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AN EXPLORATION OF THERAPISTS' PERSONAL EXPERIENCE  
OF LOSS AND GRIEF AND IMPACT ON THERAPEUTIC APPROACH

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AN EXPLORATION OF THERAPISTS' PERSONAL EXPERIENCE OF  
LOSS AND GRIEF AND IMPACT ON THERAPEUTIC APPROACH

A DISSERTATION

Presented to the Faculty of the Graduate School of  
St. Mary's University in Partial Fulfillment  
of the Requirements  
for the Degree of

DOCTOR OF PHILOSOPHY

in

Marriage and Family Therapy

Moonyeen P. O'Phelan, M.A., R.N.

San Antonio, Texas

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## Abstract

# AN EXPLORATION OF THERAPISTS' PERSONAL EXPERIENCE OF LOSS AND GRIEF AND IMPACT ON THERAPEUTIC APPROACH

Moonyeen P. O'Phelan

St. Mary's University, 2012

Dissertation Advisor: H. Ray Wooten, Ph.D.

Themes of loss and grief resonate through life. That we sustain trauma and anguish and move through it at all becomes part of our life story, worthy of being acknowledged.

Most often, it appears there is no clear-cut end or resolution to our loss. Moreover, there are too few trained individuals who are willing to “go the distance” in processing these weighty matters. The purpose of this study was to explore therapists' personal experiences of loss and grief and how these events transformed their therapeutic approach in clinical practice. Using heuristic phenomenological methodology, qualitative research was conducted in which therapists were asked to recount their lived experiences of loss and describe the essence of these phenomena. Results indicated keen interest among therapists to participate, demonstrating appreciable need for this valuable opportunity to tell one's story of loss and ensuing resilience. Several noteworthy themes emerged from the data uniting participants' lived experiences with evolving personal meaningfulness. Insights gained through this study expanded therapists' existing repertoire of knowledge, as well as provided diverse and accessible tools necessary to enhance academic acumen in the field of loss and grief therapy.

## DEDICATION

*To my mother Kathleen, father Harvey, brother Sean, and  
grandmother Caroline – all of whom reside on the other side  
of the liminal space, and who taught me about love and loss*

*and*

*to the triumvirate who resides within my heart*

*and whom I cherish beyond measure:*

*Christopher, Chloé, and my dearest, Wayne.*

## ACKNOWLEDGEMENTS

I am blessed to have many creative, bright, wise, and loving people in my life who lit the way through my doctoral work, standing in the liminal space, encouraging me when the road was dark and rocky, and now cheering for me as I take flight.

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In memory of Dr. Fred Duhl, now deceased, who would join me in saying, “It’s all about loss,” and to his sprightly wife, Verne Lee, whose positive outlook never wanes. Many thanks to Mary Frey, who encouraged me early on to “Keep my head in the game.” Thanks also to Dr. Kelley Frost, whom I can call anytime and suggest a “Coffee with Kelley” session for mutual support; and to Elisa Wooten, whose thoughtful, abiding spirit energized my commitment to finish strong.

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Ratliff, who fosters my theatrical muse. Heartfelt thanks to Dr. Glenn Sammis, whose belief in me brought me through the liminal space more than once; and to Dr. Adrian Warren, whose viewpoints during our regular “Feet to the Fire” meetings kept the conceptual momentum flowing, and thanks to Jack Williamson for his most helpful and insightful commentary on change.

There are those who may appear to be in the wings, and yet who are essential in keeping the writer’s spirit afloat: Laura Bagley from the Graduate School, Francis Farrell and Leticia Gutierrez from Counseling and Human Services/Family Life Center, Joe Lucio, evening supervisor at Blume Library who cheerfully renewed my books, and Barbara Stead, whose rapid turnaround of interviews from spoken to written words kept this research spiraling forward – special thanks to each of you for your many kindnesses to me along the way.

I am beyond blessed to have two triumvirates in my life. In addition to the scholarly triad on my committee, the three creative individuals who compose my family deserve special note. Heartfelt thanks to Christopher and Chloé, whose imaginative spirits, fire, and energy inspire me to move beyond what I thought I could do -- and to my dear Wayne, extraordinary editor, brilliant intellect, and love of my life.

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## CHAPTER I

### THE PROBLEM AND JUSTIFICATION OF THE STUDY

Canst thou not minister to a mind diseased,  
Pluck from the memory a rooted sorrow,  
Raze out the written troubles of the brain,  
And with some sweet oblivious antidote  
Cleanse the stuffed bosom of the perilous stuff  
Which weighs upon the heart?

Macbeth, Act V, Scene 3  
Lines 40-45; as cited by Clark & Wright, Eds.,  
1899, p. 141

These ancient and poignant words by William Shakespeare rouse therapists interested in working with those suffering loss and grief. For the person experiencing the bitter anguish of loss and seemingly unrelenting grief, there is no better balm than to tell one's story, perhaps repeatedly (Freedman & Combs, 1996; Love, 2007; Neimeyer, 2001; McCabe, 2003; Tick, 2005; Worden, 2009). As Gergen (1999) maintains:

Pain is a common feature of cultural life; the management of pain is one of the central challenges of the medical and therapeutic professions.... pain requires interpretation, and the way we subsequently live our lives depends significantly on this interpretation.... Through suffering, one acquires the sense of personal morality, and becomes one whose testimonies can teach and guide others. (pp. 104-105)

Therapists are viewed as premier caregivers singularly suited to guide those seeking to interpret their emotional pain and suffering (Becvar, 2001; Farnsworth, 1975; Gergen, 1999; Parkes, 1996; Rogers, 1961; Walsh & McGoldrick, 1991). Paradoxically, few therapists seem truly equipped and confident in dealing with another's sorrow (Love, 2007; McCabe, 2003; Yalom, 1980).

Typically, most people are not drawn to the study of loss and grief (Farnsworth, 1975). It makes one feel uneasy and on edge (Frommer, 2005). We would rather not deal with it, and perhaps wait until it confronts us (Becker, 1973; Parkes, 1996). It makes us trepidatious and restless to hear news of one's terminal condition or death (Yalom, 2008). Turning inward, we wonder, "Who is next?" The primary reason for resistance in addressing this subject resides at the very core of our being: fear of our temporal humanity ultimately leading to anxiety about our own demise (Becker, 1973; Farnsworth, 1975; Frommer, 2005; Kierkegaard, 1944; Yalom, 1980). More often than not, this apprehension is evident even in the most courageous of souls (Bonhoeffer, 1953; Frankl, 1959). How many times an individual yearns to tell the story of one's loss or grief, only to realize it has fallen on deafened ears, the unwilling listener wishing to change the uncomfortable subject (Parkes, 1996; Rogers, 1951, 1961; Worden, 2009)!

In distinct contrast, the ancients celebrated death, considering it a higher form of life (Becker, 1973, van Gennep, 1960). County Meath, in northeastern Ireland, is the site of the Newgrange Passage Tomb, dating back to the Neolithic period, between 3200 to 2900 BCE. This monument was constructed as a sacred and ceremonial place to honor and house the dead (Herity, 1975; O'Kelly, 1985, 1989). It is significant for two reasons. First, the early Celts believed there exists a point of tangency, a threshold, a liminal space, between this life and the next. Of liminal space, van Gennep (1960) states, "Whoever passes from one [zone] to the other finds himself...in a special situation for a certain length of time: he wavers between two worlds.... Therefore to cross the threshold is to unite oneself with a new world" (pp. 19-20). The therapist stands in this threshold and links the troubled client with the opportunity for a healed and refreshing new life

(Frommer, 2005; Love, 2007; Nouwen, 1972; Rogers, 1951, 1961). In many cases, the client will not easily pass through the liminal space. However, it is precisely in this aperture where process and resolution may take place (Becvar, 2001; Boss, 2006; Coryell, 1997; Doka, 2002; Farnsworth, 1975; Hollis, 2009; Parkes, 1996).

The second noteworthy characteristic of Newgrange features the earliest known triskele, a striking image of three interlinked spirals, with no beginning and no end, carved into the threshold at the sacred tomb's entrance (Herity, 1975; O'Kelly, 1985, 1989). The triplicity signifies a vital notion within this research, as several specific concepts discussed herein may be viewed in threes: birth, death, rebirth; client, clinician, issue; sea, shoreline, land; past, present, future; emotional problem, threshold, resolution (Fadiman, 1997; Purce, 1974). According to Sheldrake (1995),

Circles and spirals were almost certainly associated with the journey from physical existence through death to eternal life. It has been noted that spiral symbolism was common at prehistoric graves....At Newgrange in Northern Ireland, there were spirals particularly at the entrance-exit doorway through which it was believed the spirit of the deceased would pass from time-bound existence into eternity. The spiral patterns form a kind of maze, possibly representing a 'guide' to the spirit passing out of this world into the other world or acting as a metaphor of the human life-journey in general. (p. 53)

Images of liminal spaces and spirals are key metaphors used throughout this work to foster imagination and enliven a sense of spirituality. Jung (1964) suggests an image is symbolic when it “[does] not state the situation directly but express[es] the point indirectly by means of a metaphor” (p. 43). Furthermore, Duhl (1983) proposes:

The human capacity for symbolic activity [is] the ability to create symbols – to imagine, hear or feel “something” and represent it in a mode that is *not the thing itself* [emphasis added]. Ideas, images, words stand for and are symbolic representations of, yet are not experiences or things. And

human beings manifest that amazing capacity to create meaning, to create and transmit connections about the self and the world, to one another through those symbols. (p. 56)

Spirals are archetypal, dynamic, and always in motion (Arrien, 1992; Jung, 1964; O'Donohue, 1997; Sheldrake, 1995). Like the circle, spirals are structures with no detectable beginning or end (Sheldrake, 1995). Unlike the simple circle, however, spirals possess depth: they spin up, and they spin down, as do the vicissitudes of life (Bankson, 2010; Lewis, 1961; Purce, 1974). This ancient symbol conveys growth and change, and powerfully illustrates circularity, the inescapable propensity that transfuses the seasons of life (Arrien, 1992; Coryell, 1997; Purce, 1974; Sheldrake, 1995; Yalom, 2008). Purce (1974) relates, "This symbol, which is perpetually turning in on itself, expanding and contracting, has an interchangeable centre and circumference, and has neither beginning nor end" (p. 7). Applying the metaphorical spiral to the experience of living, one observes seasons and situations recurring with expected regularity. With each round, we return to the same spot, often at a greater depth and awareness than previously experienced (Bankson, 2010; Jung, 1964; Purce, 1974; Sheldrake, 1995). In the words of Purce (1974):

The more we do this, the steeper the gradient, which is the measure of our growth. The spiral we travel round life is the means we have to compare ourselves with ourselves, and discover how much we have changed since we were last in the city, met our brother, or celebrated Christmas. Time itself is cyclic, and by the spiral of its returning seasons we review the progress and growth of our own understanding. (p. 7)

When considering loss and grief, the spiral is also a powerful symbolic image looked upon by the ancients as a map for the journey from this world to the next (Purce, 1974; Sheldrake, 1995). It is no accident primeval civilizations around the globe adorned

cemeteries and tomb thresholds with their cultural version of the spiral. Besides Ireland, these images are found throughout Europe, Malta, China, Mexico, and the Middle East (Purce, 1974).

### **Statement of the Problem**

Of the nearly one hundred workshops offered at each of the last three annual American Association for Marriage and Family Therapy (AAMFT) national conferences (September 2010, 2011, and 2012), only one session clearly focused on grief.

To be a therapist means to stand in the liminal space between client and healing and facilitate one's crossing over to a new and meaningful life (Corbett, 2011; Farnsworth, 1975; Hollis, 2005, 2009; Kottler, 2010; Yalom, 1980). Significant need for healing arises in the ubiquitous domain of loss and grief (Coryell, 1997; Levine, 1987; McBride & Simms, 2001; Nouwen, 1972; Shapiro, 2007). Judging from the low priority placed on this topic at the recent AAMFT conferences, it is no wonder a quandary exists in the field. The problem is that loss and grief *are* difficult to address, and because of this, are rarely confronted (Becker, 1973; Walsh & McGoldrick, 1991). Grief work is distinct because of the magnitude of the loss (McBride & Simms, 2001). Clients and clinicians alike avoid the subject (Becker, 1973; Yalom, 1980, 2008). Self-reliance and not wanting to appear deficient in the ability to solve personal problems influence the clinician as well as the client (Stratton, Kellaway, & Rottini, 2007). It is precisely because loss seizes each of us, rendering us vulnerable, that we need a strategy for healing (Attig, 2000; Bozarth-Campbell, 1982; Hollis, 2005, 2009). The therapist is the logical, educated guide and healer (Love, 2007; Neimeyer, 2001; Parkes, 1996; Rogers,



1951, 1961; Worden, 2009). However, unless the therapist possesses a keen sense of awareness, the guided journey will languish (Doka, 2002; McBride & Simms, 2001; McCabe, 2003; Nouwen, 1972; Yalom, 1980, 2008). Awareness underpins the quest for meaningfulness vis-à-vis one's past, present, and future within the bounds of finitude, yielding personal growth, richness, and comfort beyond expectation (Frankl, 1959; Hollis, 2005, 2009; Stratton et al. 2007).

Potential and precedent for experiencing life to its fullest are evident in investigating ancient Celtic observances, which view the end of earthly life as further adventure well worth celebrating (O'Donohue, 1997, 2008; Sheldrake, 1995).

### **Purpose**

The purpose of this research study sought to understand therapists' personal experiences of loss and grief and how these experiences impact their effectiveness in dealing with a client's encounter with loss and grief. Unless the therapist is in touch with personal loss and its resolution process, the client will remain unaided, and both will suffer from lack of direction (Becvar, 2001; McBride & Simms, 2001; Nouwen, 1972; Walsh & McGoldrick, 1991). Clinicians can take clients only as far down the road to healing as they themselves have traveled (Baker, 2003; Hollis, 2005, 2009; Kottler, 2010).

### **Research Questions**

It is likely loss and grief are the crux of *any* need for therapy (McCabe, 2003; Yalom, 1980). Whether it be loss of a significant person, personal power, or even a

dream, the resulting grief may require processing with another individual to resolve painful issues (Becvar, 2001; Boss, 2006; Bruce & Schultz, 2001; Doka, 2002; McCabe, 2003). Yet what if the intended listener or therapist does not pick up the often-subtle nuances of loss in the client, as well as recognize a parallel loss or grief in the therapist's own life (Worden, 2009)? What if the grieving individual expresses meaninglessness so overwhelming the clinician becomes entrenched or even stuck along with the client (Baker, 2003; Yalom, 1980)? Where does one go next to find the solution to this pervasive experience of loss?

This qualitative research was conducted as a phenomenology, in which participants were asked to recount their *lived experiences* of loss and describe the *essence* of these phenomena to find meaning therein (Creswell, 2007; Giorgi, 2009; Moustakas, 1994). At the core of this study is the culture of therapists. This inquiry examined therapists as a specific group, linked together by a common infrastructure comprised of shared values, beliefs, behaviors, mores, and specific means of communicating (Creswell, 2007; Spradley, 1979; Sue & Sue, 2008; Wolcott, 2008). The purpose of this research was to capture clinicians' perspectives as they shared their personal, lived experiences of loss and grief, and how these events transformed their therapeutic approach (Callahan & Dittloff, 2007; Stratton et al. 2007).

Two questions were asked of the therapist-participant population: (1) What is your personal experience of loss and grief? (2) How has your personal experience of loss and grief impacted or transformed your work with clients? Common themes and threads resulting from the answers have been identified and collated for the purpose of advancing the therapy profession in the area of loss and grief.

## **Rationale**

Use of phenomenology as a strategy to study therapists' perspective on loss and grief provided an interpretive, real-life approach to researching this topic. The culture of therapists presented the context of common language, interests, education, and values (Fetterman, 1998; Spradley, 1979; Sue & Sue, 2008; Wolcott, 2008). From these commonalities prevailing themes emerged by interviewing clinicians who have experienced loss. The intent of this phenomenology was to discover what the particular experience means to therapists who provided a detailed description of it (Creswell, 2007; Moustakas, 1994). From these narratives, themes were noted and essences recorded. Professional practices and priorities have been enhanced by a study with this clear-cut, relevant focus (Creswell, 2007; Spradley, 1979).

## **Links to Literature**

The state of knowledge in theoretical and scientific literature and analysis identifies four predominant classifications of loss: *finite*, *ambiguous*, *nonfinite*, and *disenfranchised* losses. Each of these categories was elucidated in this discourse. Themes of loss and grief emerge throughout literature, from ancient texts to modern works. Selections by notable writers including William Shakespeare, C. S. Lewis, T. S. Eliot, and Thornton Wilder were integrated throughout this work to engender depth and richness of this subject matter, as well as foster a broadened interpretive scheme.

## **Justification**

Much of life is about loss (Becvar, 2001; McCabe, 2003; Parkes, 1996). Much of loss is unavoidable. Learning to deal with loss may take nearly a lifetime. However, this journey is facilitated by a therapist mindful of their firsthand experience of loss and grief (Attig, 2000; Hollis, 2005, 2009). The aim of this research was to investigate, with sensitive and positive intent, how loss and grief affect clinicians who exemplify the therapist culture, and how this encounter provoked personal transformation. With a creative and compassionate approach, the reader was introduced to four models which laid the groundwork for conceptualizing current thinking on loss and grief. The guiding premise of this research posited that the ability to work in a therapeutic setting with individuals engulfed by loss might be impacted by a clinician's insight into personal experience of loss and grief. This study sought to explore whether experiencing personal loss helps one become a therapist better able to serve grieving individuals. Moreover, this particular phenomenological research was manageable and has generated valuable insights and thoughtful commentary for further dialogue.

## **Limitations**

Due to inherent qualities of phenomenological inquiry, limiting factors exist. Although the participants in this study were all highly educated clinicians with advanced or terminal degrees, they were less ethnically and gender diverse than the general population of therapists. In addition, the sample size was relatively small, limiting transferability of findings (Krathwohl, 1998; Wolcott, 2008). An essential feature of data collection in this study is its subjective fluidity and spontaneity, which allows multiple

themes to surface. According to Moustakas (1994), the “challenge is to discover what is really true of the phenomena of interpersonal knowledge and experience” (p. 57).

Internal validity may be threatened by subjectivity in self-reporting (Creswell, 2007; Krathwohl, 1998).

### **Definitions**

**Ambiguous Loss.** A distinctive kind of loss for which there is uncertain closure; the status of a loved one is considered either “there” or “not there,” with no acknowledgment of it being a true loss. This type of loss has an undefined beginning and an undetermined end (Boss, 1999, 2006). Examples include the situation where an individual is physically present, yet psychologically absent, as with Alzheimer’s disease or brain injury. Conversely, those physically absent such as prisoners of war, or victims of natural disasters namely flood, tsunami, or tornado, are often very much psychologically present to those who await and love them.

**Celtic Spiral.** Ancient image found carved into the Newgrange Passage Tomb in County Meath, Ireland, around 3200 BCE (Herity, 1975; O’Kelly, 1985, 1989). It is a symbol consisting of three legs or spokes, radiating from the center, each ending in a spiral motif. There is neither beginning nor end in this design. It symbolizes anything trifold (e.g., life, death, and the hereafter).

**Change.** A situational, goal-oriented, external phenomena resulting in an alteration in life: a new baby or career change, moving to a new location, and death are examples of external change. These events *may* lead to transition if one is receptive to the

internal process of letting go of what has been and open to a new way of being (Bridges, 2004).

**Disenfranchised Grief.** An expanding concept developed by Doka (2002), which addresses various sectors of our changing society. “Survivors are not accorded the ‘right to grieve’.... for many reasons, such as the ways a person grieves, the nature of the loss, or the nature of the relationship...grief is not openly acknowledged, socially validated, or publicly observed” (p. 5). Examples include perinatal loss, death of a pet, suicide, or loss within a gay relationship.

**Epoché.** Derived from the Greek term for suspending, or abstaining from analysis and critique, one’s judgment about everyday life and the world around us (Creswell, 2007; Moustakas, 1994). Husserl (1906) coined the term “*epoché*” or “bracketing,” setting aside one’s life experience or prior knowledge in order to approach new phenomena with fresh, open awareness (Giorgi, 2009; Kockelmans, 1967).

**Finite Loss.** Loss which has a clear beginning and end. This may or may not be a vast, life-changing event, but is significant enough to cause an emotional reaction (Bozarth-Campbell, 1982; Westberg, 1962). Examples include death of someone who had some influence in one’s life, but who was not necessarily emotionally close, such as a grandparent, teacher, or a neighbor.

**Gelassenheit.** German word for letting go, resignation, “releasement” (Dourley, 1992, p. 116) or “serenity” (Hollis, 2005, p. 216).

**Impact Profile.** Description used specifically in this study depicting the impact a specific loss engendered in a participant’s therapeutic practice.

**Liminal Space.** A threshold which is correlated with transition to an alternative form of existence or stage of life (MacNeil, 2011; van Gennep, 1960).

**Logotherapy.** Frankl's theoretical approach which centers on "the meaning of human existence as well as...man's search for such a meaning" (Frankl, 1959, pp. 98-99). The essence of this therapy is to help clients discover *meaning* in life through becoming aware of one's deepest longings (Frankl, 1959). "What matters, therefore, is not the meaning of life in general but rather the specific meaning of a person's life at a given moment" (p. 108). Each individual is responsible to "answer for" one's own life. This responsibility yields the essence of what it means to be human (p. 109).

**Loss and Grief Profile.** Description used specifically in this study portraying each participant's experience of loss and grief.

