surprisingly, death education was characterized as "inadequate" in medical curricula (Wass, 2004). In the surveys of U.S. medical, nursing, pharmaceutical, and social work schools in 1990s by Dickinson and his colleagues, 13% of medical students and 15% of nursing students were offered a full course on grief-related subjects, and a fourth of the surveyed students took an elective grief-related course (Dickinson et al., 1992; Dickinson & Merriam, 1996). The surveys further revealed that the majority of the grief education curriculum endorsed the "stages of grief" model by Kübler-Ross.

Nearly three decades since the hospice movement, the medical and nursing associations (e.g., American Medical Association, American Association of College of Nursing) have recommended standard EOL care education programs and curricular guidance since 1995. For example, the American Academy of Hospice and Palliative Medicine (AAHPM) developed UNIPACs, a training program for nurses and physicians focusing on core knowledge, concepts, and clinical skills to effectively care for patients and families facing chronic and life-limiting illnesses, the first edition of which was launched in 1996 (Davis, 2008). UNIPACs, now expecting its 5th edition, are considered as the essential practice for hospice and palliative medicine (AAHPM, 2017); it was also one of the first training modules that included guidance for HIV/AIDS care. Over the years, other training programs in the field of medicine have also been developed and applied nationwide, such as "Education for Physician on End-of-Life Care" (EPEC), and "End of Life Nursing Education Consortium" (ELNEC).

The effectiveness of grief and EOL training is evident in the quality of care. Multiple authors published studies on how grief education has affected training outcomes and service delivery. A systematic review of U.S. medical school end-of-life (EOL) training demonstrated that the selected nationwide survey studies consistently reported higher competency among medical students who received grief and EOL education, particularly in addressing the physical, emotional, and psychosocial issues related to death, dying, grief, and loss (Bickel-Swenson, 2007). Similarly, Barrere and colleagues (2008) conducted multiple regression analyses on the influence ELNEC curriculum and concluded that integrating the curriculum throughout a baccalaureate program positively affected the attitudes of nursing students toward the care of patients faced with terminal illnesses. Aside from "compassionate pain relief" (e.g., controlled substances), the development of grief and EOL education in medical schools upholds the humanistic component of medical care and attempts to balance practical training with attention to "personal understanding and attitudes" (Wass, 2004, p. 292).

Grief Education in Counseling and Counselor Education

While considerable attention has been paid to EOL care in medical settings, there have also been increasing efforts

in advancing knowledge and practical skills in the field of counseling. As previously reviewed, the majority counseling models for grief interventions are derived from psychoanalytical theories and mainly focus on grief reactions considered “pathological.” Thus, grief counseling has remained in the domain of clinical psychologists and psychiatrists (Raphael et al., 1993). As grief counseling evolved into a professional specialty, calls for formal preparation and in-depth training were made (Worden, 1982/1991). A national survey of counselors and counselor educators indicated that more than 80% of respondents recognized the need of grief education, but only half of them had any (Rosenthal, 1981). In another preliminary report on grief counseling training in CACREP and CORE-accredited programs, Humphrey (1993) reported that more than 70% of respondents who were a department chairperson of counselor education programs across the nation considered teaching grief to be important. The report further found that more than 60% of responding programs did not offer a distinct course in grief, and most (89%) responding CACREP and CORE programs used an “infusion method” for teaching grief (p. 337). In addition, grief education in the field of counseling started primarily in the format of continuing education, workshops, and seminars (Wass, 2004), and was not extended and advanced into standardized educational programs, with only a few exceptional attempts. For example, in the early 2000s, Brooklyn College of New York City offered a grief counseling concentration in conjunction with a master’s degree program in Community Health; Hood College of Frederick, Maryland offers a master’s degree in thanatology, with a focus on grief counseling. Although there were several well-established grief counseling certificate programs (e.g., Grief Support Specialist Certificate program at the University of Wisconsin-Madison), because there is no state certification or licensure requirement for grief counseling, the credibility of the certificate training programs was sometimes called into question (Wolfe, 2003; Woody, 1997).

The fragmentation of grief education curricula and programs in the field of counseling remains an issue, leading to the call for integration and standardization (Wass, 2004). Regardless of whether certain grief reactions should be viewed as mental health issues, there is no doubt that grief education is an important component across health-related disciplines.

Need for Grief Education in Rehabilitation Counseling

Unlike medical, hospice, and mental health professionals, rehabilitation counselors started the discussion of grief issues from the standpoint of understanding whom we serve. As noted earlier, the discussion of grief issues initially addressed in 1980s (i.e., Wright, 1983), were expanded in the 1990s as an important component of psychosocial adaptation (Livneh & Antonak, 1997) and coping with chronic illness and disability (Moore & Stambrook, 1992). However, similar to the stumbling blocks encountered in the medical disciplines, early efforts and attempts to address grief issues and include grief education in rehabili-

tation counseling dissipated along with several advocating voices (e.g., Hunt, 2007; Hunt & Rosenthal, 2000; Stebnicki, 2000). Even recently, there have been only a couple in-depth studies that attempt to bring this important theme back to attention (Cicchetti et al., 2016; Heatherly, 2016).

Revisiting Livneh’s (1983) discussion on death anxiety among and toward people with disabilities, we are reminded that part of the psychological distress people with disabilities deal with is the anxiety of inevitable death that is consistently triggered by the loss (or the death) of body functions. This philosophical note reminds rehabilitation professionals of those whom we serve. As the size of the population rehabilitation professionals serve grew, the job functions of rehabilitation counselors expanded (Leahy et al., 2003). We hold a unique position in working with individuals with chronic illness and disability, geriatric populations, and veterans, among others (J. B. Patterson, 2009). Meanwhile, grief has become a theme more commonly seen and encountered among rehabilitation practitioners, educators, and researchers. For example, as highlighted by Patterson, rehabilitation counselors work with millions of aging workers, such as Vietnam veterans who are part of the baby boomer generation, providing vocational, psychological, and social support. Unresolved grieving issues associated with disabilities (e.g., aging, unemployment, loss of social identity) occurring in the process of rehabilitation require rehabilitation counselors to have the understanding and skills to provide grief support.

Grief Support Competency

Obviously, rehabilitation counselors are not alone in feeling their lack of grief competence, as surveys of medical, hospice, social work, and mental health counseling professionals also indicated concerns of this missing piece in training. Grief competence has been operationalized mostly among mental health professionals, among which two in-depth dissertation studies are worth noting. Smith (2002) defined grief competence as a counselor’s ability to cope with death-related issues based on Bandura’s self-efficacy theory, Rogers’ existential-constructivist theory, and Folkman’s coping theory. In his study, Bugen’s Coping with Death Scale (BCDS) was used among licensed counselors. He identified three variables predicting counselors’ ability coping with death-related issues, both personally and professionally: (1) counseling self-efficacy, (2) counselors’ personal experience with loss, and (3) counselors’ training on grief, death, and EOL issues. Around the same time, Charkow (2001) surveyed 147 licensed marriage and family therapists using the same scale (BCDS) and proposed four factors in predicting family-based and grief-related counseling competence: (1) family-based counseling skills (e.g., family system theory), (2) basic grief counseling skills (e.g., general models of grief and loss, diversity in bereavement and grief), (3) developmental aspects of grief knowledge and intervention (e.g., grief throughout lifespan, children and grief), and (4) resource utilization in grief support (e.g., coping strategies in grief, local grief support groups).

Herman Feifel, who rediscovered the meanings of death in psychology and served as the director of the psychiatric clinic at the U.S. Veteran's Administration in Los Angeles for over forty years, stressed that grief education is a multidisciplinary task (Wass, 2004), and that grief and death education programs must be designed and incorporated for all healthcare professionals. He furthered that actions need to be taken collaboratively by medical doctors, nurses, hospice professionals, social workers, psychologists and others to address grief education in their respective curricula. It is critical for all health professionals to understand the scientific and humanistic visions of grief and death education, and there is no doubt that rehabilitation professionals are among them.

Summary and Application

Proudly represented in the history of rehabilitation counseling since the early years of the 20th century, our profession has been in the frontline serving and advocating for people with disabilities, training generations of dedicated rehabilitation counselors, and working closely with other professionals and stakeholders. The holistic approach we use and the positive viewpoint we hold are the driving spirit of our profession. We must keep and further enrich our psychosocial identity as the philosophical foundation of rehabilitation counseling through education and practice. Understanding grief should be a critical component of this history and identity. Our profession has encountered many issues, such as concerns regarding the "two-hat" or "one big hat" argument in terms of professional identity and functions (Jenkins & Strauser, 1999; Leahy & Tarvydas, 2001; C. H. Patterson, 1957, 1966; J. B. Patterson, 2009; Whitehouse, 1975), and urgent calls for the need to unify associations (e.g., Field, 1981; Phillips, 2011). All these professional issues cannot be addressed without putting those whom we serve in the forefront, as clients and consumers are the common bond across our diverse job titles and work settings, and they have been shaping and keeping our professional identity ever since the profession of rehabilitation counseling was established. To simplify the conversation in a time of change, we should first and foremost turn to our clients to let them guide us forward. Given what we know about chronic illness and disability, grief and loss are a common phenomenon of the clients we serve.