**Nonfinite Loss.** Bruce & Schultz (2001) declare, "we use the term *nonfinite loss* to refer to losses that are contingent on development; the passage of time; and on a lack of synchrony with hopes, wishes, ideals, and expectations" (p. 7). It is the loss of "what should have been," referring to dreams and expectations of life, couched within a person's past, present, and future worldviews, and is especially influenced by one's specific fears and anxieties (p. 7). Examples include having a child with permanent physical or emotional disabilities, losing a body part, or failing to reach one's goal or dream.

**Therapist.** For the purpose of this dissertation, the terms therapist, clinician, counselor, mental health care provider, practitioner, and psychotherapist were interchangeable.

**Transition.** Psychological phenomenon which begins with “letting go of what no longer fits or is adequate to the life stage [one is] in” (Bridges, 2004, p. 128). It does not involve life-changing *events*, but “*inner orientation* [emphasis added] and self-redefinition...[necessary] in order to incorporate any [situational] changes into [one’s] life” (Bridges, 2004, p. xii).

**Triskele.** Motif of three interlocked spirals with no apparent beginning or end symbolizing the notion of anything threefold (e.g., birth, death, rebirth). This symbol is found carved into the threshold stones of the Newgrange Passage Tomb in County Meath, Ireland (Herity, 1975; O’Kelly, 1985, 1989).



## CHAPTER II

### LITERATURE REVIEW

The vocation of therapist is infused with helping others on their journeys within the recurring spiral of life, death, and the hereafter (Bankson, 2010; Coryell, 1997; Jung, 1964; Purce, 1974; Sheldrake, 1995). It is at once exhausting and exhilarating. A question arises: How does this spiraling journey transform the clinician, and future work with clients? The purpose of this literature review is twofold: (1) to investigate the labyrinth of loss and subsequent grief, and (2) to examine the niche of the therapist, a unique coterie of professionals whose work is conceivably impacted by their personal loss and grief, and for whom healing the soul is intrinsic.

#### **Loss, Spirals, and a Transition Map**

A review of the literature indicates much is written on the subjects of loss and grief (Attig, 2000; Becker, 1973; Becvar, 2001; Bonhoeffer, 1953; Boss, 1999, 2006; Bruce & Schultz, 2001; Doka, 2002; Duffey, 2005; Frankl, 1959; Kübler-Ross, 1969, 1974, 1982; McCabe, 2003; Neimeyer, 1994, 2001; Parkes, 1996; Salerno & Williamson, 2001; Tick, 2005; Walsh & McGoldrick, 1991; Westberg, 1962). Indeed, local bookstore shelves display a plethora of volumes written to help the novice griever. Poetry, essays and contemplative writings fill in where self-help books fall short. One is made aware of the inherent connection between opposites of life and death, the scope of which extends far beyond the dimensions of this analysis.

Paradoxically, each new chapter of life or transition time begins with an *ending* (Bankson, 2010; Bozarth-Campbell, 1982; Bridges, 2004; Ellis, 2006; O'Donohue, 2008). Remen (1996) articulates:

Beginnings and endings are always right up against each other. Nothing ever ends without something else beginning or begins without something else ending. Perhaps this would be easier to remember if we had a word for it. Something like “endbegin,” or “beginend.” (p. 185)

This dualistic interplay between endings and beginnings can be observed in the elementary, yet soothing, structure of a spiral (Purce, 1974). This ancient image is symbolic of growth and adaptation, beautifully demonstrating circularity, the ubiquitous dynamic that permeates the seasons of life (Arrien, 1992; Coryll, 1997; Eliot, 1943; Sheldrake, 1995; Yalom, 2008). With each round we are brought once again to the same spot, yet at a different depth and with altered awareness or recognition of that which we may have seen or encountered previously on life's journey (Boss, 1999; Jung, 1964; Lewis, 1961; Sheldrake, 1995). A perceived end becomes a beginning (O'Donohue, 2008). Regarding the spiral, Bankson (2010) states:

Within each round of call there is a predictable pattern of transition. Knowing the pattern is like having a map with familiar marks on it. Understanding this pattern can help orient us in time and space. Using the pattern as a map, we can spot transit points and anticipate feelings of sorrow and loss. (pp.18-19)

This image of a map as a useful guide through inevitable change or transition journeys can be helpful (Callanan & Kelley, 1992; Coryell, 1997; Hollis, 2009; Salerno & Williamson, 2001; Walsh & McGoldrick, 1991). Bridges (2004) defines the difference between *change* and *transition*. They must not be used interchangeably. “Change is situational...a new baby or job... move to a new city... death. Transition is

psychological...not those events, but *inner orientation* [emphasis added] and self-redefinition...[necessary] in order to incorporate any changes into your life” (p. xii). Change is goal-oriented, however: “Transitions start with letting go of what no longer fits or is adequate to the life stage you are in” (p. 128). Dourley (1992) considers Jung’s use of the German word, *gelassenheit*, meaning “resignation or releasement” (p. 116). This yields a tighter definition in reference to the notion of “letting go.” Individuals encountering the inner work of self-redefinition in the face of transition often have little else to do but resign oneself to the shift and release previously held expectations of how life should be (Bruce & Schultz, 2001; McCabe, 2003; O’Donohue, 1997; Westberg, 1962; Salerno & Williamson, 2001).

Bridges’ (2004) pensive approach positions endings *first*. *Endings* are often painful, symbolic experiences of inevitable letting go of relationship, attitudes, plans for the future, self-concept, and perhaps even having a place to belong. It is a “cleaning house,” of sorts, essential unpacking in preparation for the subsequent phase.

O’Donohue (2008) writes:

Endings seem to lie in wait. Absorbed in our experience, we forget that an ending might be approaching. Consequently, when the ending signals its arrival, we can feel ambushed. Perhaps there is an instinctive survival mechanism in us that distracts us from the inevitability of ending, thus enabling us to live in the present with an innocence and wholeheartedness. Were we to be haunted by the prospect of ending, we could not give ourselves with freedom and passion. (p. 155)

What ensues is the *Neutral Zone*, a necessary fallow time of waiting and emptying oneself in preparation for impending internal transformation. Individuals report feeling stalled out, “crazy,” or on unstable emotional footing at this point (Bruce & Schultz,

2001; Callanan & Kelley, 1992; Haugk, 2004; Hollis, 2009; Levine, 1987; Lewis, 1961; Siegel, 1999). Bridges (2004) expresses, “The transition that brought you to this place cannot be undone” (p. 143). It is during this period of confusion that the inner soil of “re-vision” takes place, and the seeds of a new beginning start to sprout. O’Donohue (2008) suggests, “Often what alarms us as an ending can in fact be the opening of a new journey – a new beginning that we could never have anticipated; one that engages forgotten parts of the heart” (p. 156).

Finally, the *Beginning*: back to where it started, but at a deeper level of experience and understanding than previously encountered (Bridges, 2004). Jung (1964) observes:

What restores the old order simultaneously involves some element of new creation. In the new order, the older pattern returns on a higher level. The process is that of the ascending spiral, which grows upward while simultaneously returning again and again to the same point. (p. 225)

Not everyone takes this mapped out, spiral journey along the same paths. Life presents different curves to each individual, with the choice of taking or turning away from the trail. Sometimes, a *Beginning* may be apparent before one has completed time in the *Neutral Zone*. Bridges (2004) believes it is not a sudden change which marks a *Beginning*, but a subtle remodeling from within, perhaps a thought or image, which lines up with our deepest longings, and launches us.

### **Paradoxes of Life and Death, Beginnings and Endings**

Embedded in the adventure of being human is the resonant interaction of unrelenting opposites (Becvar, 2001; Bonhoeffer, 1953; Corbett, 2007; Fromm, 1956; Hollis, 2005). Becker (1973) bleakly posits:

Man is literally split in two: he has an awareness of his own splendid uniqueness in that he sticks out of nature with a towering majesty, and yet he goes back into the ground a few feet in order blindly and dumbly to rot and disappear forever. It is a terrifying dilemma to be in and to have to live with. (p. 26)

To dwell in this existential murkiness evokes despondency and fear (Kierkegaard, 1944). One cannot linger within these thoughts *and* sustain quality of life (Becker, 1973; Frankl, 1959; Tick, 2005). Yet these issues must be confronted in order to foster consciousness and balance (Yalom, 1980, 2008). Love is the counterpoise of death (Attig, 2000; Fromm, 1956; May, 1969). In Rollo May's book, *Love and Will* (1969), Chapter 4 opens with poignant words by Abraham Maslow, written as he recovered from a heart attack:

The confrontation with death--and the reprieve from it--makes everything look so precious, so sacred, so beautiful that I feel more strongly than ever the impulse to love it, to embrace it, and to let myself be overwhelmed by it...Death and its ever present possibility makes love, passionate love, more possible. I wonder if... ecstasy would be possible at all, if we knew we'd never die. (p. 98)

These vibrant words of love engender hope and creativity, essential ingredients for a meaningful life (Attig, 2000; Bankson, 2010; Bruce & Schultz, 2001; Frankl, 1959; Fromm, 1956; Hollis, 2005, 2009; Love, 2007; May 1969; Parkes, 1996; Salerno & Williamson, 2001; Walsh & McGoldrick, 1991; Weaver, 2009; Yalom, 1980). The topic of meaningfulness will be addressed later in this work.

“What we call the beginning is often the end, and to make an end is to make a beginning. The end is where we start from” (Eliot, 1943, p. 58). As noted above, it is necessary to begin this aspect of study with solid understanding of the *ending*.

Knowledge of how death fits into our human scheme is remarkably paradoxical (Becker, 1973; Becvar, 2001; Boss, 1999; McCabe, 2003). We experience piercing, terrifying fear of death, from which no one escapes (Becker, 1973; Becvar, 2001; Erikson, 1963;

Frommer, 2005; Neimeyer, 1994; Walsh & McGoldrick, 1991; Yalom, 2008). We fear isolation and loneliness (Becvar, 2001; Boss, 1999, 2006; Levine & Levine, 1995; Lewis, 1961; McCabe, 2003; Parkes, 1996; Salerno & Williamson, 2001; Westberg, 1962; Yalom, 1980). We fear loss of control over our life (Bruce & Schultz, 2001; Lewis, 1961; O'Donohue, 1997; Weaver, 2009). We fear annihilation (Becker, 1973; Erikson, 1963; Frankl, 1959; Levine, 1987). And we fear the seemingly bottomless well of loss and sorrow, which threatens our sense of security at its core (Bonhoeffer, 1953; Bozarth-Campbell, 1982; Doka, 2002; Hollis, 2005; Love, 2007; Siegel, 1999; Yalom, 1980, 2008). In order to deal with this angst, we attempt to cleanse our minds of these trepidatious thoughts, and cover up with a thick blanket of denial (Becker, 1973; Becvar, 2001; Boss, 1999, 2006; Kübler-Ross, 1969, 1974; Levine, 1987; Parkes, 1996). This blanket is woven with avoidant and addictive behaviors, which muffle our senses and perceptions, impairing our dealings with reality (Bateson, 1972; Boss, 1999; Duffey, 2005; Hollis, 2005, 2009; Johnson, 1973; O'Donohue, 1997). Other reality-evading issues include an obsession with youth culture, which dismisses the aging population and unique gifts many of these individuals have to offer (Bankson, 2010; Hollis, 2005, 2009; O'Donohue, 1997). Despite desperate attempts to elude “reminders from the *other side*,” death has the final word (Callanan & Kelley, 1992; Parkes, 1996; Sheldrake, 1996).

Herein lies the paradox: it is precisely this exquisite anxiety and fear of our demise that hurls us towards the basic survival instinct to cling fiercely to life (Becker, 1973; Bruce & Schultz, 2001; Erikson, 1963; Frankl, 1959; McCabe, 2003; Neimeyer, 2001; Yalom, 2008). At a profound, unconscious level dwells the tenacity to remain committed to exist: the will to live (Bonhoeffer, 1953; Remen, 1996; Tick, 2005). Yalom

(1980) suggests, “Death and life are interdependent: though the physicality of death destroys us, the *idea* of death saves us” (p. 40). Fear of our demise underpins daily pursuits, reinforcing self-preservation. Indeed, this distress must not overtake our zeal, robbing us of urgency necessary to live our lives in full measure (Becker, 1973; Bonhoeffer, 1953; Farnsworth, 1975; McCabe, 2003; O’Donohue, 1997). Frommer (2005) proposes “being in touch with what there *is* to lose, with the transience of ...life, is what makes [life] experience vibrant” (p. 497). No one expresses this sentiment more beautifully than Thornton Wilder (1938) in his play *Our Town*. In the final act, Emily, who has died, makes her way to her grave. She stops, and in a loud voice to the Stage Manager (also a character in the play) cries:

I can’t. I can’t go on. It goes so fast. We don’t have time to look at one another. I didn’t realize. So, *all that* was going on and we never noticed. Take me back--up the hill--to my grave. But first: Wait! One more look. Good-bye, Good-bye world. Good-bye, Grover’s Corners...Mama and Papa. Good-bye to clocks ticking...and Mama’s sunflowers. And food and coffee. And new-ironed dresses and hot baths...and sleeping and waking up. Oh earth, you’re too wonderful for anybody to realize you! Do any human beings ever realize life while they live it--every minute? (p. 100)

Encircled within these constructs is the notion of *identity*. We distinguish our *self* by personal beliefs, values, abilities, dreams, and passions; it is the part of who we are which seeks the purpose of our being alive (Boss, 1999, 2006; Hollis, 2005, 2009; Carter & McGoldrick, 1991; Erikson, 1963; Frankl, 1959; Fromm, 1956; O’Donohue, 1997; Rogers, 1961; Weaver, 2009). We also identify ourselves by our fears, experiences, insecurities, inabilities, and losses (Bruce & Schultz, 2001; Hollis, 2005, 2009; Lewis, 1961; Westberg, 1962; Yalom, 1980, 2008). We discover who we are by those with whom we are in relationship (Attig, 2000; Boss, 1999; Doka, 2002; Frankl, 1959; Levine

& Levine, 1995; May, 1969; McCabe, 2003; O'Donohue, 1997). Most significantly, we discern who we are vis-à-vis our belief system in relation to something bigger than ourselves, perhaps a higher power, source of energy, or Creator (Becker, 1973; Bonhoeffer, 1953; Bozarth-Campbell, 1982; Corbett, 2007; Farnsworth, 1975; Hollis, 2005; Lewis, 1961).

### **Categories of Loss**

Loss happens; and whether it is expected or not, we stumble suddenly into new territory. We find ourselves in the liminal space between “holding on” and “letting go,” between certitude and doubt (Callanan & Kelley, 1992; Corbett, 2007; Frommer, 2005; Lewis, 1961; Parkes, 1996; Sheldrake, 1995). It is in this threshold where we feel stretched beyond imagining, balancing between what we know in life, and what we fear most (Boss, 1999; Bruce & Schultz, 2001; Levine, 1987; MacNeil, 2011; O'Donohue, 1997). To be sure, manifestation of loss is the “materialization of fear” (Bruce & Schultz, 2001, p. xiii). If the experience of loss then remains unresolved, the delayed grief affects future relationships (Siegel, 1999). He indicates:

The effects of unresolved loss or trauma in relation to specific overwhelming events can be powerfully disorganizing and often hidden from conscious awareness. Knowledge of impaired resolution of grief or trauma is crucial, given its devastating effects on the individual and its potential to impair attachment with future offspring. Attachment disturbances in the children of parents with lack of resolution result directly from the impairments to contingent, collaborative communication. (p. 296)

Literature analysis identifies four predominant categories of loss: *finite*, *ambiguous*, *nonfinite*, and *disenfranchised* losses. Each will be explicated in the following section.



## Finite Loss

The prevailing definition of loss falls into the classification of what is considered *finite loss*, which has an eventual ending, a resolution (Attig, 2000; Boss, 1999; Bozarth-Campbell, 1982; Coryell, 1997; Kübler-Ross, 1969, 1974, 1982; Westberg, 1962).

Historically, Freud's psychoanalytic model, in his 1917 commentary, "Mourning and Melancholia," (1917/1957) manifests itself as one of the first to dissect grief and loss. He called attention to the clinical issues of mourning through his intrapsychic lenses, and initiated interest in this area of study (Parkes, 1996). For the purposes of this literature inquiry, Freud's model and subsequent psychodynamic ideologies will not be reviewed.

One of the pioneers undertaking the study of normal grief symptomatology was Erich Lindemann, MD (1944), a psychiatrist at Massachusetts General Hospital. On November 28, 1942, a devastating fire occurred in Boston, at the Cocoanut Grove Nightclub, after a college football game, in which 492 revelers and workers were killed. Lindemann (1944) observed 101 patients including those who lost a family member or friend, those who survived the fire, and relatives of members of the armed forces (Lindemann, 1944, p. 141). He identified several common attributes of grief:

These five points – (1) somatic distress, (2) preoccupation with the image of the deceased, (3) guilt, (4) hostile reactions, and (5) loss of patterns of conduct – seem to be pathognomonic for grief. There may be a sixth characteristic, shown by patients who border on pathological reactions, which is not so conspicuous as the others.... This is the appearance of traits of the deceased in the behavior of the bereaved. (p. 142)

Lindemann (1944) defined successful grief work as "emancipation from the bondage to the deceased, readjustment to the environment in which the deceased is

missing, and the formation of new relationships” (p. 143). He is recognized for his premier work in laying the groundwork for what is now known as Post-Traumatic Stress Disorder, or PTSD.

According to Duffey (2005), Elisabeth Kübler-Ross (1969, 1974, 1982) was among the first to develop the notion of universal, predetermined stages in approaching death. Kübler-Ross (1969, 1974, 1982) changed the paradigm of caring for terminally ill patients in her extraordinary work during the mid-1960s with students from Chicago Theological Seminary. She suggested patients advanced through the following stages, though not necessarily in this order: Denial and Isolation, Anger, Bargaining, Depression, and Acceptance. Kübler-Ross (1974) asserts:

The outline of these five stages is only the common denominator that we found in most of our terminally ill patients. Many do not flow from stage one to stage five in a chronological order, and this is totally irrelevant to their well-being. Our goal should be to elicit the patient’s needs, to find out where he is, and then to see what form and manner we can help him best, no matter how much time he has. (p. 71)

In the following paragraphs, Kübler-Ross’ (1969, 1974, 1982) Stages of Grief will be explicated.

**Denial.** Though not continuously aware of it, we perpetually dwell in the liminal space between life and death. One moment, life is progressing, full, promising. We are in the threshold of anticipation. With few words, or a sudden impact, this can change in a trice. It feels like a strong, dizzying blow to the head or a douse with icy water. We find ourselves thrust through the portal, life changed forever. Our first reaction is to feel stunned. “No! It can’t be!” According to Kübler-Ross (1969), this is the universal initial

response to shocking news, whether it comes at the moment of diagnosis, or much later, when the patient reaches comprehension on his or her own.

Denial, at least partial denial, is used by almost all patients, not only during the first stages of illness or following confrontation, but also later on from time to time. Denial functions as a buffer after unexpected shocking news, allows the patient to collect himself and, with time, mobilize other, less radical defenses. Denial is usually a temporary defense and will soon be replaced by partial acceptance. (pp. 52-53)

It is exceedingly difficult to fathom one's death, the ending of life as we know it. We can swallow this daunting reality only in very small doses, before we must move on to remain vital and engaged in the remaining time we have (Callanan & Kelley 1992; Levine, 1987; Weaver, 2009). How a patient hears the news, and how much time may be left to absorb this diagnosis influences use of denial as a defense mechanism. Not surprisingly, an individual who has learned to address traumatic situations throughout life will likely move through the denial stage more rapidly than someone who has not (Farnsworth, 1975; Shapiro, 2008; Tick, 2005).

In her research, Kübler-Ross (1969, 1974) noted patients' use of denial with regard to others. The patient may sense a family member or caregiver using denial in order to cope with the illness, and she or he may select certain other individuals to talk over the deteriorating situation. At the same time, the patient may act as if health is improving, in order to foster hope in those for whom denial is a protection. Ultimately, Kübler-Ross (1974) believes:

If the patient requires more time in a given stage or if he has no intention of really facing his finiteness, if he prefers to remain in the stage of denial, we do him a better service to allow him to stay in the stage of denial. (p. 36)

Mindful people begin to work through the reality of their own mortality while healthy enough to do so (Callanan & Kelley, 1992; Frommer, 2005; Lewis, 1961; O'Donohue, 1997; Worden, 2002). Once the prospect of death is accepted, as much as possible in light of well being, life takes on new meaning and becomes more precious (Bonhoeffer, 1953). It is these individuals who are better prepared to help ease patients through not only the denial stage, but also the remaining stages of grief (McCabe, 2003; Yalom, 1980, 2008).

In summary, Kübler-Ross (1969) maintains denial is the first emotional response a person experiences upon learning traumatic, shocking news and being propelled through liminal space into life forever transformed.

**Anger.** Denial eventually wears thin and gives way to anger at this unrelenting situation. If denial is characterized by the words, "No! It can't be true," then the second stage, anger, is distinguished by this disconsolate phrase, "Why me?" This stage is difficult to endure for all involved. The patient has red-hot feelings of rage and rancor, and deploys this resentment towards God, family, and caregivers alike (Becvar, 2001; Parkes, 1996). These caring individuals become hurt by the often random outbursts, as does the patient, who is trying to make sense of an unwinnable situation. It stands to reason anger would appear in the face of one's life becoming prematurely shortened, and remaining days colored by potential pain, diminishing strength, and irrefutable fear. Nothing appears right for the patient, and emotional flare-ups abound, making it difficult for others to offer assistance. Neither family nor caregivers can assuage this profound inner pain and anxiety. They may try to understand by viewing life from the patient's eyes and allowing him to vent, while remaining non-judgmental, and not taking this fury

personally. Going the extra distance to be respectful and present to the individual, active listening, and enabling as much control of his or her environment as possible are supportive interventions (Callanan & Kelley, 1992; Levine, 1987; Satir, 1972, 1983; Tick, 2005). The patient must be cared for and treated with dignity as a valuable human being (O'Donohue, 1997). Kübler-Ross (1969) writes:

I...emphasize the importance of our tolerance of the patient's rational or irrational anger. Needless to say, we can do this only if we are not afraid and therefore not so defensive. We have to learn to listen to our patients and at times even to accept some irrational anger, knowing that the relief in expressing it will help them toward a better acceptance of the final hours. (p. 67)

As caregivers, we must be aware of our own fears of death and defense mechanisms, which may impede our efforts to care for terminally ill individuals (Callanan & Kelley, 1992; Frommer, 2005; Niemeyer, 1994; Yalom, 1980, 2008).

To sum up, anger is the second stage in Kübler-Ross' (1969) paradigm, logically though not necessarily following denial as the reality of a critical life change begins to set in.

**Bargaining.** In stage three, bargaining, the patient might be wondering, "If I do this, then maybe God will bless me with..." The individual, who perhaps had been previously angry with God, now earnestly hopes for favorable change. With almost childlike expectation, the patient considers, "If God did not answer my request when I was angry, then maybe if I ask kindly, He will listen." Reverting back to youthful behaviors, one imagines there may be a slim chance for a reward, specifically for the prolongation of life. Bargains are usually made secretly between God and the patient,

and others may not be privy to this stage. The individual may feel guilty for not having been a good person, or not attending worship services on a consistent basis, and hope to remedy this by offering a life dedicated to altruism. Kübler-Ross (1969) maintains:

The bargaining is really an attempt to postpone; it has to include a prize offered “for good behavior,” it also sets a self-imposed “deadline” (e.g., one more performance, the son’s wedding), and it includes an implicit promise that the patient will not ask for more if this one postponement is granted. (p. 95)

This stage appears to dissolve just as quickly as it emerges. It has little holding- power, as the actuality of declining health persists.

**Depression.** In time, the patient’s health deteriorates to the point where he can no longer ignore his worsening condition. Denial, wrath, and bargaining eventually yield to a profound sense of overwhelming loss (Kübler-Ross, 1969). Most patients suffer many privations along this difficult journey, resulting in changes in body image, strained relationships, and limited meaningful connection with the outside world (Callanan & Kelley, 1992). Self-concept and sense of purpose may be challenged as job, hobbies, and joys in life decrease.

Kübler-Ross (1969) delineates two types of depression. The first, she identifies as “reactive depression.” In this case, the individual responds emotionally to the loss of “what has been.” A strong, beautiful body or head of hair, active and enjoyable parenthood, meaningful work and interests in life – all of which are unavoidably diminished by failing health. Loss of hope, dreams unaccomplished, and unresolved issues restlessly come to the surface. This type of depression, though significant, can be mitigated by processing concerns with the patient, thus helping gain perspective and

resolution. Often shame or guilt underpin this type of depression, as illness prevents continuation of life as it has been, and the individual is unable to fulfill one's previous roles. Kübler-Ross (1969) rather harshly determines this to be "unrealistic guilt or shame" (p. 98), and comments on how rapidly a patient's depression eases when these problems are solved. The patient typically has many concerns to discuss at this juncture, and often necessitates assistance from a variety of services

Kübler-Ross (1969) states the second type of depression is associated with the specific grief a terminally ill patient must face in order to ready oneself for emotional separation from the present world. This is described as "preparatory depression." The individual is not so much concerned with previous loss: body image, profession, etc., but with imminent losses, focusing on what the future holds. It is a pivotal time for patient and caregivers alike. As the patient advances towards the inevitable ending, those caring for her must allow her passage. Words of cheer and "get well" wishes are inappropriate. The individual must not be expected to be upbeat, but to prepare emotionally and focus on approaching death (Callanan & Kelley, 1992; Farnsworth, 1975; Worden, 2009). Indeed, this is *the* time for caregivers to be quietly present, offering comfort measures as needed. Kübler-Ross (1969) suggests:

When the depression is a tool to prepare for the impending loss of all the love objects, in order to facilitate the state of acceptance, then encouragements and reassurances are not as meaningful...It would be contraindicated to tell him not to be sad, since all of us are tremendously sad when we lose one beloved person. The patient is in the process of losing everything and everybody he loves. If he is allowed to express his sorrow he will find a final acceptance much easier...this type of depression is necessary and beneficial if the patient is to die in a stage of acceptance and peace. Only patients who have been able to work through their anguish and anxieties are able to achieve this stage. (pp. 99-100)

This is a fragile time in one's life, yet with rich potential for growth and depth of meaning, so far as one can overcome fear (Bozarth-Campbell, 1982; Yalom, 2008).

**Acceptance.** Given the time and caring environment, a terminal patient who has been allowed to pass through the above phases most often reaches the stage of acceptance. This is not a lighthearted period, but one of quiet acquiescence. The struggle appears to have resolved, and the individual emotionally turns inward (Callanan & Kelley, 1992). Interest in the outside world lessens, and visitors are usually not sought out. If they do come, time together should be kept short and peaceful. Simply holding the patient's hand and other gentle gestures are all that is needed. Communications become increasingly non-verbal, and extraneous noises, radio and TV, are unwelcome. Kübler-Ross (1969) proposes:

[The patient]...will be tired and, in most cases, quite weak. He will also have a need to doze off or to sleep often and in brief intervals, which is different from the need to sleep during the times of depression. This is not a sleep of avoidance or a period of rest to get relief from pain, discomfort, or itching. It is a gradually increasing need to extend the hours of sleep very similar to that of a newborn child but in reverse order...It is as if the pain had gone, the struggle is over, and there comes a time for the final rest. (p. 124)

There are those individuals who put up a valiant fight to the bitter end, hoping for an answer or a cure. Many times this is in response to medical personnel or family members who are unable to accept the patient's death. Kübler-Ross (1974) states:

If we as physicians have the need to prolong life unnecessarily and to postpone death, the patient often regresses into the stages of depression and anger again and is unable to die in peace and acceptance. The second... more frequent problem is the immediate family which "hangs on" and cannot "let go." (p. 37)



The goal is to determine the individual's needs and desires, and do what is necessary in order to fulfill them in one's remaining time on earth. Utmost consideration should be taken to satisfy these final wishes, whenever possible. Most importantly, the patient must be allowed to die with dignity, knowing all has been done to accomplish this end (Callanan & Kelley, 1992).

Kübler-Ross's (1969, 1974) model, the Five Stages of Grief, was the prime analytic paradigm from the 1960s through the 1980s. Though this model was significant in early bereavement research, it is essentially limited to the dying patient, and does not correlate well with survivors' responses to loss (Callanan & Kelley, 1992; Love, 2007).

Over time, other theorists have expounded on these stages. Coryell (1997) discusses these stages from a Judaic perspective. There is a distinct awareness of the cycle of life, which plays into the spiral of mourning in the Jewish faith. Each dawn brings a new day, which brings a new month, and a new year. There are "firsts" acknowledged throughout this year: the first day without the beloved one, the first week, the first month, and on. According to Jewish ritual, the bereaved are set apart during certain periods of time to honor the deceased. Coryell (1997) describes the custom of sitting *shiva*, where family does not leave home for the first seven days following the funeral. Instead, family and friends come to visit, mourn, and offer support. Traditionally, mirrors in the home are covered, so the focus is on grieving, and not looking at oneself. Coryell (1997) draws a parallel with Kübler-Ross (1969, 1974):

If we line up Kübler-Ross's stages with the Jewish model we have:  
 Denial – Day  
 Depression – Week  
 Anger – Month

Bargaining – Year

Acceptance – Ongoing

Of course, we know that these emotional stages are not sequential, it is more like a spiral. We keep coming back...but each time we are a bit different, a little changed by the interval, and so we experience a spiral movement...Grief ultimately connects us to the rhythms of life itself as day follows night and light comes again after the darkness of loss. (pp. 94-95)

In the last several years, there has been a trend moving away from prescribed stages of grief, to a more redefined and dynamic understanding of loss (Doka, 2002). The following concepts elucidate these refined approaches.

### **Ambiguous Loss**

Within the last thirty years, a therapeutic distinction in the domain of loss, the theory of *ambiguous loss*, has been cultivated. Pauline Boss (1999, 2006) is the predominant researcher in this area of study. Boss (2006) links the notion of ambiguity with loss, and has formulated an enhanced understanding of this phenomenon. She defines ambiguous loss as:

a unique kind of loss that defies closure, in which the status of a loved one as “there” or “not there” remains indefinitely unclear...with no official recognition of there even being a real loss...there is a lonely and oft misunderstood mourning with an indefinite beginning and an indefinite end. (p. 4-5)

The following real life anecdotes illustrate diverse forms of ambiguous loss:

At one time, Helen was a young widow with 3 small children. She stubbornly made her own way, selling Tupperware to support her young family. Eventually, she was able to start her own business. At the height of her career, in her late 60s through her 70s, she was a community leader, nationally known speaker, and owner of one of the most

successful businesses in a large metropolitan area. Then, in her mid-80s, when inappropriate responses lead family to believe she was losing her hearing, she received the life-shattering diagnosis of dementia. The world turned upside down for her family.

Edward was a B-17 bombardier for the Royal Canadian Air Force during WWII. In December 1943, he was shot down over the ball bearing factory in Schweinfurt, Germany (Homdrom, 2001). Hundreds of soldiers bailed out of bombers, parachuting in the dark of night, during a very strong wind. Edward was captured and detained in a German Prisoner of War camp. His widowed mother and older brother received a telegram from the Red Cross saying Edward had been shot down, however there was no sign of him. This was understandably devastating news for his small family. They presumed he was dead, as many soldiers died during that raid, and had a memorial service for him at their parish church.

Charlie, a 47-year-old husband and father of two school-aged daughters, was employed as a heavy equipment operator for over half his life. He faithfully went in early to work, putting in long hours on potentially very dangerous machines, and was one of the company's best laborers. About one year ago, he received a pink slip, and was discharged temporarily due to a shortage of work. He remains out of work, trying to pick up odd jobs, chop wood for sale, and plow snow in the wintertime.

In an account from National Public Radio (August 27, 2010, Morning Edition) the experiences of countless Americans reveal changes which heretofore have been less significant. The current economic situation has left innumerable families without work or homes. The report describes a couple who were engaged and purchased a home three

years ago. Now two years later, they have broken off the engagement, and though frustrated, they continue to live together, unable to sell their home.

“Every time I’d come home, it was a heartbreak,” [Kelly] Christiansen says. It was both awkward and painful to mourn the loss of a shared future, yet still share a joint fate because they could not afford to sell their home, which still continues to lose value.

Martha is a 52-year-old adopted daughter of a schoolteacher and draftsman. She had always wondered who her birthparents were, and just before her adoptive mother died, she told Martha where to find the documents necessary to locate these individuals. Martha learned of her birthmother’s name, and since it was an unusual one, easily found uncles and cousins who were eager to meet her. From them, she learned of her birthmother’s background, and the name of the man her new-found relatives suspected was her biological father. After much diplomatic and discrete research, her efforts paid off. She met with an elderly priest, who shared many of her same physical characteristics, and introduced herself as his daughter. He unhesitatingly responded, “You are the special intention I have been praying for for over 50 years.”

This matter of unsure and blurred loss is nothing new (Boss, 1999, 2006; Bruce & Schultz, 2001; Doka, 2002; Westberg, 1962). It has been a prominent theme from ancient literature through current motion pictures (Boss, 1999). Indeed, no one is untouched by uncertainty in life. The above narratives describe disconcerting situations and unanswerable questions to which most individuals can relate.

Whereas Kübler-Ross (1969, 1974, 1985) presents a relatively linear, psychodynamic approach to grief in her five stages, Boss’ (1999, 2006) strategy is clearly

contextual, taking in the entire family system. For purposes of elucidating this topic, the following discussion will ensue primarily from Boss' (1999, 2006) research findings.

Boss (1999, 2006) views loss through the systemic lens of a Marriage and Family Therapist. She became interested in ambiguous loss during the Viet Nam War, in the 1970s, when she studied families who had a loved one missing in action. Indeed, in 1975, she first coined the term "ambiguous loss" as a result of working with these families where a parent or adult child was absent (Boss, 2006, p. 10).

During the 1980s, Boss (1999, 2006) focused on situations where a family member became psychologically distanced by diseases of the mind, addictions, or chronic physical illness. When the tragic events of September 11, 2001, occurred, she began to study the responses of the survivors whose loved ones had been vaporized or burned past recognition. Each of these events involved situations far beyond one's control (Boss, 2006, p. 37). Unresolving grief is not a defect *in* the individual or family, but must unequivocally be considered within one's *external* context (Boss, 1999). "From this more contextual perspective, pathology is attributed to a client's situational context and environment rather than to the psyche or family...context can influence the complexity of family loss, trauma, and resilience" (Boss, 2006, pp. 2-3). When a family system is able to stand back and recognize that what is occurring is outside their control, they are often more willing to seek therapy and learn to differentiate the potential for change (Becvar, 2001; McCabe, 2003; Walsh & McGoldrick, 1991).

Boss (1999) reframes the intrinsic nature of family by dissecting the difference between what she names as the "physical" and the "psychological" family. Simply

because a group of individuals lives together in one building, does not mean they constitute a family unit. Essential to a thriving family is the quality time taken to stay involved in each other's everyday lives (p. 57). Boss' (1999) definition:

By family, I mean that intimate group of people whom we can count on over time for comfort, care, nurturance, support, sustenance, and emotional closeness. Family can be people with whom we grew up – called the family of origin – or it can be people we select in adulthood – called the family of choice... This view of family stresses the criterion of being *present* [emphasis added] psychologically *and* physically – even more than that of related. (p. 4)

Heightened stress results from futile attempts to fathom unclear and traumatizing situations, and make sense of them (Boss, 1999). Due to the confounding nature of ambiguous loss, this tension creates emotional paralysis, compromising one's ability to embrace life. Boss (1999) believes educating the family about the causes of their stress and validating the accompanying pain may help in managing this trying time (p. 21). She also uses “experiential and structural” therapies to help families recoup (p. 22). Finally, Boss (1999) states, “with ambiguous loss the trauma (ambiguity) continues to exist in the present...it is typically a long-term situation that traumatizes and immobilizes” (p. 24). For example, in the case of an individual being told he has cancer, families swing between receiving a terrifying diagnosis and garnering hope the chemotherapy will work; a terminal prognosis, and a possibility of seizing life with resolute gusto.

Boss (1999, 2006) cogently parses the two kinds of ambiguous loss. Harkening back to the story of Helen, we see a woman who is physically present in the family system, yet dementia has taken away her ability to be psychologically available to her children. This ambiguous loss visibly distorted parameters of her family system as

evidenced by heightened anxiety and increased conflict among family, physicians and those trying to help. Individuals with brain injury, Alzheimer's or other diseases of the mind fall into this category. Those with addictions to drugs, work, or even other relationships are included as well. Boss (1999) names this situation "good-bye without leaving...these people are at home, but their minds are elsewhere" (p. 4). The family members are left to provide care to someone who is there, but is not there, often to the end of life. "The question of who determines 'the end,' however, is not always clear, especially when heroic measures conflict with living wills or ambivalent family members" (p. 50). This becomes a set-up for confusion and burnout as life is put on hold for the caregivers.

Edward's experience of being held in a German POW camp demonstrates the second type of ambiguous loss, in which he was physically missing, but psychologically very present within this family. For many months, they did not know whether he was alive or deceased (Homdrom, 2001). Lack of concrete information implied he could not truly be mourned, as he might return one day. Though they eventually got word of him being held in a work camp along the Baltic Sea, the ambiguity of his state of health or what may happen to him caused a great deal of stress for his mother and brother. Boss (1999) refers to this type of ambiguous loss as "leaving without a good-bye" (p. 26). Other experiences of psychological presence and physical absence are found in parents with kidnapped, missing, or adopted out children; immigration; imprisonment; ethnic cleansing; natural calamities such as tornadoes, floods or earthquakes; and other "missing-in-action" circumstances connected within the context of war (Boss, 2006, p. 7).

Divorce is a prime example of a situation where “the marriage is lost, but the parenting continues...the trouble is not divorce...but the ambiguity and unresolved loss that accompany it” (Boss, 1999, p. 31). Salerno and Williamson (2001) believe, “Divorce means letting go of not only the marriage but also of other pieces of baggage packed along with our fears, our guilt, and our sense of failure” (p. 9). These are ambiguous losses to be sure. Gender plays a noteworthy role in the experience and reaction to ambiguous loss of a parent through divorce, as well. Though both sexes have a difficult time with the fracturing family system, it appears they manifest it in dissimilar ways. According to Clarke-Stewart & Brentano (2006), “boys are more likely to externalize their distress and girls to internalize it...Another suggestion is that girls suffer more before the divorce and boys after it” (pp. 155-156). Boss (1999) recommends, “Identifying what has been lost and grieving it while also identifying the connections that continue in their lives is a healthier approach for children” (p. 31).

Both types of ambiguous loss are prevalent. Developmental stages within the family life cycle are rife with loss. “The temporal coincidence of loss with other major stress events, including multiple losses and other developmental milestones, may overload a family, posing incompatible demands” (Carter & McGoldrick, 2005, p. 187). Everyday events such as a child briefly leaving the nest for the first day of kindergarten through that child moving away to college or a new job, leaving the nest empty, confirm how common--and stressful--ambiguous losses have become (Hollis, 2005, 2009).

These traumatic situations produce poignant questions among family members: “Is my loved one *in* or *out* of the family system?” “Am I still married if my spouse is



missing, or does not recognize me anymore?” “Am I a parent if I gave my child up for adoption?” As stated by Boss (2006):

Absence and presence are not absolutes. Even without death, the people we care about disappear physically or fade away psychologically...The ambiguity between absence and presence creates a unique kind of loss that has both physical and psychological qualities...The premise is that ambiguity coupled with *loss* creates a powerful barrier to coping and grieving and leads to symptoms such as depression and relational conflict that erode human relationships. (p. 1)

According to Boss (1999, 2006) ambiguous loss is the most catastrophic of all types of loss simply because it is most uncertain. “At some level, we all wrestle with the paradox of human connections: the absent as present and the present as absent” (Boss, 1999, p. 138). Does one grieve – or not? This confusion yields not only the above manifestations, but as she notes, “the greater the ambiguity surrounding one’s loss, the more difficult it is to master it and the greater one’s depression, anxiety, and family conflict” (Boss, 1999, p. 7).

Boss (1999) proposes five reasons why ambiguous loss leads people to feel powerless and have physical and emotional symptoms. First, since this loss is unclear, individuals are unable to truly comprehend the problem. They become stuck trying to resolve a decidedly vague issue. Second, family members become immobilized and unable to adjust to new roles as a result of the loss and subsequent confusion (pp. 7-8). Third, the family experiencing ambiguous loss receives little support or validation from society. Rituals to make the loss more concrete are essentially non-existent since by its nature, loss is not a static experience. Fourth, because ambiguous loss is incongruous, uncertain, and awkward, people who might have been sympathetic to a clear loss do not

offer their support. They often do not know what to say or do in this difficult and persistent situation. Fifth, ambiguous loss does not appear to have an ending, and may continue for a long, long time (p. 8). Diseases of the mind, addictions, and support for the chronically ill take their toll on the caregivers (Callanan & Kelley, 1992; Johnson, 1973; Levine, 1987). For those who await news of a cherished one's whereabouts, time seems to stand still. This distortion of time leaves loved ones emotionally consumed, with little physical energy left to participate in what life has to offer. Since the nature of ambiguous loss is cloudy and unending, there is no true conclusion to the grieving process. Boss (1999) states, "It feels like a loss but it is not *really* one. The confusion freezes the grieving process" (p. 11). This notion is reminiscent of the spiral image introduced earlier in this review, with no obvious or apparent end (Arrien, 1992; Bankson, 2010).

In the turbulence of ambiguous loss, it is not surprising contradictory emotions leave caregivers in a quandary. "They dread the death of a family member who has been hopelessly ill...but they also hope for closure and an end to the waiting...love and hate for the same person; acceptance and rejection of their caregiving role" (Boss, 1999, pp. 61-62). Boss differentiates between the words *ambiguity* and *ambivalence*. Such distinction is a necessary component of understanding ambiguous loss. If Boss (2006) views *ambiguity* as being "uncertainty about one's absence or presence," then "*ambivalence* arises when emotions are added to the mix," collapsing to coinciding reactions:

Ambiguity feeds ambivalence; ambivalence feeds the uncertainty about which action to follow, which decision to make, which role to play, or which task to perform. Immobilization follows...ambivalence freezes

the healing process, and family members are ambiguously lost to one another forever. (p. 144)

For most people, waiting takes its toll, and halted healing under the spell of ambiguity/ambivalence eventually gives way to a seed of change (Love, 2007). Perhaps the confluence of time passing, reality of the situation, and weakening defenses affect family members in such a way that it feels right to begin moving on (Boss, 1999, p. 106). It is not unlike the addict's experience of "hitting bottom," when the only things left to do are "stay stuck," or accept the actuality that one must change both thoughts and actions in order to live a vibrant life (Clark, 1994; Johnson, 1973). Boss (1999) believes:

To regain a sense of mastery [of one's life] when there is ambiguity about a loved one's absence or presence, we must give up trying to find the perfect solution. We must redefine our relationship to the missing person. Most important, we must realize that the confusion we are experiencing is attributable to the ambiguity rather than to something we did--or neglected to do. (p. 107)

Rather than remaining paralyzed, this becomes a freeing phenomenon, where interpretations and perceptions are re-evaluated and normalized, and one begins to take charge of life, despite living with the strain of ambiguity (Boss, 1999, p. 108). When an individual makes a redefining, cognitive change *inside*, this empowers revisions on the *outside* (Boss, 1999, p. 109). Once this occurs, the person is no longer stuck, but able to continue the grief process and move on with life: the important thing is to keep moving (Bridges, 2004; Salerno & Williamson, 2001). The tasks here are to stay connected with trusted individuals and make every effort to comprehend the causes of this very difficult and abstruse situation (Haugk, 2004; Shapiro, 2008).