Rehabilitation professionals focus on the functionality of an individual, seeking optimal opportunities for persons with chronic illness and/or disability to participate in all aspects of life. Rehabilitation counseling training emphasizes holistic approaches, recognizing the uniqueness of all individuals. In this sense, it is natural for us to view grief issues, which many of the clients we serve will encounter, as a psychosocial commonality and provide grief support in non-judgmental ways. This begins with acknowledging some foundations to this: the belief that non-pathological assertion emerges from classical theories; that grief experiences are more likely to be captured and attended to when psychosocial factors are considered; and that there is no "proper" way to grieve.

In sum, the importance of familiarizing rehabilitation professionals with a thorough understanding, as well as appreciation, of grief comes from the following considerations: (a) grief and loss is the central theme to both bereavement and the experience of living with chronic illness and disability; (b) providing grief support along with rehabilitation counseling can potentially improve the efficacy of rehabilitation services and interventions; (c) the psychosocial identity of the rehabilitation profession can provide unique insight in understanding grief; and (d) it is a great opportunity to strengthen our psychosocial identity by including grief education at this time.

Lessons learned from the efforts and attempts made by medical, hospice, and mental health professionals in the past half century have consistently demonstrated that grief education involves multiple and complex dimensions. Thus, grief education must address didactic theoretical content supplemented by clinical training and relevant field experience. To address the many dimensions and practical goals, particularly in the context of chronic illness and disability, the following themes and suggestions are made:

- **Non-pathological themes:** place clear and consistent emphasis on the assertion that grief is a psychosocial concept and grief experiences are unique for each individual.
 - Rehabilitation counselors and rehabilitation counselors-in-training should be provided with opportunities for trainings and courses specific to practices of grief support, particularly in the context of chronic illness and disability. When providing grief support education and training, it is important to emphasize the importance of reconceptualization and redefinition within the DSM structure (i.e., non-pathological, individualized experience).
 - Counselors should be prepared to address grief-related issues when serving consumers. To achieve this goal, interdisciplinary communication should be enhanced. For example, bringing content experts in trauma-informed care, psychology, psychiatry, and thanatology to the classroom and rehabilitation agencies to expand the scope of psychosocial understanding of both life and disability experience.
- **Curriculum, course development and clinical training:** familiarize professionals and students with classic and modern grief theories, research foundations, and limitations.
 - Rehabilitation educators should explicitly and intentionally teach both theoretical and applied content by dedicating components of theories and techniques courses to grief education in the curriculum. It is felt that some grief theories and discussion points are important for students and practicing counselors to understand via student-led discussions and classroom activities, such as role play. For example, the concept of "denial" has been reconceptualized in the context of psychosocial adaptation; students should

- be encouraged to explore the multifaceted layers of how denial manifests in different ways.
- Rehabilitation educators should expand classroom experience into the community for the students. Many programs have encouraged the development of community-based courses and content, which provides great potential to enhance grief education experiences for the students. By connecting with local agencies and content experts, students can gain valuable, in vivo experience via activities such as interviews, shadowing, and communicating with practitioners and consumers in the community.
 - Rehabilitation educators and administrators should expand clinical training settings and field experiences to facilitate conversations and interactions with other health professionals (e.g., hospice counselors, physicians).
 - Rehabilitation professionals, educators and administrators can actively work with the counseling accreditation body (CACREP) to further specify how to enhance grief support competency in curriculum and clinical training standards.
 - **Grief research:** further understand the complex nature of grief; identify optimal supports and interventions for consumers experiencing grief.
 - Rehabilitation scholars can strive to further understand the relationship between grief reactions and experiences upon acquiring disabilities and adapting to life with disability.
 - Specific topics, such as job loss grief, can be further understood in the context of vocational rehabilitation services.
 - New research initiatives to supplement our understanding of individualized grief experience among different disability populations are needed.
 - Rehabilitation counselors should be familiar with the use, application, and limitation of the existing assessment tools. Furthermore, new instruments to assess grief experiences in the context of chronic illness and disability should be developed.

Prevailing societal perceptions and attitudes towards grief issues can lead to the avoidance of and lack of willingness to discuss grief openly. Unfortunately, rehabilitation counselors are susceptible to these prevailing societal attitudes. It is important to keep in mind that we are embedded in our time and culture, and without intentionality, disability and grief topics may be avoided. Rehabilitation counselors and counseling educators are trained to work through and become comfortable with such ambivalence and avoidance. Our role as future researchers and educators is to help promote grief education through training as an integral component to rehabilitation counseling practice, which would allow our clients to explore and cope with their grief in individualized and meaningful ways.

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