The final step in Boss' (1999) theory of ambiguous loss is one of finding *meaning* within unresolved grief. "This is yet another paradox--to transform a situation that won't change...It is not the *situation* [emphasis added] that changes but what they hope for" (p. 119). This is a universal theme in life and similar words are echoed elsewhere in psychospiritual literature (Attig, 2000; Bankson, 2010; Bonhoeffer, 1953; Frankl, 1959; Frommer, 2005; Hollis, 2005, 2009; May, 1969; Remen, 1996). In the midst of wavering perplexity, one may learn to choose health and creatively exist and even grow within ambiguous tension, learning to face life with newfound courage and personal strength (Becvar, 2001; Boss, 1999; Edwards, 2010; Hollis, 2005; Lewis, 1961; Remen, 1996).

### **Nonfinite Loss**

Another twist on the labyrinth of loss and subsequent grief is found in work by Elizabeth J. Bruce and Cynthia L. Schultz, namely, *Nonfinite Loss and Grief* (2001). The foundation for this theory was formulated in identifying the convoluted components of unremitting grief faced by parents with special needs children, specifically those with intellectual impairment. From there, they set out to create psychoeducational programs to support those families and caregivers who work with this population (p. ix).

Nonfinite loss is couched within a person's past, present, and future worldviews, and is especially influenced by one's particular fears and anxieties (Bruce & Schultz, 2001, p. 7). When this form of grief is embedded in one's past, particularly as children, we experience fear and anxiety as a result of what Bruce & Schultz (2001) call "random dreaded events....The realization that bad things happen to good people and bad things do not necessarily go away is, for most people, unfathomable" (pp. 4-5). When those

“bad things” occur, we spiral back to our childhood memories and cognitions, arousing behaviors which once offered comfort when we were in the crucible of stress (Bozarth-Campbell, 1985; Remen, 1996).

With little stretch of imagination, one can easily apply this type of grief to many of life’s circumstances. According to Bruce & Schultz (2001), the majority of people in developed countries, expecting a reasonable amount of personal security, have the possibility of creating a future for themselves. Survival is not dependent upon gathering food and finding safe shelter, and life is relatively predictable (Remen, 1996). We surmise things will effectively “go our way.” When agonizing news of a life-changing-forever event becomes apparent, we again find ourselves in that *liminal space* between “the world that is known and the world that is dreaded” (Bruce & Schultz, 2001, p. 5), the *threshold* separating certitude and doubt (Callanan & Kelley, 1992; Corbett, 2007; Frommer, 2005; Hollis, 2005, 2009; Lewis, 1961; Parkes, 1996). If Boss’ (1999) indicator for ambiguous loss is “present, but not present,” then Bruce & Schultz’s (2001) criterion for nonfinite loss is “what should have been” (p. 8).

Bruce & Schultz (2001) expound, “we use the term *nonfinite loss* to refer to losses that are contingent on development; the passage of time; and on a lack of synchrony with hopes, wishes, ideals, and expectations” (p. 7).

There are four developmental factors suggested by Bruce and Schultz (2001), which are fundamental to understanding nonfinite loss within the context of the past. These include, “(1) familiar patterns in relation to psychological well-being, (2) socioemotional states and learning in childhood, (3) internalized models of the ‘world

that should have been,' and (4) the public and private reputation of dreaded events" (p.

7). Referring to the first two factors, and in the opinion of Becker (1973), the prime tasks of childhood are to overcome anxiety, learn to face one's fears of powerlessness and death, and live with grit and self-assurance (pp. 53-57). Erik Erikson (1963) believes it is essential that one learns to draw a distinction between anxiety and fear:

Fears are states of apprehension which focus on isolated and recognizable dangers so that they may be judiciously appraised and realistically countered. Anxieties are diffuse states of tension...which magnify and even cause the illusion of an outer danger, without pointing to appropriate avenues of defense or mastery...to be aware of fear, then, without giving in to anxiety; to train our fear in the face of anxiety to remain an accurate measure and warning of that which man must fear, this is a necessary condition for a judicious frame of mind. (pp. 406-407)

"The fact [is] that in the end, the ability to master one's fears may be the biggest hurdle and the most precious skill to have learned in dealing with nonfinite loss and in facing one's own death" (Bruce & Schultz, 2001, p. 90).

Additional attention must be paid to factor number three, regarding one's hopes and dreams, for this is an often-misunderstood notion. Bruce & Schultz (2001) assert:

nonfinite loss can germinate in a period of childhood and adolescence when an individual had a feeling of 'specialness' bestowed on him or her (e.g., because of a skill, talent, or illness) but then lost that special feeling...When someone's dreams and hopes falter, they are often overlooked or dismissed by others...considered to be 'just a part of life.' ...for some individuals, irrespective of their stage in life, the falling away or the relinquishment of their dreams is a cause for continuing grief. 'Who I could have been,' 'who I should have been,' or 'who I should have become' are possibly the connecting themes. (pp. 8-9)

While some of these hopes and dreams may be taken from us because of life circumstances beyond our control, other losses spawn regret for choices we "could have"

or “should have” made. According to Roese (2005), adults surveyed consistently place the following four regrets, in order of importance, at the top of the listings: education, career, intimacy, and parenting. Education heads the list since it is considered the portal to other opportunities for advancement, upgraded career, financial achievement, intellectual challenges, and personal satisfaction (Roese, 2005). “Research on women from several generations has suggested that women’s life regrets often focus on missed opportunities for education and career development” (Stewart & Vandewater, 1999, p. 271). Striving for personal growth is the key to advancing beyond regret (Hollis, 2005, 2009; Rogers, 1961). “Facing existential questions usually associated with the middle stage of life is not easy; it often entails conflicts between what one is and what one should or could be (or between one’s beliefs and experience), but is also opens up new possibilities” (Weaver, 2009, p. 9).

Necessary to understanding nonfinite grief is in the explication of two paradigms in what Bruce & Schultz (2001) refer to as “dreaded events,” namely those with a “public reputation,” and those with a “private reputation” (p. 7). The very core of our reaction to negative occurrences in life is *fear*, which is rooted in experiences, behaviors, and perspectives adopted in childhood. In essence, we incorporate attitudes and opinions demonstrated by our caregivers and peers, believing these viewpoints to be appropriate and admirable. Only later, we may learn they were not necessarily true.

Bruce & Schultz (2001) assert the first of these two paradigms manifests when, as children, we discovered that others were “different” from ourselves, and hence, unappealing (pp. 100-101). From early on, as our identities unfold, we want to be part of the “group” (p. 101). The public reputation maxim we absorb is “dissimilar is

intrinsically *not good*.” Consequently, anyone we see who is ill, impaired, impoverished, or awkward in any way, quickens primitive fear within (p. 103). We do not want to be nearby, or even look their way. “Linking back to the early formation and importance of groups, it is emphasized that the fear of dreaded events and the fear of being ostracized from the group are inextricable” (p. 107). We innately want to belong in the milieu most like ourselves or with those whom we wish to emulate (Erikson, 1963). Even if it is a family member who does not fit this precondition, “many siblings...are sometimes terrified by brothers or sisters with behavior problems related to an intellectual disability or autism spectrum disorder” (Bruce & Schultz, 2001, p. 104). This situation, colored by fear of rejection and shame, advances the experience of dread for parents and children alike. Those individuals whose disabilities are visible may either withdraw from the crowd or try to become acclimatized to the inequality and curiosity of others (p. 103).

If Bruce & Schultz (2001) maintain the first paradigm has to do with threats from *outside* ourselves, the second, also conceived in early identity development, focuses on threats *within*, which question our own private reputation, attitudes, and beliefs (pp. 109-111). Bruce & Schultz (2001) write:

The development of--and attachment to--versions of self is complex. Over time, a relationship unfolds wherein certain roles, skills, and attributes become enmeshed with identity and linked with self-esteem. In the end, it makes up an individual’s notion of what he or she considers “me” or what makes “me” feel special. (p. 111)

Since our identities are forged and verified within the social realm, we are vulnerable with regard to current values and expectations (Anderson, 1997; Bruce & Schultz, 2001; Gergen, 1999). If these distinctive, personal qualities become threatened,



and who we are at the core of our existence is in jeopardy of being lost or at least diminished, fear again emerges (Becker, 1973; Erikson, 1963). When this happens, angst arises in either losing a reputation which has become significant to one's being, or acquiring a dreaded reputation (Bruce & Schultz, 2001, p. 116). "Confronted with a self that is seen as damaged, the individual grapples with losing the esteem of others and of his or her self-esteem" (p. 150). Examples of this type of threat include: not making it into a particular club, school, or sports team, having a physical feature or body shape that is not pleasing in the eyes of others from whom we seek attention, divorce, being a victim of abuse, losing one's job, not fitting in, or simply basic personal insecurity (pp. 109-116). Nonfinite loss ignites childhood fears of abandonment and shame, and shakes the foundation of one's private reputation. Bruce & Schultz (2001) identify the most difficult issue caregivers and those with special needs encounter, "is adaptation to...continued threat and uncertainty within themselves – perhaps the hardest thing for the psyche to tolerate" (p. 152).

The foundation of nonfinite loss involves a non-linear pattern, as it includes cyclic living through past, present, and future. Once again we envisage the spiral. "The concept of ever-evolving cycles and recurring states of mind provides scope not only for shifting time frames, but also for the nonlinear and individual natures of the grieving process" (Bruce & Schultz, 2001, p. 153). Those experiencing nonfinite loss are presented with a profoundly difficult and recurring reality with unimaginable tribulation. Just as Kübler-Ross (1969; 1974; 1982) illuminated stages of grief in her work with patients in terminal decline, so too, do Bruce & Schultz (2001) examine the cycles they

observe in nonfinite loss. Following each description, C.S. Lewis (1961) aptly recounts his experience in the loss of his beloved.

**Cycle 1: Shock.** According to Bruce & Schultz (2001), the individual and caregivers are thrown into a state of numbness and denial upon hearing the threatening announcement. Anxiety and fear ensue as the overwhelming news yields little sleep and diminished appetite, concentration, energy, and desire to go on. Others may think those suffering are “doing well” despite the horrific news, though in reality, they are on the edge of devastation (pp. 154-155). “No one ever told me that grief felt so like fear. I am not afraid, but the sensation is like being afraid. The same fluttering in the stomach, the same restlessness, the yawning. I keep on swallowing” (Lewis, 1961, p. 15).

**Cycle 2: Protest/Demand.** Numbness and denial begin to dissolve as reality starts to register. Questions like “Why me?” and “What have I done to deserve this?” arise. “With identity under threat, an interplay between hope and resistance is crucial. The individual attempts to minimize the threat by resisting the acknowledgment of the possible consequences of the threat” (Bruce & Schultz, 2001, p. 156). Intense desire to keep things the same surfaces. Feelings of fear, sadness and being out of control persist (pp. 154-157).

There are moments, most unexpectedly, when something inside me tries to assure me that I don't really mind so much, not so very much, after all. Love is not the whole of a man's life. I was happy before I ever met H. I've plenty of what are called 'resources.' People get over these things. Come, I shan't do so badly.  
(Lewis, 1961, pp. 15-16)

**Cycle 3: Defiance.** Protest grows as reality slowly seeps in, and a bit of strength to fight begins to surface. Searching messages to the effect of, “I can/will get through this,” fuel hope and expectations. At the same time, nonacceptance of possibly being like others with a loss or disability unfolds (Bruce & Schultz, pp. 156-159). “Between two worlds, aligned with neither, a sense of isolation is amplified” (p. 158).

Meanwhile, where is God? This is one of the most disquieting symptoms. When you are happy...you have no sense of needing Him.... But go to Him when your need is desperate, when all other help is in vain, and what do you find? A door slammed in your face, and a sound of bolting...on the inside. After that, silence. Why is He so present a commander in our time of prosperity and so very absent a help in time of trouble? (Lewis, 1961, pp. 17-18)

**Cycle 4: Resignation and Despair.** Here we spiral back to Jung’s use of the German word, *gelassenheit*, meaning “resignation or releasement” (Dourley, 1992), for it is an apt description of the tasks in this phase. Regaining what was lost is impossible. Thoughts of this experience being potentially purposeful may come to light. “An adaptive process is taking form. For the identity to survive, connections with new versions of the world have to be made” (Bruce & Schultz, 2001, p. 158). Renewed sense of spirituality may set in, though emotional struggles with anger and melancholia persist as expectations of healing lessen (pp. 158-161).

Yet H. herself, dying of [cancer], and well knowing the fact, said that she had lost a great deal of her horror at it. When the reality came, the name and the idea were in some degree disarmed. This is important. One never meets just Cancer, or War or Unhappiness (or Happiness). One only meets each hour or moment that comes. All manner of ups and downs. Many bad spots in our best times, many good ones in our worst. (Lewis, 1961, pp. 24-25)

**Cycle 5: Integration.** The primary undertaking of this stage is to cherish life and the new identity one has acquired, appreciating one's strengths and gifts. This is not a carefree time, as unabating course corrections characterize the integration of what has been and what will be. "Ongoing griefwork is a phenomenon of nonfinite loss" (Bruce & Schultz, 2001, p. 163). Balance and new vision offer some decrease in emotional distress as physical decline persists (pp. 158-163).

Still there's no denying that in some sense I 'feel better,' and with that comes at once a sort of shame, and a feeling that one is under a sort of obligation to cherish and foment and prolong one's unhappiness. I've read about that in books, but I never dreamed I should feel it myself. I am sure H. wouldn't approve of it. She'd tell me not to be a fool. So I'm pretty certain, would God. (Lewis, 1961, p. 66)

Returning to the spiral analogy, Bruce & Schultz (2001) reflect:

There is an inescapable feeling of being unsettled and of incompleteness in grieving nonfinite loss. The cycles are not linear, have no end-point, and are prone to recycling again and again...In particular, beliefs about the self, about the schemata of the world that should have been, and of dreaded events are isolated. They represent an underlying dialogue in the individual's relationship with loss. (pp.163-164)

It is not difficult to deduce that these cycles overlap with Kübler-Ross' (1969; 1974; 1982) stages of grief. Boss' (1999; 2006) notion of ambiguous loss and nonfinite losses coexist, as well. The question arises: What about losses which do not fall into the categories of finite, ambiguous, or nonfinite? Those oblique losses which seem to slip through the cracks of our lives, leaving us wondering, "*What just happened* to that which I have loved and is now gone?"

## Disenfranchised Grief

The circuitous path in understanding loss and grief presents yet one more dimension through groundbreaking writing by Kenneth J. Doka (2002), who proposes a theory consisting of five principles to define *disenfranchised grief* as “the grief that persons experience when: (1) they incur a loss that is not recognized or, (2) cannot be openly acknowledged, publicly mourned or socially supported, and (3) from which the griever is excluded” (Doka, 2002, pp. 10-13). A few years later, he amplified this definition to include: (4) “disenfranchising death and the ways an individual grieves (based on newer work on cultural differences), and (5) styles of grief” (pp. 10-17).

These tenets are shaped and informed by a variety of cultural guidelines and expectations which determine how to conduct oneself, especially with regard to emotions, actions, and thinking (Doka, 2002). These implied rules include how to manage oneself in the face of loss and grief. “They govern what losses one grieves, how one grieves them, who legitimately can grieve the loss, and how and to whom others respond with sympathy and support. These norms exist...as ‘laws’” (p. 6). Grief “laws” vary from culture to culture, and even within subcultures.

In many societies, the expression of grief is linked only to those within the family (Doka, 2002; Carter & McGoldrick, 2005; van Gennep, 1960). However, reality is many people love many things in life. Besides attachment to family and friends, deep, life-giving bonds are created with special people, places, pets, traditions, belongings, and even objects (Doka, 2002; McCabe, 2003; Walsh & McGoldrick, 1991). What happens when connections with these pleasures in life are terminated for whatever reason? When

this occurs, one's expression of grief may not be compatible with society's expectations, and the right to grieve the loss is effectively denied. Doka (2002) attests:

In such situations, the personal experience of grief is discordant with the society's grieving rules. The person experiences a loss, but the resulting grief is unrecognized by others. The person has no socially accorded right to grieve that loss or to mourn it in that particular way. The grief is disenfranchised. (p. 7)

Much of loss is not associated with death, though where one experiences loss, grief is also present (Doka, 2002). We form attachments to people outside our familial circles. Friends, colleagues, teachers, therapists, clergy, health care workers, and pets can become as important to us as immediate family (Baker, 2002; Becvar, 2001). Military personnel comprise a unique subset of this group due to regimented and compliance-driven lifestyles necessitated by austere training and combat environments which create *esprit de corps* and tenacious bonds that may last a lifetime (Tick, 2005). Similarly, relatives and friends of those who suffer from disorders or situations society considers to be murky--such as Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS), mental illness, alcohol, or drug abuse--constitute yet another grieving community (Doka, 2002; McCabe, 2003; Walsh & McGoldrick, 1991; Worden, 2009).

Suicide is perhaps the ultimate disenfranchised loss a family could encounter (Becvar, 2001; Walsh & McGoldrick, 1991). Often, the survivors experience a profound sense of shame, rejection, or guilt for not having been able to preempt the loss of life. Worden (2009) states:

The survivors' ...sense of shame can be influenced by the reactions of others. "No one will talk to me," said the woman whose son

killed himself. “They act as if it never happened.” This added emotional pressure not only affects the survivor’s interactions with society but can also dramatically alter relationships within the family unit....[they] adjust their behavior toward each other based on this knowledge [of the death]. [The] feeling of guilt is particularly difficult when the suicide happened in the context of some interpersonal conflict between the deceased and the survivor. (p. 180)

When we are immutably separated from cherished relationships such as these noted above, there is often little understanding from others regarding our emotional pain.

Grief emerges when people are separated through divorce, move to a new locality, lose employment, experience unwanted retirement, adopt out a child, or suffer captivity (Becvar, 2001; Boss, 1999, 2006; Doka, 2002; Parkes, 1996; Salerno & Williamson, 2001). The secondary losses from situations such as these generate a ripple effect in which one no longer has the support system or sufficient self-worth to persevere (Doka, 2002, p. 12). Furthermore, loss manifests as plans and dreams for the future dissolve, perinatal death occurs, or we lose possessions in fire, natural disaster, or even burglary (Callahan & Dittloff, 2007; Doka, 2002; Worden, 2009).

Several factors trigger denial of grief for those affected by unconventional loss (Doka, 2002). *First*, family is the predominant component of our society. By definition, blood relatives suggest clear and legal boundaries, not to be broken by others outside the system. Nontraditional relationships are a growing part of the complex network of our diverse society (Doka, 2002, pp. 10-11). These include friendships, Lesbian, Gay, Bisexual, and Transgender (LGBT) relationships, foster and step parents, cohabitation of unmarried persons, relationships with therapists, clergy, roommates, caregivers, ex-spouses, internet-based ties, and lovers (Doka, 2002; Sue & Sue, 2008). Certain

relationships may challenge the status quo with regard to long-established norms and values. When members of such associations experience loss, the significance of these relationships is often not respected or even recognized by society. The aforementioned “grief laws” act to reinforce familial structures by refusing to acknowledge unconventional and “socially unsanctioned” bonds (Doka, 2002, p. 8).

In reference to these rigid “grief rules,” Doka (2002) believes the *second* reason why grief may be denied those who experience unorthodox loss is that for organizations and businesses to acknowledge the loss of non-kindred members would disrupt company policies and payrolls. “Organizations would be forced to define levels of friendship or types of loss....By limiting acknowledgement of loss to family members, organizations avoid confusion and...[the] need to assess whether this loss...is entitled to recognition” (p. 8).

A *third* notable factor connects grieving laws to the use of customary rites and observances (Doka, 2002, p. 8). Societal norms and expectations pave the way for the articulation of grief by fostering group participation in rites such as wakes, memorial services, and funerals (Becvar, 2001; Coryell, 1997; Doka, 2002; Parkes, 1996; Walsh & McGoldrick, 1991; van Gennep, 1960; Worden, 2009). “The rite of the funeral publicly testifies to the right to grieve” (Doka, 2002, p. 9). At best, these events connect those grieving with the past, promote durability while living in the present moment, and impart hope and courage for the future. “Rituals have the potential to increase a sense of group identity within families” (Becvar, 2001, p. 210). Rituals and memorial services also carry the capacity for alienation, rejection, and further disenfranchisement of those grievers whose presence others deem uncomfortable or unacceptable at the function.



Besides those who would be unwelcome because of societal prejudice, others with diminished developmental capabilities might likewise be excluded from the service (Carter & McGoldrick, 2005; Doka, 2002). Oftentimes, subcultures may stand alone in proffering support to those whom society refuses to sanction. For example, a tightly-knit LGBT community may rally support for an individual whose partner has died from AIDS. Additionally, Doka (2002) concludes his list of factors:

grieving rules can differ among subcultural groups, whether defined by class, ethnicity, or another organizing factor. Thus, subcultures may mitigate the sense of disenfranchisement...this fact implies that grieving rules do differ between cultures. In certain cultures, certain ways of grieving may be understood as valid expressions of grief, whereas in other cultures the same behaviors may be disdained as excessive or inappropriate. (p. 9)

In every culture, people may encounter and grieve a loss in such a way that challenges the indigenous grieving laws of that society (van Genep, 1960; Carter & McGoldrick, 2005). The same social and cultural factors that allow one to grieve are the very ones which countermand and invalidate another's grief. These circumstances become experiences of disenfranchised loss (Doka, 2002, p. 10).

### **Transformation and Meaningfulness**

What becomes of the individual whose abject experience of loss and subsequent grief are so profound that carrying on seems impossible? The spiral winds downward, and hope dissipates (Lewis, 1961). It is the natural consequence of dispossession. In his collection of *Letters and Papers from Prison*, Dietrich Bonhoeffer (1953) asserts:

Nothing can make up for the absence of someone whom we love, and it would be wrong to try to find a substitute; we must simply hold out and see it through. That

sounds very hard at first, but at the same time it is a great consolation, for the gap, as long as it remains unfilled, preserves the bonds between us. It is nonsense to say that God fills the gap; he doesn't fill it, but on the contrary, he keeps it empty and so helps us to keep alive our former communion with each other, even at the cost of pain.... the dearer and richer our memories, the more difficult the separation.... gratitude changes the pangs of memory into a tranquil joy.... I've learnt here especially that the *facts* can always be mastered and that difficulties are magnified out of all proportion simply by fear and anxiety. (pp. 176-177)

Accordingly, these words speak to the absence of *some thing* as well, such as loss of health, a dream, or freedom.

Around the same (WWII) time frame, Viktor Frankl (1959) reached similar conclusions. Having survived intact, despite years spent in several Nazi prison camps, he determined reasons for finding the will to live. This quest culminated with the paradigm he called Logotherapy. In his words, "Logotherapy focuses rather on the future...on the meanings to be fulfilled by the patient in his future....[it] is a meaning-centered psychotherapy" (Frankl, 1959, p. 98). The essence of this therapy is to help clients discover *meaning* in life through becoming aware of one's deepest longings (Frankl, 1959, pp. 101-103). Then and now, it appears those individuals most likely to survive the horrors of imprisonment realize there is a freely chosen duty or goal to complete. "What matters, therefore, is not the meaning of life in general but rather the specific meaning of a person's life at a given moment" (Frankl, 1959, p. 108). Each individual is responsible to "answer for" one's own life. This responsibility yields the essence of what it means to be human (p. 109). Frankl's (1959) words entailing the individual's confrontation with "life's *finiteness* as well as the *finality* of what he makes out of both his life and himself" (p. 109) spiral back to Frommer 's (2005) views and Emily's thoughts in Wilder's (1938) *Our Town* previously described in this document.

Frankl (1959) suggests meaningfulness in life can be ascertained in three ways:

(1) by creating a work or doing a deed; (2) by experiencing something... such as goodness, truth, and beauty – by experiencing nature and culture or, last but not least, by experiencing another human being in his very uniqueness – by loving him.... and (3) by the attitude we take toward unavoidable suffering. (p. 111)

Frankl's (1959) theory of meaningfulness is accessible to each person at some level. Even without a loving relationship, an individual bears the potential for creativity, kindness, hard work, and openness to new experiences. To remain engaged in life becomes an intensely personal choice (Corbett, 2011; Frommer, 2005; Hollis, 2009; Lewis, 1961; Yalom, 1980, 2008).

Hollis (2005) opines life is lived with “a profound, irresistible urge toward meaning, [and] our anguish at the loss of meaning” yields the most exquisite suffering of all (pp. 6-7). He considers the difference between pain and suffering. Pain is *physical* and best eliminated whenever possible since it wears down one's spirit and somatic vigor. “Suffering is *spiritual*, for it inevitably raises questions of *meaning* [emphasis added]. If we are free of suffering, we are less likely to engage with those questions that ultimately define who we are” (Hollis, 2005, p. 210). He continues, “suffering is the first clue that something is soliciting our attention and seeking healing” (p. 64). For Hollis (2005), the quest in life is to answer the yearning from one's inmost being, *grow* a bigger life, and *risk* taking complete responsibility for “how our lives turn out” (p. 76). Instead of assuming a victim role as the result of loss, this risk shifts the onus of effort--and therefore potential richness of life--onto the individual who learns to live with the vicissitudes of life.

Baker (2003) quotes Zeiss (1996), who further elaborates on the invitation to risk-taking:

You face life...you move towards it and dive into it. In doing that, you take control of it. You join it in a way that works. If you're afraid of getting rolled [in the waves], the advice was 'Go get rolled. Make it happen.' You know then how to make it happen. You know where the wave is going to catch you in a certain way...what it feels like...how that works...discover that it's not fun, that you might get some water down your nose, but learn that you'll pop back up again. The wave will carry you to the beach, and deposit you on the beach. There you'll [safely] be. (p. 66)

This metaphor illustrates two key elements crucial in living life to the fullest: courage and resilience. It takes courage, coupled with a positive spirit and sense of humor, to dive into the unknown waves of life, surrender to being tossed about, and trust one will be delivered to the shore, albeit in a heap, with one's unquenched spark intact (Stratton et al. 2007).

In the Serenity Prayer, attributed to Reinhold Niebuhr in 1943, the speaker appeals for "the courage to change the things I can." These humble words link the virtues of courage and resilience in addition to requests for "serenity" and "wisdom." It is by no accident this nonsectarian prayer is recited in many group gatherings of addicts, and included in chaplain prayer books worldwide (Clark, 1994).

Becvar (2001) posits, "Resilience is defined as the ability to meet and handle successfully both normal developmental challenges and unanticipated crisis and change" (p. 257). Within the past few years, our nation marked the demise of a courageous woman, Elizabeth Edwards. A report on National Public Radio (December 8, 2010) described her as being remembered for her "fortitude and grace." After surviving

agonizing challenges, including the loss of a teenage son, a highly publicized affair by her husband, and terminal diagnosis of breast cancer, she was quoted as saying:

Resilience is accepting your new reality, even if it's less good than the one you had before. You can fight it, you can do nothing but scream about what you've lost, or you can accept that and try to put together something that's good.

Having examined paradigms created by outstanding scholars and practitioners in the field of loss and grief therapy--Elisabeth Kübler-Ross, Pauline Boss, Elizabeth J. Bruce and Cynthia L. Schultz, and Kenneth J. Doka--to use as guides through this spiraling journey of life transitions, we now consider the unique *culture* of the therapist. Unlike the cardiac surgeon, whose culture employs technology, precision tools, and medical expertise to heal a malfunctioning heart, the therapist's culture utilizes *inner* tools, namely curiosity, compassion, creativity, and context to help restore emotional brokenness (Corbett, 2011; Kottler, 2010; Nouwen, 1972; Rogers, 1951, 1961; Satir, 1972, 1983; Wampold, 2001).

### **The Liminal Space**

Professor and writer, Anne Fadiman (1997), offers images suggestive of the liminal space discussed earlier, which prompt investigation of the culture of therapist:

I have always felt that the action most worth watching is not at the center of things but where edges meet. I like shorelines, weather fronts, international borders. There are interesting frictions and incongruities in these places, and often, if you stand at the point of tangency, you can see both sides better than if you were in the middle of either one. This is especially true, I think, when the apposition is cultural. (p. viii)

Accordingly, in the context of this analysis, loss and grief stand in *apposition* to the culture of the therapist. Indeed, we find ourselves "at the point of tangency" standing

between our examination of loss and grief on one hand, and the therapists' culture on the other (Fadiman, 1997). Having reviewed the state of understanding of loss and grief, we now consider the vocation of therapist and pursue how loss and grief leverage the therapist's transformation.

## **Therapist Culture**

### **Definition of Culture**

Culture is the dynamic confluence of various components in a society, which include common beliefs, language, values, ethics, rituals, customs and knowledge (Monk, Winslade, & Sinclair, 2008). Sue & Sue (2008) elaborate further, "Culture consists of all those things that people have learned to do, believe, value, and enjoy. It is the totality of the ideals, beliefs, skills, tools, customs, and institutions into which each member of society is born" (p. 140). Wolcott (2008) posits, "Culture refers to the various ways different groups go about their lives and to the belief systems associated with that behavior" (p. 22). In Spradley's (1979) words, "culture...refers to the acquired knowledge that people use to interpret experience and generate social behavior" (p. 5). Shared patterns of cognition, language, and behavior comprise the core of culture (Creswell, 2007; van Gennep, 1960; Wolcott, 2008).

In this research, the focus is deeming therapists as a specific subgroup in society, which is framed by common knowledge, values, language, and ethical behavior: ergo, a *culture*. Counselors acquire necessary knowledge and language, thereby building a foundation for the vocation of healer. Presumably, they share common values, such as the innate worth of a human being, openness to diverse populations, and desire to bring

wholeness and healing to the world (Becvar, 2001; Ellis, 2006; Nouwen, 1972; Sue & Sue, 2008). Clinicians uphold a collective corpus of ethical imperatives such as respect for others, authenticity, and beneficence (Bernard & Goodyear, 2009; Kottler, 2010; Rogers, 1951, 1961; Skovholt & Jennings, 2004). Therapists with a specific focus, such as grief therapy, make use of refined techniques and strategies in dealing with those who are bereaved (Love, 2007; Wampold, 2001; Worden, 2009; Yalom, 1980, 2008).

### **Role of Therapist**

What is the role of therapist in today's world? We begin by examining the niche of the therapist. While there is variation within the helping professions of exactly what a clinician does, a basic ideology prevails (Wampold, 2001). Under the umbrella of "therapist" dwell numerous and diverse professions, from counselor or marriage and family therapist, to pastoral caregiver or social worker. While each of these has a different vocational slant, the essence of the therapist's role is to stand at the "point of tangency," (Fadiman, 1997, p. viii), between the distressed client and hope for healing. In this liminal space, the therapist extends a hand to the distressed client, while at the same time reaching for curative resources from the clinician's culture: turmoil and brokenness meet the potential for wholeness (Corbett, 2011; Nouwen, 1972; O'Donohue, 1997). It is a profoundly poignant place in which to stand.

### **Training**

Unlike the prevailing culture in which one lives, clinicians *choose* to become part of the therapeutic culture. Many years of rigorous training, study, and experience are necessary to make the transition from being a person who simply wants to help someone

in need to becoming a skilled professional (Kottler, 2010; Rogers, 1951, 1961; Skovholt & Jennings, 2004; Stratton et al. 2007). For each therapeutic discipline there exists a corresponding certification process culminating in licensure or certification. The Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) and the Council for the Accreditation of Counseling and Related Educational Programs (CACREP) are accrediting programs used in higher education, created to ensure courses and curriculum fulfill necessary requirements and quality assurance, thus satisfying professional standards.

Skovholt & Rønnestad (1992) describe pivotal stages of professional development for clinicians:

**Conventional Stage.** In this stage, the person is interested in helping those in need, and has very little, if any, education in the arena of counseling; being a friend to others suffices. Occupations such as peer or camp counselor, youth worker, or mentor provide opportunities to support those seeking guidance. The tendency is to become over involved with the one in need because boundary awareness is lacking (Baker, 2003; Kottler, 2010). Satisfaction occurs when one has felt success in helping and using one's relational skills (Skovholt & Rønnestad, 1992, pp. 17-20).

**Transition to Professional Training Stage.** This stage is designated by the time from when the helper decides to enter graduate training through the first year of training. Crucial to this stage is the choice to pursue counseling as a career and absorption and mastering an abundance of new material (Skovholt & Jennings, 2004). Excitement about learning and applying techniques, developing relationships with instructors and



supervisors, and personal growth through reading, self-reflection and discussions with prevails (Skovholt & Rønnestad, 1992, pp. 22-29; Wampold, 2001).

**Imitation of Experts Stage.** Skovholt & Rønnestad (1992) describe the student as having been in the program for two or three years at this point, and begun to single out personal theoretical preferences, while remaining open to new ideation and techniques. The individual looks to experts as examples to imitate, though may become frustrated if their highly sought feedback is not validating or balanced (Bernard & Goodyear, 2009). Introspection escalates, as does motivation to complete the educational process and begin practice. Curiously, the student's evaluation of the graduate program is most antipathetic at this stage, as the student finds the course offerings, school politics, and instructors insufficient. Tentativeness about one's role as a therapist gives rise to personal feelings of inadequacy and the student seeks identification with "experts" of any magnitude. Sometimes the most significant learning comes from time spent with one's own therapist (Baker, 2003; Skovholt & Rønnestad, 1992, pp. 30-41).

**Conditional Autonomy Stage.** This stage is all about supervision. The student is involved in supervised practicum, learning to work with skill and varying levels of self-assurance. There is increased need for encouragement and feedback. If the intern is in personal counseling, the resulting personal growth is highly beneficial (Skovholt & Jennings, 2004; Stratton et al. 2007). The seriousness of learned theories gives way to spirited confidence and sense of humor. Case notes become more succinct and the intern may begin to receive more complex clients. Apprehension decreases as the student feels less responsible for clients' improvement (Skovholt & Rønnestad, 1992, pp. 42-49).

**Exploration Stage.** The student has graduated, and becomes immersed in professional development, investigating the world of therapy. Self-awareness grows as the individual sloughs the “imitation” therapist and moves in the direction of individuation (Rogers, 1951, 1961). A steep learning curve, evidenced by therapists taking on tasks for which they feel unprepared, yields diminished confidence and increased anger and resentment. The therapist seeks support from peers as well as confidantes in the office. Newfound freedom is experienced as instructors and supervisors no longer have power over the individual (Skovholt & Jennings, 2004). Clinicians begin to see more clearly the importance of the therapeutic relationship, and work hard to gain new clinical skills, through which one’s personality comes into play (Baker, 2003; Rogers, 1951, 1961). Self-reflection is the primary learning mode at this stage, along with taking more responsibility for one’s actions (Kottler, 2010). From this spins uncertainty about one’s success as a therapist, and the need to form trusted collegial relationships with other professionals (Skovholt & Rønnestad, 1992, pp. 50-61).

**Integration Stage.** The therapist has worked in several positions in the years following graduation by this stage, and has acquired advanced professional status, honing in on genuine, unique style and favored techniques. Acceptance of one’s limitations and working with preferred client issues transpires. Personal insight into the change process is most important (Corbett, 2011; Rogers, 1951, 1961). Fulfillment comes from an energizing work environment, sharpening clinical skills, financial compensation and a growing sense of inner peace (Hollis, 2005, 2009). The role of “professional elder” expands and becomes professionally satisfying (Skovholt & Rønnestad, 1992, p. 66). “Individuals at this point seem to be more open in talking about how their own personal

life has affected their therapy/counseling work” (Skovholt & Rønnestad, 1992, p. 64).

Other attributes in this stage are enhanced flexibility, refined understanding of relationships, and the ability to “be deeply involved with the other person and yet distant enough from the person’s problems” (Skovholt & Rønnestad, 1992, p. 68).

**Individuation Stage.** Besides becoming more skilled with years of practice, those in this stage continue to evolve personally, becoming higher-functioning individuals (Bernard & Goodyear, 2009). Greater sense of genuineness, enhanced satisfaction with work, and a progression towards positive energy thrives (Hollis, 2009; Rogers, 1951, 1961). The caveat in this stage is a pull towards “...intellectual apathy and emotional exhaustion” (Skovholt & Rønnestad, 1992, p. 75). Growth through personal therapy is challenging and fruitful (Titleman, 1987). It is important for the clinician to avoid burnout and stay the course by utilizing good self-care, time away from work, and enjoyable pastimes (Baker, 2003; Bankson, 2010; Kottler, 2010). Emotions oscillate between gratification and dissatisfaction with work. “Distress can result from feeling one has reached a plateau on a central dimension such as competence, motivation or interest in one’s work.... [also] an unsupportive work environment” (Skovholt & Rønnestad, 1992, p. 77). Acknowledgement of one’s personal qualities and natural talents is an established fact and the counselor derives satisfaction from using these gifts to help others (Corbett, 2011; Rogers, 1951, 1961; Skovholt & Rønnestad, 1992).

**Integrity Stage.** This final stage consists of therapists who have been working most of their lives in the field, and are nearing retirement. Use of personal theories and experience dominates their practice, unless they adopt another sphere of affiliation, in which the learning curve once again increases (Hollis, 2005). The thrust is to creatively

persist in one's work, while at the same time acknowledging retirement in the fairly near future (Bankson, 2010). Acceptance becomes the theme of life and work for the clinician: accepting one's developmental stage, personal gifts, history, successes and failures, and finally, acceptance that one's career, to which so much has been given, is winding down (O'Donohue, 1997; Weaver, 2009). Loss, grief, or regret may surface as failed opportunities and endings come into view (Roese, 2005). "The role of professor/supervisor/mentor/therapist is almost always filled by an older, wiser person and the *person* at this stage is *now* [emphasis added] the older, wiser person" (Skovholt & Rønnestad, 1992, p. 91). Some therapists at this stage take renewed delight in supervising upcoming clinicians, though there is a growing pull to let go because of age. Others take great pleasure in living every day and making a contribution (Bankson, 2010; Corbett, 2011; Hollis, 2005, 2009; O'Donohue, 1997; Rogers, 1961; Yalom, 1980).

The above key stages crystallize aspects of the culture which constitute knowledge, language, values, and beliefs of the therapist. Though the profession of healer manifests many facets such as counselor or marriage and family therapist, this is the common ground on which they stand, and from which they proffer restoration and health. Several additional factors must be considered.

## **Ethics**

A strong backbone of *ethical principles* supports crucial decisions therapists encounter in their work (Beauchamp & Childress, 1979; Heppner, Kivlighan, & Wampold, 1999; Krathwohl, 1998). Ethical imperatives are fundamental and vital reservoirs from which to draw direction as a professional. Each discipline maintains its

own Code of Ethics promoting a solid foundation for assuming personal responsibility, making sound decisions, and self-reflection (Bernard & Goodyear, 2009; Corbett, 2011).

**Competence.** As claimed by Skovholt & Jennings (2004), five eminent ethical values of master therapists are noted, the predominant being competence. These clinicians are “highly motivated to move beyond the minimum competence level required... [and] place a high value on building and maintaining their skill set” (Skovholt & Jennings, 2004, pp. 109-110). Personal experience is indispensable in maximizing competence (Heppner et al. 1999; Hollis, 2005, 2009; Mason, 1996; Remen, 1996; Rogers, 1951, 1961; Skovholt & Jennings, 2004; Wolcott, 2008). “Experience, combined with clinical consultation, ongoing traditional academic training and personal reflection yields a deeper level of professional growth” (Skovholt & Jennings, 2004, p. 110).

**Relational Connection.** The second ethical value advancing personal proficiency is cultivating professional contacts and maintaining openness to supervisory and other collegial relationships (Skovholt & Jennings, 2004; Skovholt & Rønnestad, 1992). Solid relationships restore vitality and energy, thus precluding burnout (Baker, 2003; Hollis, 2005, 2009; Kottler, 2010).

**Nonmaleficence.** Nonmaleficence is the third value master therapists espouse. Counselors must be cognizant of the potential they hold for helping or hurting the client within the context of therapy. The bedrock for this principle is that individuals are not harmed by taking part in therapy or research (Beauchamp & Childress, 1979; Diener & Crandall, 1978). Recognizing one’s shortcomings encourages good therapists to keep

expanding knowledge and experiences, rather than thinking one has “all the answers” (Bernard & Goodyear, 2009; Kottler, 2010; Skovholt & Jennings, 2004; Skovholt & Rønnestad, 1992).

**Autonomy.** The fourth ethical value is autonomy. “Master therapists appear to greatly respect the phenomenological worldviews of their clients and hold the belief that for change to occur, clients, for the most part, need to be allowed to determine the direction of the therapeutic process” (Skovholt & Jennings, 2004, p. 115). Counselors provide a safe environment where clients learn to endure apprehension and unpredictability in life so as to grow into self-determination and personal freedom (Frankl, 1959; Heppner et al., 1999; Hollis, 2005; Kottler, 2010; Rogers, 1951, 1961).

**Beneficence.** Beneficence is the fifth ethical value, which conveys the clinician’s interest in relieving human suffering (Beauchamp & Childress, 1979; Corbett, 2011; Skovholt & Jennings, 2004). “Compassion must become the core” (Nouwen, 1979, p. 17). Fromm (1956) names this as “active concern for the life and growth of the other” (p. 25). For the therapist who seeks satisfaction in work, the value of beneficence encompasses its essence (O’Donohue, 1997). Speaking for the therapist, Corbett (2011) believes “...it is useful to have a framework that allows us to be with suffering with a degree of equanimity, whether the suffering is our own or that of the people with whom we work” (p. 261). Heppner et al., (1999) believe a further interpretation of this value includes giving back to the community in a spirit of altruism (p. 81).

Beauchamp & Childress (1979) suggest two additional ethical values:

**Justice.** This value is based on fairness and the declaration that all people are, or should be, treated equally (Beauchamp & Childress, 1979). “The concept of justice also implies just rewards for one’s labor, and ownership of the fruits of one’s labor” (Heppner et al., 1999, p. 82).

**Fidelity.** This principle connotes loyalty to agreements, specifically elective interpersonal relationships, such as client/therapist, or participant/researcher. “Issues of fidelity and trustworthiness are central to the helping professions” (Heppner et al., 1999, p. 82). Fidelity is fractured when contracts go unfulfilled or confidentiality is violated, resulting in lasting unintended consequences for the client as well as the practitioner and the profession at large (Beauchamp & Childress, 1979; Mason, 1996).

### **Confidentiality**

Clients are entitled to privacy and it is the practitioner’s responsibility to ensure this right to the extent it can be provided. Clinicians must discuss this principle with their clients, as there are circumstances when absolute confidentiality cannot be promised (Baker, 2003; Bernard & Goodyear, 2009; Kottler, 2010). Exceptions to complete confidentiality include the client’s intent on harming oneself or others, and it becomes the clinician’s responsibility to inform appropriate individuals or law enforcement (Diener & Crandall, 1978).

### **Informed Consent**

Informed consent is a legal and ethical agreement formulating a partnership between client and practitioner in which rules of engagement such as goal-setting,

obligations, limitations, roles of the client/therapist relationship, risks, and expectations are clarified (Beauchamp & Childress, 1979; Bernard & Goodyear, 2009). “The issue of informed consent revolves around the fundamental ethics and principles of autonomy and fidelity” (Heppner et al., 1999, p. 98). It is unequivocally necessary whenever participants may be put at risk or are asked to relinquish their rights (Diener & Crandall, 1978).

### **Unprofessional Interactions**

Therapists must conduct multiple tasks and roles in an ethical manner, being aware of the power differential which exists in counseling others as well as in supervisory relationships (Baker, 2003; Bernard & Goodyear, 2009; Corbett, 2011). Sexual association with a present client is unbecoming of a professional as well as illegal and unethical (Kottler, 2010). Sexual involvement with a previous client is also deemed unethical. Provocative clothing, posture, and language fall within this rubric as well.

There appears to be much debate and little agreement regarding nonsexual multiple relationships (Bernard & Goodyear, 2009). In the words of Corey (2009):

Some examples of *nonsexual* dual or multiple relationships are combining the roles of teacher and therapist or of supervisor and therapist; bartering for goods or therapeutic services; borrowing money from a client; providing therapy to a friend, and employee, or a relative; engaging in a social relationship with a client; accepting an expensive gift from a client; or going into a business venture with a client. (pp. 48-49)

The constantly changing therapeutic climate demands openness, reflection, and dialogue on the part of clinicians with regard to ethically-centered issues (Corbett, 2011; Kottler, 2010).



## **Therapist Self-Care**

Clinicians are oftentimes metaphorically referred to as “instruments” of healing (Baker, 2003; Creswell, 2007; Nouwen, 1972). The primary tool employed by therapists is *oneself*. To function optimally, the practitioner must be well-tuned and primed for the challenging work of caring for others’ emotional needs (Hollis, 2005, 2009; Rogers, 1951, 1961). Meticulous self-care is crucial (Kottler, 2010). Baker (2003) illuminates the following three fundamentals in this domain:

**Self-Awareness.** Of primary concern is the therapist’s sense of self (Baker, 2003; Kottler, 2010). Willingness to look at oneself honestly and objectively, with openness to change one’s thoughts and behaviors is pivotal (Bernard & Goodyear, 2009; Frankl, 1959; Fromm, 1956; Hollis, 2005, 2009; Rogers, 1961). Baker believes:

If we are not adequately self-aware, we risk acting out repressed--and thereby unprocessed and unmanaged--emotions and needs in ways that are indirect, irresponsible, and potentially harmful and costly to our self, personally and professionally, and to our patients, family, and others....we may unconsciously and unintentionally neglect our patients or exploit them to meet our own needs for intimacy, esteem, or dominance. (p. 14)

**Self-Regulation.** This label applies to the control we have of our physical and psychological urges and inclinations (Baker, 2003). Being able to focus on and manage our personal lives as well as relationships is vital to abiding self-esteem and wholeness (Hollis, 2009; Kottler, 2010; Skovholt & Jennings, 2004). Setting appropriate boundaries and knowing when to ask for supervisory assistance is essential (Bernard & Goodyear, 2009). The proficiency for self-regulation escalates as self-awareness is strengthened (Corbett, 2011; Hollis, 2005, 2009; Rogers, 1961).

**Balance.** Balance is crucial in living out one's needs and desires in a healthy way personally as well as professionally. Regarding balance, Mahoney (1997) suggests the fulcrum:

I've begun to realize that you can't be working at the boundaries without a sense of the center.... that's what life is... always in movement and often off-balance a little bit. You never quite attain the static equilibrium which, of course, would be the end of life if you did...but learning to catch myself at earlier and earlier moments of leaving center, and coming back to that. (p. 16)

Nouwen (1972) refers to the healer who attempts to “reach a moment, a point or a center, in which the distinction between life and death can be transcended and in which a deep connection with all of nature, as well as with all of history, can be experienced” (p. 16). This describes yet another liminal space.

#### **Four Dimensions of Wellness**

Therapists influence clients in multitudinous ways, and for this reason, sustaining a healthy way of life and engaging in its fullness is of vital import (Baker, 2003; Kottler, 2010). “Our most powerful technique is our ability to model aliveness and realness. It is an ethical mandate that we take care of ourselves” (Corey, 2009, p. 34). Literature identifies four key interrelated spheres upon which a therapist can build a healthy, balanced practice: physical, emotional, sociocultural, and spiritual (Roper, Logan, & Tierney, 1996). Each domain will be further elucidated.

**Physical.** In order to promote a genuine, holistic spirit, practitioners are well-advised to make the same healthy choices they ask of their clients. Physical considerations over which the individual has some control, such as adequate

nourishment, sufficient rest, ample exercise, and bridled use of alcohol determine one's desire to continue choosing life (Baker, 2003; Kottler, 2010; Rogers, 1961).

**Emotional.** Clinicians' effectiveness, positive spirit, and authenticity are greatly enhanced by pursuing their own psychotherapy. Through exploration of life experiences, perspectives, wounds, weaknesses, and issues, one can grow personally as well as professionally (Baker, 2003; Corbett, 2011; Hollis, 2005; Rogers, 1961). In the succinct words of Corey (2009):

As counselors we can take our clients no further than we have been willing to go in our own lives. If we are not committed personally to the value of examining life, we will not be able to convince clients the worth of personal exploration. (p. 21)

Dissecting one's own life may appear formidable: it is not for the faint of heart. However, recurring rewards arising from the journey within enhance one's life personally and professionally (Arrien, 1992; Bankson, 2010; Sheldrake, 1995). From a personal standpoint, therapy urges the individual towards growth, change, integration, greater wholeness and increased self-confidence (Hollis, 2005, 2009; O'Donohue, 1997; Titelman, 1987). The process of parsing one's own woundedness and lifting out barriers to growth becomes a truly freeing experience (Lewis, 1961; Love, 2007; Nouwen, 1972; Tick, 2005; Weaver, 2009). At the least, it would be wise for practitioners to seek therapy during inevitable developmental life changes, since unfinished issues are likely to re-emerge during these times (Carter & McGoldrick, 2005; Worden, 2009). Professionally, it is helpful for the clinician to experience being in the "other chair" in order to see through the eyes of the client (Callahan & Dittloff, 2007; Skovholt & Rønnestad, 1992; Stratton et al., 2007).

**Sociocultural.** Associations with people immersed in similar interests such as sports, music, arts, or other hobbies all increase one's circle of stimulating connections (Bankson, 2010; Hollis, 2005, 2009). Likewise, interacting with various cultural and ethnic groups broadens and enriches the practitioner's worldview (Bernard & Goodyear, 2009; Monk et al., 2008; Sue & Sue, 2004).

**Spiritual.** A sense of one's spirituality rounds out the factors necessary for the thriving therapist's consideration (Fromm, 1956). Corbett (2011) proposes:

...the spiritual search can be added to the list of motivating factors which are important in self-regulation, self-organization, and relationships with others. I do not believe that we progress from the psychological to the spiritual levels, with the implication that the spiritual is somehow higher, because the spiritual dimension is present at all levels of the psyche. (p. 150)

Those who enter therapy, either as a client or a practitioner, generally seek further depth and meaning in life (Frankl, 1959; Hollis, 2005, 2009; Weaver, 2009). Pursuit of higher consciousness embraces compassion, verve, gratitude, and solid relationship with God, others, self, and nature (Bonhoeffer, 1953; Fromm, 1956; O'Donohue, 1997).

### **Integration**

Ultimately, the role of therapist is to stand with the client, in the liminal space between "place and journey" (Sheldrake, 1995), the "endbegin" (Remen, 1996), perhaps using a "life map" (Bankson, 2010), and assist that individual in transitioning to the other side, which holds promises of insight, growth, meaning, and peace. This study sought to explore how the therapist, transformed by personal experiences of loss and grief, influences and promotes the client's resolution and healing in this journey.

## CHAPTER III

### METHODOLOGY

The experiences of loss and grief are at once heartbreaking, diverse, and ubiquitous (Attig, 1996; Becker, 1973; Becvar, 2001; Ellis, 2006; Lewis, 1961). For those who recount their sorrowing story, the potential for healing is tenable (Love, 2007; Neimeyer, 2001; Nouwen, 1972; Tick, 2005). It appears the *only* way grief is truly resolved, the *only* way one passes through the portal of mourning is through the telling of one's story, perhaps many times over (Anderson, 1997; Becvar, 2001; Ellis, 2006; Freedman & Combs, 1996; Parkes, 1996; Tick, 2005; Walsh & McGoldrick, 1991; Worden, 2009; Yalom, 1980). In order to heal, we seek out those who are trained in the art of listening (Anderson, 1997; Freedman & Combs, 1996; Rogers, 1951, 1961; Satir, 1972, 1983; Worden, 2009), and who are considered wise (Hollis, 2005, 2009; Keeney, 1983), to help us through this narrow threshold. In our current society, those whom we presume hold these gifts dwell within the vocation of the psychotherapist (Corbett, 2011; Farnsworth, 1975; Parkes, 1996; Rogers, 1961; Walsh & McGoldrick, 1991). Focus on the meaning of therapists' lived experiences of loss and grief propelled the research design of this inquiry.

#### **Qualitative**

This research was created to determine common threads among therapists who have personally experienced loss and grief, and how these aforementioned phenomena

have influenced them and their work. Consequently, this particular study lent itself well to qualitative analysis.

As stated by Denzin & Lincoln (1998), qualitative research suggests “an emphasis on *process and meanings* [emphasis added] that are not rigorously examined, or measured.... Qualitative researchers stress the socially constructed nature of reality, the intimate relationship between the researcher and what is being studied, and the situational constraints that shape inquiry” (p. 8). Supplementing this view, Creswell (2007) stresses, “the *process* of research [as] flowing from philosophical assumptions, to worldviews, and through a theoretical lens, and on to ...studying social or human problems” (p. 37). The subject matter of this work demanded a sensitive, non-judgmental attitude, and attention to process (Fetterman, 1998; Moustakas, 1994; van Kaam, 1966).

### **Research Design**

In examining lived experiences of the therapist, the most appropriate design for this research was a qualitative analysis, specifically using the phenomenological approach. Historically, the philosophical term *phenomenology* came into use as early as 1765 (Kockelmans, 1967). “What appears in consciousness is the phenomenon. The word *phenomenon* comes from the Greek *phaenesthai*, to flare up, to show itself, to appear.... Phenomena are the building blocks of human science and the basis for all knowledge” (Moustakas, 1994, p. 26).

Edmund Husserl (1859-1938), mathematician and philosopher at the turn of the twentieth century, is considered the founder of phenomenology, which aims at understanding anything experienced through consciousness, rather than objective analysis

(Georgi, 2009). His interest was in uncovering meaning not through the “real world,” but “in perceptions, judgments, and feelings *as such*, in their *a priori* nature, in their very *essences*” (Kockelmans, 1967, p. 79). Husserl’s philosophy influences data collection and analysis in this dissertation with purposeful findings, that is, essences, relevant to therapy.

Although there are several possible research phenomenological models from which to choose, such as Hermeneutic (Dilthey, 1976), and Empirical Phenomenological (Georgi, 2009; van Eckartsberg, 1986; van Kaam, 1966), the one which best suited this researcher *and* the study is the Heuristic model (Moustakas, 1994). This framework provided the necessary constructs by and through which this researcher could best understand and discuss the experience of therapists’ loss and grief. “The self of the researcher is present throughout the process and, while understanding the phenomenon with increasing depth, the researcher also experiences growing self-awareness and self-knowledge” (Moustakas, 1994, p. 17). Self-discovery was inherent in this model as the researcher sought to answer personal questions of significant import.

In clarifying these constructs, Moustakas (1994) relates four key points which distinguish the Heuristic model from others. First, the inquiry draws from a deep and broad base rather than a single situation. Second, in addition to narratives, the investigator used other personal artifacts such as photos, poetry, music, and art that portrayed and enhanced the experience. Third, the focus was on individual accounts rather than broad brush-stroke dynamics. Fourth, participants were regarded as whole persons and vital throughout the investigation, “...telling their individual stories with increasing understanding and insight.... in vivid, alive, accurate, and meaningful

language” (Moustakas, 1994, p. 19). Once the stories of participants’ conscious, lived experience were gathered and transcribed, and artifacts and documents were assembled, the researcher created individual portraits. From this “a composite depiction is developed.... [into a] creative synthesis” (Moustakas, 1994, p. 19).

The intent of this research was to discover the meaning of the clinicians’ encounter with loss, and to furnish a detailed description of it (Moustakas, 1994; Stake, 1995). Through personal narratives participants spoke of their loss, how they persevered, and how their work with others had been influenced by this loss. Due to the very personal nature of inquiry regarding one’s loss, great care was taken to promote the clinician’s experience of healing and “really feeling understood” (van Kaam, 1966, p. 325), thus encouraging a positive outcome.

### **Assumptions and Rationale for Design**

The benefits of using qualitative analysis for this particular phenomenological inquiry were many. This researcher is open-minded and curious about the subjects of loss and grief, with the goal to refine knowledge gathered within context and to bring vigor to a topic often considered tenebrous and bleak (Fetterman, 1998). Stake (1995) suggests a rationale for employing qualitative design:

A distinction between what knowledge to shoot for fundamentally separates quantitative and qualitative inquiry....the distinction is related to a difference in searching for causes versus searching for happenings. Quantitative researchers have pressed for explanation and control; qualitative researchers have pressed for understanding the complex interrelationships among all that exists. [It is] the distinction between inquiry for making explanations versus inquiry for promoting understanding. (p. 37)



The purpose of this research was to explore, with a positive, fresh, and holistic approach how loss and grief affect those who share in the culture of psychotherapist-clinician-healer (Creswell, 2007; Krathwohl, 1998). This community of therapists is bound together with “an underlying cohesiveness” (Wolcott, 2008, p. 95), a shared infrastructure comprised of common values, beliefs, behaviors, mores, and specific means of communicating. The subject matter in this research was well suited to be scrutinized as a phenomenology.

### **Philosophical Assumptions Underlying Qualitative Research**

Several philosophical assumptions underpin the researcher’s selection of a qualitative research design (Creswell, 2007; Guba & Lincoln, 1994; Mason, 1996; Maxwell, 2005). These concepts will here be explicated from this researcher’s socially constructed worldview.

**Ontological.** This assumption refers to the essence of reality. Bateson (1972) considers “how things are, what is a person, and what sort of world this is” (p. 313). This researcher recognizes the presence of multiple realities, primarily based on interviewing numerous individuals offering differing personal viewpoints (Bateson, 1972, pp. 18-19). “A shared ontology is largely the byproduct of a common language” (Gergen, 1999, p. 81). Observation and common language, both verbal and non-verbal, yield a subjective reality as perceived by both participants and researcher in this inquiry. This researcher views reality through varying perspectives proffered by the participants.

**Epistemological.** “There are the problems of how we know anything, or more specifically, how we know what sort of world it is and what sort of creatures we are that

can know something (or perhaps nothing) of this matter” (Bateson, 1972, p. 313). Mason (1996) deems epistemology as “...[one’s] theory of knowledge....and how [this] knowledge can be demonstrated” (p. 13). The epistemological assumption applies to the researcher’s commitment to become knowledgeable of and as much a part of the participants’ lives as is appropriate. This researcher has spent several years in effort, study, and networking to become a competent therapist, pursuing higher education and broadening the scope of personal proficiency and clinical knowledge.

**Axiological.** The question is: how do the values of this researcher and the research interrelate? In the words of Creswell (2007), “the inquirers admit the value-laden nature of the study and actively report their values and biases as well as the value-laden nature of the information gathered from the field” (p. 18). This researcher places a high priority on being cognizant of and clarifying her values through persistent inquiry and frequent discussions regarding value-laden issues.

**Rhetorical.** On the subject of rhetoric, the question arises: how is this research affected by language? “The use of language and specific terms is very important for creating a ‘sharedness of meanings’ in which both interviewer and respondent understand the contextual nature of the interview” (Denzin & Lincoln, 1998, p. 68). It is the intent of this researcher that the parlance of this qualitative study is literary, yet personal and appealing to the reader, with creative use of metaphor and development of meaningful interpretations (Bateson, 1972; Corbett, 2011; Denzin & Lincoln, 1998; Duhl, 1983).

**Methodological.** Creswell (2007) specifies, qualitative methodology is “characterized as inductive, emerging, and shaped by the researcher’s experience in

collecting and analyzing the data” (p. 19). Since this researcher is also a clinician interviewing other therapists, rationale underpinning the methodology arose from within this context, and research questions were assessed as need became apparent (Creswell, 2007; Stake, 1995). Her receptive stance and inquisitiveness with respect to how individuals discern meaning in their lives set the scene for phenomenological study (Krathwohl, 1998; Moustakas, 1994).

**Paradigm or Worldview.** Bateson (1972) states, “All [qualitative researchers]...are philosophers in that universal sense in which all human beings...are guided by highly abstract principles” (p. 313). These theoretical tenets determine how one views the world. Creswell (2007) explains, “Paradigms used by qualitative researchers vary with the set of beliefs they bring to research, and the types have continually evolved over time” (p. 19). The paradigm this author espouses is under a social constructionist framework. This notion suggests meanings are interpreted through the individual’s subjective narrative discourse (Anderson, 1997; Denzin & Lincoln, 1998; Gergen, 1999; Maxwell, 2005). The mastery of one’s world is built upon interaction with others, and influenced by historical and societal standards that operate within the individual’s experience of reality (Creswell, 2007; Freedman & Combs, 1996; Gergen, 1999). The intent of this research was to rely upon therapists’ perceptions as they shared their experiences of loss and grief, and how these events have impacted their lives. This illustrates the author’s ontological perspective by acknowledging the presence of multiple realities and individual differences advanced by each participant.

## Participants and Role of the Researcher

The amicable relationship between researcher and participant is crucial in a successful phenomenology (van Kaam, 1966). Trust and solid rapport must evolve in order for honest and valuable information to emerge (Creswell, 2007; Spradley, 1979). Participants were viewed as co-researchers who were able to articulate the meaning of their lived experiences of loss and grief (von Eckartsberg, 1986). Understanding the participants' personal worldviews was balanced with observation (Denzin & Lincoln, 1998). Wolcott (2008), believes:

Researchers [are] indoctrinated so rigorously in rigor that they no longer appreciate or trust what each of us accomplishes through *personal experience* and may need to be reminded of the *human capacity for observation* [emphasis added] and to recognize that ultimately everything we know comes to us that way. Participant observation is founded on firsthand experience in naturally occurring events. Today, we no longer have to pretend to a level of objectivity that was once fashionable; it is sufficient to recognize and reveal our subjectivity as best we can. (p. 49)

## Participant Selection

Following approval from the St. Mary's University Institutional Review Board, participant selection began. Participants were local therapists apprised of this research by word of mouth. News of this study quickly extended into the professional community so much so that dispersal of a solicitation letter became unnecessary due to a spiral of curiosity in this topic. When the interview was scheduled, participants were given a letter in which a brief description of each classification of grief was defined. Those who wished to take part determined their most appropriate grief situations. The interview

consisted of therapists telling stories of their conscious, lived experiences of loss and grief, and how their work has been impacted by these events.

Participants were Counselors, Marriage and Family Therapists, Psychologists, and Pastoral Caregivers. They were provided an informed consent document to sign before the interview process began and received a copy for their personal records (Bernard & Goodyear, 2009; Krathwohl, 1998). Bearing in mind the need for confidentiality, this researcher made every effort to meet with the participants in their offices or other contextual locations of their own choosing, since details are best gathered in the natural setting of the participants (Maxwell, 2005; Spradley, 1979; van Kaam, 1966). Though time constraints existed, this research was not hurried, but maintained a thoughtful and focused perspective (Moustakas, 1994; van Kaam, 1996). Participants were not compensated monetarily in return for participation in this research study; however, perquisites became apparent in the opportunity to tell one's story of loss to someone who truly cares. Participants were apprised of grief experts in the local community, should this interview stir up personal issues needing resolution. Thus far, it has been this researcher's experience that when asked to talk about one's encounter with loss or grief most individuals are more than amenable to telling their story.

### **Role of the Researcher**

Foremost, use of a qualitative phenomenology best fit the style of this researcher, who conveys a curious, compassionate, and humane interest in the tenor of this study (Moustakas, 1994; Wolcott, 2008). Creswell (2007) describes the researcher as a "key instrument" in the process of qualitative analysis, rather than depending on surveys and

other measurement devices (p. 38). According to Denzin & Lincoln (1998), each researcher brings to the table a “personal biography...who speaks from a particular class, racial, cultural and ethnic community perspective...[and] configures, in its special way, the multicultural, gendered components of the research act” (p. 23). From this personal biography, presuppositions spawn, which are composed of the “unquestioned belief that things are what they appear to be, and that all sane persons share the same world” (Barker, Pistrang, & Elliott, 2002, p. 77). In addition, the researcher suspended personal, lived experience by the use of *epoché*, or “bracketing,” setting aside these expectations and assumptions in order to be fully present to the participant as well as “take a fresh perspective toward the phenomenon under examination” (Creswell, 2007, pp. 59-60).

This researcher has encountered loss and grief professionally as well as personally over much of her adult life. As a Registered Nurse for many years, she worked with oncology (cancer) patients on a 30-bed hospital unit, as well as leading weekly support groups for patients and those who care for them. She has spent innumerable hours caring for the terminally ill in hospice settings, supporting not only their physical requirements, but emotional and spiritual needs of patients and families, as well. Personally, she cared for her mother and father, as well as a younger brother, all suffering from terminal cancer (at different times). Each was able to die comfortably at home in their own beds, surrounded by family members. Additionally, the vicissitudes of life have brought other occasions of loss, from which she has grown and become curious regarding the grief experiences of others. This author has been astonished at the lack of insight therapists demonstrate concerning loss. That people in general do not want to discuss loss and grief is no surprise, but that clinicians so often miss the silent cues of anguish presented by

their clients is incongruous. For this reason, exploring therapists' experiences of loss and grief was the thesis of this writing. The impetus for this study was to investigate this incongruity.

### **Data Collection Procedures**

The type of information collected in this phenomenology was of a personal nature. Therapists were asked to share their particular experiences of loss and grief in a single interview. Every care was taken to promote a respectful, positive, and non-threatening atmosphere wherein the individual felt safe and free to tell their story (Freedman & Combs, 1996; van Kaam, 1966). Since the interviews transpired in the clinician's choice of location, this mitigated the potential for discomfort (Creswell, 2007; Spradley, 1979), and perhaps enhanced the possibility of healing (Corbett, 2011; Wampold, 2001).

Questions were clear, understandable, and open-ended to promote ease in telling one's story, and to allow for expounding on thoughts and feelings as they arose (Anderson, 1997; Krathwohl, 1998; Rogers, 1951). The conversations were digitally recorded, transcribed, and stored on computer files (Creswell, 2007; Denzin & Lincoln, 1998; Maxwell, 2005). These documents were locked and retained in the researcher's office. Interviews lasted approximately sixty to ninety minutes, though this researcher remained flexible with time allotments. Due to the unique character of this subject matter, written questionnaires and other such impersonal instruments were not utilized.

Two questions were asked of the therapist-participant population: (1) What is your personal experience of loss and grief? (2) How has your personal experience of loss and grief impacted your work with clients?

### **Strengths and Weaknesses of Data Collection**

#### **Strengths**

Since this phenomenology maintained a narrative approach, stories told provided a holistic, diverse, and original strategy to understanding the vocation of clinicians and how loss and grief have impacted them personally and in their work (Krathwohl, 1998; Moustakas, 1994). This produced the potential for a dynamic and expanding study built upon realism (Creswell, 2007), since it was created by the researcher from an emic or insider's point of view (Krathwohl, 1998; Stake, 1995; Wolcott, 2008). Gaining access to this population was facilitated by networking with the researcher's colleagues in the various fields of psychotherapy (Creswell, 2007). Use of a translator was not necessary, since data was collected using the author's native language (Spradley, 1979).

#### **Weaknesses**

The nature of qualitative phenomenological inquiry presumes a relatively small sample in order to obtain information of sufficient depth and breadth to discover the essence of clinicians' experience of loss. Additionally, this sample was less ethnically and gender diverse than the general population of therapists, yielding limited transferability of findings (Creswell, 2007; Krathwohl, 1998; Wolcott, 2008).



## Data Analysis Procedures

After collecting, assembling, and cataloging data, the next step was to search for significant statements, in a process called “horizontalization,” wherein each account was regarded as having equal value and relevance to the research (Creswell, 2007; Moustakas, 1994). Systemic consistencies and topics within the narratives were then gathered into meaningful units called “clusters,” yielding prevalent themes common to the participants (Creswell, 2007; Moustakas, 1994). This information was sorted into relevant components or “codes,” which were then refined to determine the frequency of significant themes (Creswell, 2007, Stake, 1995). Textural description of these themes became the essence of this phenomenology (Moustakas, 1994). Care was taken to associate themes to the literature and culture of the group under scrutiny (Krathwohl, 1998; Spradley, 1979).

Fetterman (1998) offers incisive strategies for data analysis from which this research was drawn. First, *a clear, open mind* addressing pertinent and attainable information was essential in accomplishing this project (pp. 92-93). Researching therapists’ grief experience and their subsequent transformation is not only relevant, it is also a viable undertaking. It appeared most individuals, when given the opportunity to tell their grief story to someone who truly cares, grasped at this chance.

Second, the use of *triangulation* was recommended to demonstrate trustworthiness and authenticity (Fetterman, 1998). Triangulation may improve the quality of data and the depth, accuracy, and richness of phenomenological discovery (Heppner, et al., 1999; Krathwohl, 1998; Mason, 1996; Stake, 1995). This researcher

secured two other clinicians to read the narratives and assist in identifying underlying themes.

Third, *recognizing patterns* of behavior and thought became part of data analysis (Fetterman, 1998). After data collection, the phenomenologist has a network of information to sort out into groups of applicable material. Next, comparisons were made until an identifiable thought or behavior emerged. Eventually, further themes began to materialize yielding additional patterns. “The level of understanding increases geometrically as the (researcher) moves up the conceptual ladder – mixing and matching patterns and building theory from the ground up” (Fetterman, p. 97). Use of the software program MAXQDA was essential in storing, organizing, interpreting, coding, and classifying emerging themes.

Fourth, discovery of *key events* within the therapists’ narratives presented a portal through which to observe this particular group of individuals (Fetterman, 1998). “In many cases, the event is a metaphor for a way of life or a specific social value” (p. 99). These events were significant in that they helped the researcher understand the lived experience of the therapist.

Fifth, use of *content analysis* was performed in a similar way that observed behavior is evaluated. Researchers “triangulate information within documents to test for internal consistency. They attempt to discover patterns within the text and seek key events.... Because this material is often in a database...extensive manipulation...is even simpler” (Fetterman, 1998, pp. 102-103). Juxtaposing content analysis data and observed data appreciably strengthens “quality of findings” (p. 103).

The stirring image of a crystal symbolizes Fetterman's (1998) sixth strategy. It is "typically the result of a convergence of similarities that spontaneously strike the investigator as relevant or important to the study" (Fetterman, 1998, p. 108).

*Crystallization* manifested as pertinent information became clear to the researcher. This metaphor best fits the investigator's notion of phenomenological research being multidimensional and vibrant. According to Richardson & St. Pierre (2005):

"Crystals are prisms that reflect externalities and refract within themselves....What we see depends on our angle of repose....Crystallization, without losing structure, deconstructs the traditional idea of "validity"; we feel how there is no single truth, and we see how texts validate themselves. Paradoxically, we know more and doubt what we know. Ingeniously, we know there is always more to know. (p. 963)

Repeated analysis was necessary as significant patterns, themes, and details surfaced, requiring the pursuit of further investigation.

### **Methods for Verification**

Two methods were used in order to establish trustworthiness and authenticity in this inquiry. (1) The interview sessions were digitally recorded and transcribed verbatim. Once the original transcript was completed, it was sent to the participant using a process called "member checking" to verify this conversation for accuracy, and make any necessary changes (Stake, 1995). (2) Investigator triangulation was utilized, where two other therapists well versed in loss and grief issues, surveyed the interviews and discussed insights with this researcher (Fetterman, 1998; Krathwohl, 1998; Wolcott, 2008). If participants were interested in the results, the findings of the overall themes were made available.

## CHAPTER IV

### RESULTS

“...and maybe stories are just data with a soul.”

Brené Brown, TEDxHOUSTON, June 2010

Data collection became a most powerful component of this dissertation.

When word spread among the professional community that therapists had the unique opportunity to tell their story of loss, volunteers readily offered to participate.

Surprisingly, distribution of a solicitation letter was deemed unnecessary due to the groundswell of interest in this topic. Once the interview was scheduled, participants were given the mandatory paperwork, including consent form, and the required procedures and signatures were accomplished.

Interviews were recorded, transcribed, and subsequently each participant received a copy to review and make any necessary changes before returning it to the researcher.

In addition, two clinicians well versed in the field of grief therapy read the verbatims to assist in identifying underlying themes. Confidentiality was assured by the use of pseudonyms in all documents. Furthermore, the researcher maintains sole access to sensitive information concerning each participant.

In order for the reader to better understand each participant, a brief biography is provided.

## Descriptive Data

**Participants.** Ten individuals were interviewed, eight women and two men.

Ages ranged from late 20s through late 70s. There were five MFTs and five LPCs. Two clinicians had additional training in Pastoral Care. Each individual was quite eager to be involved in this research. Most included God or a higher spiritual power in their story; however, a few seemed to have no place for this in their lives. Some were brought to tears as they spoke; others appeared rather detached. The stories of loss were wide-ranging and poignant; some included humorous anecdotes, others were replete with pathos.

Table 1

### *Summary Demographics*

<b>Name</b>	<b>Age</b>	<b>Race</b>	<b>Occupation</b>	<b>Years of Experience</b>	<b>Level of Education</b>
Eileen	79	Caucasian	LPC/Educator	20/40	M.A., M.Ed.
Brylee	29	Caucasian	MFT	4	M.A.
Fiona	48	Caucasian	MFT	9	M.A.
Alec	35	Caucasian	LPC	5	Ph.D.
Claire	49	Caucasian	LPC	7	Ph.D.
Norah	54	Caucasian	MFT	9	Ph.D.
Tori	28	Asian	MFT	5	M.A.
Leah	51	Caucasian	MFT	4	M.A.
Sheila	65	Caucasian	LPC	28	M.A.
Daniel	67	Caucasian	LPC	32	M.A.

## Overview of Participants

### Eileen

Eileen is a 79-year-old MFT who has worked in the field for over 30 years. She is also an educator, and has taught pre-kindergarten through college courses throughout her life. Passionate about children, she confidently and creatively deals with conflict-resolution and other issues specifically pertaining to bullying. She uses play, art, and talk therapies.

Her demeanor was warm and friendly, always eager to meet new people and learn about “what it means to be *you*.” This is a favorite line of hers. She is the oldest participant in this study, and despite health concerns and the relatively recent loss of her second husband, she does not let these obstacles stop her. She loves life.

Growing up in Annapolis, MD, Eileen is the middle of three sisters. There was no mention of childhood hurts or loss during the interview. Early on, she spoke of losing her first husband. He was a Naval officer, and together they had four children. She adored this man and her life as a military wife and mother. Over the course of the eleven years they were married, he became a very abusive alcoholic. On one occasion, he held their children hostage at gunpoint. Though she tried hard to please him, this eventually resulted in her loss of self and her “voice.” The ensuing divorce, though heartbreaking, gave her the moxie to further her education and improve life for the children. Not surprisingly, some of her children suffered emotional problems and experience issues to this day.

Many years later, she met a dashing, brilliant therapist, and they married. Through life's ups and downs, they truly enjoyed one another. They were married nearly 20 years, when his health began to decline with a series of strokes, leading to her necessary decision to remove him from the ventilator Christmas Day, 2010. She is now retired, and helps care for her 14-year-old granddaughter, who is undergoing chemotherapy for non-Hodgkins lymphoma.

### **Brylee**

Brylee is a woman in her late-twenties who loves her work as an MFT. She humbly and fervently lives out her Mormon faith, which is the foundation for her life. She grew up in Colorado, and is the eldest of five children. Her husband's job brought them to San Antonio several years ago.

The Mormon culture encourages very short engagements so couples can marry quickly and begin having large families. There was no reason for this couple to believe they would not have a nest full of children - until month after month no pregnancy occurred. All around her, friends who had married around the same time were adding babies to their families, and yet Brylee's arms were empty. This caused deep sadness and feeling "left out" of the rhythms of life.

Finally, pregnancy test results were positive, and they eagerly anticipated parenthood. She enjoyed sharing the excitement of pregnancy with family and friends, though physically, she did not feel well. While visiting her parents in Colorado (at six months' gestation), she began to feel alarmingly ill. Brylee's mother brought her to the emergency room, and it was determined she would miscarry this long-awaited little boy.

Her husband was working in San Antonio at the time of this crisis, and telephone connections were inconsistent. He caught the earliest flight to CO, which was the next day. Brylee miscarried their son, mother at her bedside, who intermittently left the room to phone updates to her son-in-law. When he arrived the next day, they were taken to the room where the baby was and mother and father were able to hold him.

When they flew home, her body's pregnancy hormones lingered, a further reminder of what Brylee had lost. In her grief, she has written poems and created a lovely mountain garden which is maintained by the local Boy Scout troop. Future pregnancy is on hold at this time.

### **Fiona**

Fiona is in her mid-late forties, and works as an MFT. She is happily married without children, and is the middle of five siblings. While she is personable, she does not appear particularly warm or inviting. She was very eager to participate, however, and considerable mutual effort was made to provide the interview.

She told the story of her older sister who was diagnosed 13 years ago with an aggressive form of Multiple Sclerosis, a progressively debilitating disease which affects the central nervous system. There is no cure for this condition, and how the family deals with it is the essence of this participant's story of loss. Currently 53, her sister Alice had always been single, independent, and rather inflexible. This rigidity has only worsened as her health has declined. The parents are elderly, and neither can turn down their ill daughter's demands for help, despite the fact that there truly are some things she can do on her own. Fiona does not live in the same city as her parents and sister, but makes the



four-hour drive weekly to help each of them with chores and transportation. Other siblings simply have left town, returning only for holidays, and choose not to help at all.

Loss is experienced in how this fractured family spins around a member who is very physically and emotionally needy, and yet she does nothing to ingratiate herself or contribute to the vitality of the familial unit. In fact, Alice's abusive behavior and unwillingness to accept help turns others away. Compassion and hope for change motivate Fiona to keep returning to the scene; however, guilt is a stronger driver for her. For example, she cannot fully enjoy a family trip or holiday because her big sister has special needs, and is unable to or chooses not to attend.

### **Alec**

Alec is an LPC in his mid-thirties, the father of two young children, who is very involved in their education and welfare. He is warm and gentle, and portrays interest in others. His office contains several of his original paintings, displaying a talent which he recently discovered as a result of his loss.

Within the past five years, Alec admitted to himself and the world that he is gay. Though divorce followed, he maintains a strong commitment to his former wife and their children. The loss he described concerned his first relationship after coming out. Alec felt completely authentic with this man and enjoyed the time they spent together. The relationship went well for about a year until his partner began picking fights and appearing short-tempered, volatile, and mean. Things generally disintegrated between them, causing Alec to seek a variety of therapies: medication, breath work, and art therapy. While this mitigated emotional pain, the relationship continued to deteriorate as

his partner's physical health declined precipitously. A trip to the ER landed the partner in ICU with symptoms of pneumonia, and Alec in the formidable position of being responsible for life and death decisions. The partner feared HIV, but stated previously he had been tested with negative results. Over time, his story began to unravel, as did the relationship. What he had told Alec did not match with what he was experiencing. After some time in ICU, it was determined the partner was indeed HIV Positive and deteriorating rapidly with full-blown AIDS. Alec was put in a very untenable situation between his partner and the partner's family, who appeared detached from their son. Ultimately, Alec recognized the need to extricate himself from this situation, offer forgiveness, and bid farewell.

### **Claire**

Claire is a bright, good-natured woman is an LPC in her late forties who is happily married and the mother of two grown children. She maintains a solid, refreshing sense of spirituality and belonging in the world, and the atmosphere surrounding her appears safe and welcoming.

She noted her losses: her parents' divorce when she was a child, the death of her stepfather, the deterioration of her relationship with her brother, and challenges with her rather unstable mother. Claire married very young, and after one miscarriage, their son was born. This marriage did not last, and she became a single mother. Claire eventually found a good job with a very promising career - and this is where she met a wonderful man and they married. Because both were in forward-moving careers at the same place, she decided to quit work and focus on their new marriage. This was when Claire began

to grieve not only the loss of her first marriage, but also the loss of her high-powered job and all its benefits. This brought her to a serious loss of identity and resulting depression. Claire sought therapy, and from this, decided to return to school and earn an MBA. Her second baby was born, and she began teaching at the college-level. Life provided an opportunity to return to school to further her education in counseling, which she enjoys.

Challenges with her mother persist, and she continues to grieve the loss of her childhood, in which *she* became the caretaker of her mother. This role carries on today, since her stepfather has died, and mother moved nearby. The barren relationship with her brother remains static.

### **Norah**

Norah is a 54-year-old woman has been a successful MFT for several years. She has a quick wit, strong personality, and described heart-wrenching loss and grief.

She began by recounting the loss of family members: her father, a sister, and a nephew. However, the first serious loss she described was the divorce from her third husband. He was the stepfather to her children, and very abusive. Norah had held a highly successful job (not as a therapist) when she met him, and because they married, she had to leave her job. This was a major blow to her self-esteem. During the pre-divorce days, Norah also had a very difficult hysterectomy, and needed to take care of her young children post-op, with no help from him. This loss and general upset was superseded only by the very recent death of her 25-year-old son, a Marine Lance Corporal, killed by friendly fire in Afghanistan.

Norah described in great detail how she heard the news, the necessary communication between his father and herself, and the protocol required by the military to “care for their own.” To a non-military mother, this in itself was foreign and restrictive. In addition, it was a “high profile” death, with media coverage of the military funeral. Hundreds of people were in attendance. In order to deal personally with this profoundly sad situation, she helped create a photo video of her son, which was shown at his “Celebration of Life” after the military observance. Also, Norah has dedicated a wall in her office waiting room to her son’s memory, displaying photos, his military awards, and other memorabilia. She believes this helps her clients open up and ask her about how she is doing, and this leads them to talking about their own situations. Dealing with this grief is often a moment-to-moment issue for her. Though the military offers counseling for the rest of her life, Norah is not certain this will alleviate her pain.

### **Tori**

Tori, the youngest participant in this study, is in her late 20s has a background in both Pastoral Care and MFT. She has continued straight through with her education, garnering two Master’s degrees and now working on her Ph.D. She is lively, curious, and demonstrates interest in many areas. She is the middle of three sisters, and has a significantly strained relationship with her older sister. The younger sister is developmentally challenged. Tori dearly loves her younger sister, and vice versa.

The first loss she recounted was that of her grandfather, who died by falling off a ladder when she was ten. She was aware of the grief of others around her, but not truly upset herself. Tori’s beloved dog died when she was 18, and she remembers this loss.

Subsequent losses include broken relationships with men. She did describe the loss of feeling special to her uncle. When she was born, he took a shine to her and they had a good relationship throughout her life. Tori enjoyed being treated like his little sister. Once he married and had a little girl of his own, the relationship changed, and he began treating Tori as an adult. She was not expecting this, and realized it as loss.

Over the course of her various educational programs, she made friends with classmates and roommates. When she graduated and moved on, she recalled these as losses, since life would never be the same among these friends again. This was also somewhat true when she left her family of origin to attend college. Although she was not far from home, Tori no longer had the protection from her father she had always assumed would be there. The antagonistic feelings between herself and her older sister linger, and now may worsen since her sister recently announced her first pregnancy. She does not feel loved by this sister, and does not see potential for healing.

### **Leah**

Leah is a highly creative woman in her early 50s, who decided to become an MFT in the second half of her life. Her three children are grown, her husband is a retired military officer and she puts her keen mind to good use working with young women addicted to drugs and alcohol.

Her childhood was fraught with serious physical, sexual, and emotional abuse at the cruel hands of her parents and other relatives. She is the third of four children, and when her mother hadn't gained weight the last two months of her pregnancy, they

prepared for a stillbirth. Leah states she felt her mother had already disconnected from her emotionally, even before birth.

The utter instability of her parents drove her to leave home at age 18 and she set out to become a culinary expert. This provided a lucrative forum for her to become self-sufficient. Leah's first relationship did not last, though it produced a baby boy. This child became severely ill with bacterial meningitis at 9 months of age. He was given last rites and not expected to live, when he suddenly awakened and warmly greeted his mother. Her two other children also experienced critical illness and thrived.

Leah spoke of numerous romantic relationships, the most poignant being a fellow she had met in high school. He was the first person to really believe in her and their love was true. When he joined the Navy, she did not hear from him, despite her frequent letters to him. It wasn't until a few years ago that she learned her mother had proudly destroyed his letters before Leah could see them. To this day, she carries the burden of guilt for her mother's malicious actions which changed the course of both his and Leah's lives.

She states the most painful loss was her husband's sudden death from a brain aneurysm 10 years ago, when their daughter was a little girl. Leah continues to experience this intense loss daily.

### **Sheila**

Sheila is a lively woman in her late 60s, who has been an LPC for many years, specializing in childhood Obsessive Compulsive Disorder (OCD). She is petite in stature, and in her office are child-sized chairs for her young clients. She is the mother of

two grown sons, and a former military wife. Sheila draws strength from her sense of spirituality, and has a good sense of humor.

Her interview began with the story of her mother's death 31 years ago. Sheila was pregnant with their second baby when her parents were in a car accident in west Texas. It was very early in the morning, and her father was driving. Her mother had just removed her seatbelt for unknown reasons. Sheila's father dozed off, hitting a guardrail. Mother remained conscious for about an hour before death, and the nurse caring for her noted she made mention of her daughter who was pregnant.

Their son was born three weeks later, and shortly thereafter, her husband was transferred to California. In moving, Sheila lost her support system, as well as her meaningful participation in supporting her grieving father. After only 15 months, they were transferred to Spain, which further reinforced her sense of isolation and abandoning her father. She poured herself into raising their sons.

When asked about her interest in OCD, she admitted to having this condition. She knew of her "difference" from childhood on, yet there was no acknowledgement or recognition of this as a disorder at that time, except the slightly derogatory implication that she was a perfectionist.

Of humorous note, Sheila discussed the need to replace the family sofa, which had been enjoyed for many years. She stated, "I really felt the loss of that couch."

**Daniel**

Daniel is in his mid-late 60s and is an LPC. He worked for over 20 years in the Air Force before retiring, and now maintains a vibrant practice, working with Vets. He has a very strong background in Pastoral Care, which comes through clearly throughout the interview.

At the outset, he spoke of his most profound loss, the suicide of his younger brother in 1973. This was especially painful for him, not only personally, but at the same time he held a high-ranking position in the Mental Health Division of the US Air Force. He strongly feels he should have been able to detect his brother's intentions. The whole family had been together during Thanksgiving 4 days earlier, and enjoyed a good time. Receiving this tragic news from his grief-stricken father over the phone 750 miles away was incomprehensible. He described going to the morgue in attempt to identify his brother, who was a decorated USAF sergeant. At the last minute, he decided not to identify the body, because decomposition had set in and he was warned of the potential for a traumatic experience in viewing his brother. To this day, he regrets not following through as he wonders, "Was that really my brother?" knowing full well it was. Despite his strong faith in God, he questions whether his brother is in heaven after having committed suicide.

He described two other former clients who had committed suicide several years later, when they were no longer his clients, and considers them losses in his life. Despite these deaths by suicide, he feels the lessons he has learned have helped him save many



more individuals from taking their own lives, and this offers him comfort and perspective.

Table 2

*Types of Loss Experienced by Participants*

<b>Name</b>	<b>Ambiguous Loss</b>	<b>Disenfranchised Loss</b>	<b>Finite Loss</b>	<b>Nonfinite Loss</b>
Eileen	X	X	X	X
Brylee	X	X		X
Fiona	X	X		X
Alec	X	X		X
Claire	X	X	X	X
Norah	X	X		X
Tori	X	X	X	X
Leah	X	X		X
Sheila	X	X		X
Daniel	X	X		X

### **Categories of Loss**

To refresh the reader, the first question asked of the participants was, “What is your experience of loss and grief?” Themes were expected to emerge throughout data collection related to the literature. These themes or presuppositions cluster beneath the umbrella of “Categories of Loss.” A brief definition of each loss is accompanied by participants’ narratives. These accounts constitute a “Loss and Grief Profile,” containing the essence of each participant’s conscious, lived experience of the phenomena.

#### **Finite Loss**

The prevailing definition of loss falls into the classification of what is considered *finite loss*, which has an eventual ending, a resolution (Attig, 2000; Boss, 1999; Bozarth-

Campbell, 1982; Coryell, 1997; Kübler-Ross, 1969, 1974, 1982; Westberg, 1962). This is the model most therapists acknowledge when asked about what they have learned regarding grief.

Claire laughed as she had initially forgotten to count her first marriage as a loss, demonstrating even something as significant as marriage can become quite finite.

*Claire:* You know I'm forgetting one of my biggest losses. This is hilarious! That leads me to my next loss, which is like - wow! How did I forget that one? One of the two losses I can think of, and it's kind of funny that it didn't come up sooner. Anyway, I had my son, but my marriage didn't withstand that. And I didn't even think about those losses. Yeah, and so our relationship was a little rocky and was really one of those really dumb things when you think children would help. And hindsight 20/20 that made things even worse. In essence my husband was kind of like a child to me and I already had a child. And it felt like two children. And so we struggled and we stayed together another year and divorced when my son was a year old. And yeah, isn't that crazy that I didn't think of the loss of my marriage? Why it didn't hit top of mind is that it really lead me to a much better place.

Tori sustained a loss which many find familiar: the death of a beloved grandparent.

*Tori:* I lost my grandfather when I was about 10. It was like a huge fluke. One of those crazy accidents. He was taking a bird nest off the roof and he had on foot on the ladder and one on the roof and apparently the ladder fell back and he hit his head open. We went to the hospital and slipped into a coma. Then he doctors told my grandma there was nothing they could do. So they took him off life support. I was one of his favorites. They opened up his wallet and mine was the only photo that was in there. I remember being sad, but not overwhelmingly devastated. I think I cried. And he is someone I wonder about occasionally. I think of him from time to time but it's not something that I was like overwhelmingly sad about.

### **Ambiguous Loss**

Boss (2006) is regarded as the leading researcher in this category. Her definition of ambiguous loss:

a unique kind of loss that defies closure, in which the status of a loved one as “there” or “not there” remains indefinitely unclear...with no official recognition of there being a real loss...there is a lonely and oft misunderstood mourning and an indefinite end. (pp. 4-5)

This loss is to be comprehended within one’s *external*, situational context, when what is occurring is *outside* one’s control.

When Brylee experienced the stillborn death of her baby boy, ambiguous loss manifested in unannounced ways. Was she a mother? Or was she not?

**Brylee:** I was six months pregnant, and having some unusual discharge. I didn’t feel too well. My doctor told me to go to the Emergency Room. Everything dropped, and we went there right away. On our way there, my water broke, and I was shocked. When I went to the Triage Desk, they told me I had just wet myself. And I was crying and went to the restroom. And my mom was there and I told her my water broke. But the nurses just said I had wet myself and was having a little bleeding...Later on, when the doctor checked me, he called out to the nurse, “She’s losing her baby!” So at that point, I knew what was happening.

A few days later when Brylee and her husband were flying home from Colorado, this happened:

**Brylee:** I was wearing my maternity clothes because I didn’t fit into anything else. And so a couple of days before, I had been in my maternity clothes, pregnant. And now I’m pregnantless and feel like an empty shell. My epidural left some pain in my back that made it really hard to move. And so then I remember, it was the craziest thing was my milk came in and I was like, “Why?” I felt like some evil joke had been played. I had no clue. I had no idea. And so my milk came in. My breasts hurt so bad. And I was like, “What do I do? Why did this happen?” I know it makes sense biologically, but I had never thought of that. It was a cruel twist of fate.

Alec did not expect the fabricated story told by his first partner after having disclosed his sexual preference. The repercussions of these untruths caused self-doubt and anxiety for those involved.

*Alec:* He was my first real relationship after coming out and the first relationship where I felt completely authentic. And things seemed to be going really well for quite some time. For at least the first year, things were going really well with integrating life and negotiating and blending families. And then in January of last year he started picking a lot of fights, and he was getting just so mean. Around that time, he was getting sick, just a low-level sickness, asthma, some fever, just some real fatigue. Didn't think a whole lot of it. Then in April, he was diagnosed with pneumonia and was given antibiotics and something for anxiety. He had given verbal consent for me to sign the papers. He was afraid that he had HIV but told me he had been tested in January and was negative. So, my understanding was you don't go from January being negative to April being in full-blown AIDS. So that wasn't what I thought was going on. I really didn't know.

Alec decided to bring in his partner's mother as his health was deteriorating rapidly, despite the ill man's wishes to exclude her. He was on life support at the time, and it would soon have to be terminated. His partner had given Alec the name of a friend he wanted called:

*Alec:* Some things just started not making sense from things he had told me all the time we had been together. I had to follow up on some things that weren't making sense. So I called his friend back and found out that everything he had told me about his life before we met was a lie. Everything. Where he was born. Where he went to school. That he went to his school and his career and what he said was his marriage then his adopted child. Everything. Everything had been a lie. And so all of a sudden the night before I am ready to terminate his life support, I find out I don't even know who he is. And that put me in such an ethical dilemma that I can't terminate life support for someone I don't know... The last order I gave before I handed in my Power of Attorney was to lift the "Do Not Resuscitate." An hour after I had left that morning, he coded. If I had not rescinded the DNR, he would have died and I would have felt the responsibility.

The reader will remember Norah whose son was killed in Afghanistan. Her poignant story of hearing this news depicts ambiguity and stunning loss.

*Norah:* As I'm walking down the jetway and my phone rings and I look at it and it's my daughter. And I'm like, why is she calling me? I just talked to her an hour ago. And she can annoy me sometimes, you know. So I answer and

say, "This better be good because I just saw you and talked to you and I hope the house is burning down!" And she said, "Mom, there's two Marines at our house." I just remember my knees buckling and I dropped my bags to the ground. I fell against the wall of the jetway, and people were lining up to get on the plane. And I said, "I'm sorry...my son is fighting in Afghanistan and my daughter just called to say there are two Marines at our front door." And I told my daughter, "Put the Marines on the phone with me." And she goes, "No, they will not talk to you on the phone. They will have to see you in person." And I said, "Then they will have to see me in Little Rock." Then I called [my son's] father and heard his wife crying in the background. "And I thought, "This can't be!" And I said, "What's going on? [Our daughter] called to tell me there are two Marines at our house." And he said, "That's right, there is a protocol they have to follow. I've got two Marines here with me...give me your address in Arkansas and they will have two Marines meet you at that address and they'll tell you what you need to know." And so I'm thinking, "This is really bad. This is really, really bad." But then I'm thinking, "Well, maybe they just come to your door when they're severely injured? It's possible he's not dead."

### **Nonfinite Loss**

Bruce & Schultz (2001) are recognized for their work in nonfinite loss based originally on unremitting grief faced by parents with special needs children, specifically those with intellectual impairment. Nonfinite loss is couched within one's past, present, and future world views, and is fueled by one's fears and anxieties. "The realization that bad things happen to good people and bad things do not necessarily go away is, for most people, unfathomable" (Bruce & Schultz, 2001, pp. 4-5). The criterion for nonfinite loss is "what should have been" (p. 8).

Eileen experienced a divorce after several tumultuous years being married to a violent alcoholic. Her loss is unending.

***Eileen:*** When the divorce finally came through, which was like two years after the separation, that is when my mother said to me, "You are going to feel so good. This will be over. It will be done with." And I told her I felt like I was going to a funeral. And it wasn't that I thought, "Well, we took a separation because we thought maybe we could get back." I thought maybe we could get back together,

but I don't think Al ever really thought that. I experienced that as such a major failure. Major. It was not in my picture of what I thought my life would be. The divorce was a major failure and it took years for me to even acknowledge. And it really took my children saying, "You know, you've got to stop beating yourself up about this because if you hadn't made that choice, we might not have survived." But I never really got myself together. I never really got over the divorce issue. Of course, I absolutely took it as a personal failure.

Later in the interview, Eileen talked about her son, presenting yet another layer of

nonfinite loss, lifelong chronic illness:

**Eileen:** My [son] was diagnosed with diabetes at age 6, and he was in and out of the hospital an awful lot. That was another thing. I had a child who went into insulin reaction so fast because he was so brittle. So...yeah, it was the loss of the dream of a perfect child and he was wonderful and he really did take care of himself. But Al never went to see him in the hospital and he was hospitalized so many times. His excuse was, "I don't like hospitals." Good for you. Thanks. You know it was like he couldn't grow up. He stayed so immature. And I think alcoholism stunts one's spiritual and personal and even intellectual growth. It does. So that's that. I feel I got fractured a little bit.

Fiona grieved the collective loss within her family as they struggle with her older sister's diagnosis of multiple sclerosis, and accompanying broken dreams.

**Fiona:** My sister was in a wheelchair already, a mechanical wheelchair. She had a little bit more mobility. Already from Day 1 it was confusing. She thought everybody was trying to control what was going on. We were just trying to find out what was going on. Physicians won't talk to family members. Alice was so tight-lipped about everything. I'll just never forget hearing my father say something to the fact, "This is not what I had envisioned for retirement." You know, something to that effect. And my first reaction was, "How selfish of you!" And then I thought, "Well, OK. That's how he is looking at it." I didn't think it was going to be this way, either. So everybody has their loss. There's the loss of the relationship that you used to have with that sibling, that daughter. The changes. What you do with the changes. As a caregiver, the loss of your freedom. Huge. He's grieving the loss of everything he had planned to do. And goals. There's that ever present potential for guilt. In other families they say, "Hey, we're going to the Bahamas. We're going to Hawaii. Everybody buy their tickets!" For me, it's like, "Oh that must be nice. We couldn't do that because..." I mean, everybody's got their struggles. But everybody seems to have this

freedom to go and do and be. We're somehow letting...somehow it feels like we're being held back.

Leah met the love of her life right before she moved away from home. In light of the emotional pain she suffered, the following nonfinite loss was yet one more heartbreak for her:

**Leah:** So I had this boyfriend, David. We were very much alike. And he went away to the Naval Academy and I went to San Francisco. Put myself through two years of school. And we wrote every week. And we talked every week. It was hard when he was away because he was everything. He was my world. There's no question. And my mother didn't like him. And I couldn't understand why. He was everything I would have wanted for my daughter. He was a gentleman. He was intelligent. He was goal-oriented. And he was doing well for himself and we were really happy. We were good kids. And maybe that's what she didn't like was that I had what she didn't. In her own grief, she wanted to destroy it, which she did. I didn't find out until about ten years ago. I never really understood how the relationship fell apart. It just did. I was very insecure, so I didn't ask questions. And that was back before we had cell phones and computers. You had to use a pay phone and use your \$10.00 worth of quarters and in ten minutes it was up. And you'd write letters, but I wasn't bold enough to ask or say things I really probably needed to say and wanted to ask because my self-esteem was so low. But the relationship fell apart and I believe it was shortly after my daughter was born. I was holding Karie and adoring her, "How beautiful! My beautiful little girl!" And my mother made a comment and said, "Good thing I didn't let you end up with that David guy and got rid of those letters, or you never would have had this beautiful little girl." And in that moment, my heart sunk. Well, I saw the letters for the first year or so and then she decided she was going to end the relationship. The fact that we were doing great and we were so very much together. He had pinned me. She started getting nervous like, "Oh I might marry this guy and move away and be gone." I think she probably thought that the long-distance relationship would fall apart on its own, but it didn't. And she decided to destroy it herself, which she did. So letters I wrote went unanswered, and I thought, "Well, I guess that's it." And I remember specifically writing him telling him I was afraid. And no response. And it wasn't until my mom made that comment about my little girl that I realized she had taken those letters and thrown them away because that way she destroyed my happiness, my future, my...And I don't know that I've ever recovered from that. In fact, I'm pretty certain I haven't. I know that I haven't.

## Disenfranchised Grief

Doka (2002) advanced a theory consisting of five principles to define disenfranchised grief as “the grief that persons experience when: (1) they incur a loss that is not recognized or, (2) *cannot* be openly acknowledged, publicly mourned or socially supported, and (3) from which the griever is excluded” (Doka, 2002, pp. 10-13). A few years later, he amplified this definition to include: (4) “disenfranchising death and the ways an individual grieves (based on newer work on cultural differences), and (5) styles of grief” (pp. 10-17).

The reader may remember Claire who divorced and became a single mother trying to survive, too busy to grieve her failed marriage.

**Claire:** I didn’t grieve the loss of my first marriage when I got divorced because I was too busy. I was a single mom and I was in survival mode. So there was no real opportunity. I had to get up and get to work and take him to daycare. I had to keep pushing forward. And so I just kind of hung on and kept saying, “Keep going forward. Keep going forward.” And so my now husband came into my life, and my life sure got better. But it was hard because he didn’t have kids and I had my son. When the grief hit was when we got married.

Leah sustained tremendous disenfranchised grief, even as a child. To her credit, she worked and educated herself to move beyond this loss in order to help her clients and live a personally satisfying life.

**Leah:** The earliest loss for me was that of my childhood innocence. I was sexually abused as a child from the time I was 6 until I was 15 when I was able to get out of the house. I remember, but I’ve read journal entries where I asked my family doctor when I was 13, if my whole family was crazy or if I was. I’m pretty sure the doctor knew what I was going through but he couldn’t get me to say anything. I wouldn’t tell anyone because for one, it was pretty shameful. I didn’t want anyone to know. I felt dirty. I was embarrassed that people in my family would do this to me. And so secretly, I worked and worked and saved money from the time I was 12 years old. Worked full-time from the day I turned



16. And on my 18th birthday, I got in my car, loaded up my things and moved to San Francisco. I got a job and put myself through school. There's a lot of loss in there. Loss of the family I never had that I wished I had. Dreams, hopes, my childhood, my innocence and in a lot of ways, because of what I went through I think I was grief-stricken so much that I didn't learn how to handle situations gracefully. It was messy and crazy and loud and chaotic in my home growing up. My mom was really upset that I was leaving and she said, "If you get in that car and leave, don't ever call me 'Mom' again." And I said, "Okay, good-bye Jean." And I got in my car and drove off. And I cried. I knew I had to save myself. But everything was conditional and I recognize it was my mom's own despair. I was in a double bind all my life. I couldn't win. I could only lose. I couldn't sleep. I was always afraid of what was going to happen in the dark. And a lot of (Post-Traumatic Stress Disorder) PTSD... In my Junior year of high school, I was very sick. And I had pneumonia plus my asthma was much worse because of all the stuff going on in my home and I attempted suicide. Because I didn't know how I was ever going to get out of there.

Suicide is perhaps the ultimate disenfranchised loss a family could encounter

(Becvar, 2001; Walsh & McGoldrick, 1991). Often, the survivors experience a profound sense of shame, rejection, or guilt for not having been able to preempt the loss of life.

Daniel shared his loss:

**Daniel:** I had something horrendous happen. I lost my youngest brother to suicide. He was 21. He was going to UT and was in the Airmen Enlisted Commissioning Program with the Air Force. And ironically enough, I was Chief of Mental Health for the Air Force and this happened. But anyway, my little brother, Mark. On a Thursday prior to taking his life, which was just a day or two earlier, we were all in Victoria, TX, celebrating Thanksgiving. We were all getting along and smiling and eating turkey and Thanksgiving ended and he had to get back up to Austin to sign in for the Air Force. And he signed in on that Friday. And ummm, you know, surfaced a smile while we were all getting together, but I think he was a master of disguise in the sense he had something really bothering him down deep which was effectively clothed and nobody picked up on it, or I wasn't alerted to it. He helped wash dishes after the meal. I think it was my mother's birthday, which was another highly unfortunate thing. But I don't think that had anything to do with him taking his life. But I think there was a girlfriend. On Monday night, I got a call from my dad. He said, (crying), "Your brother shot himself. I can't take it. Here's your mother." So she gets on the phone and lays it out real quick. And that night, I drove from Clovis, NM, 750 miles to Austin and got there at 7:15 in the morning. I immediately go to the apartment manager and said, "Tell me everything that happened. Tell me everything." And so he tells me, "A maintenance man was walking by. Checked

things out and this is what he found...” And I had my first big cry. Big cry. Tears. Well, he left a note. I got to read it. It was typed and I got to read it once. I don’t remember the long and short of it, except in the middle of it he said, “My brothers are right. They said think long and hard about joining the Air Force because once you do, you’re on 24 hours a day...” And that note my mother held onto and I never saw it again and I don’t know where it went. I’d love to get it back and take it apart. But I didn’t have the opportunity. My mom’s gone. But I remember it impacted all of us. Even to the rest of our lives it will.

### **Themes Arising from Experience of Loss**

The aforementioned themes and descriptions were based on presuppositions brought to this study by the investigator. Prompted by the first research question, subject matter yielded defining features and coherent examples of specific types of loss and grief experienced by the participants. Using bracketing, or setting aside these presuppositions, unpredicted themes emerged, creating ample material for in-depth analysis.

Table 3

#### *Unpredicted Themes and Participant Responses*

<b>Themes</b>	<b>Participant Responses</b>
Depression	10/10
Cultural Influences	8/10
Empathy	8/10
Obtained Personal Therapy	8/10
Loss of Identity/Sense of Self	6/10
Post-Interview Comments	6/10
Self-Care	6/10
Spiral	6/10
God	5/10
Resilience	4/10
Guilt	3/10
Denial	1 admitted

## Depression

Each of the ten participants (10/10) suffered depression as a result of their lived experience of loss. The following soulful stories illustrated their pain. After Eileen separated from her husband, she did not want him driving their children, believing she could not trust his sobriety. During his visitation weekends, she let him stay in the family home with the children, while she found a place to stay.

**Eileen:** I really didn't want him driving. So I would leave. I would disappear. Sometimes that was very painful. That was very difficult. I'd go driving around and sometimes I would see this big tree in front of me and think, "I just might hit that big tree." I mean there were moments like that. There really were. So I had to stop that. Those kinds of things...Those were red flags that said, "You need to get some help."

About the divorce:

**Eileen:** I experienced that [divorce] as such a major failure. Major. It was not in my picture of what I thought my life would be. The divorce was a major failure and it took years for me to even acknowledge. And it really took my children to say, "You know, you've got to stop beating yourself up about this because if you hadn't made that choice, we might not have survived."

Brylee shared her sadness:

**Brylee:** I was realizing that every time I grieved every missed cycle, every missed fertility event, that I would be so heart broken. And it was almost that...I was losing Kevin again and again my hopes of having a child again and again. And so I realized every time I would think about Kevin, or talk about him, that all of the ensuing fertility cycle was drawn into it. And so, instead of my sorrow and heart break about losing Kevin, I was losing Kevin and all of these other cycles and these things my body was doing or not doing...just the constant pain and the headaches and wow! The pain was just intense physical pain. And so when I realized that I was combining my grief of it, that it was multiplying [my grief] in fact. And so I worked really hard to kind of compartmentalize. Like I lost Kevin, that was a very traumatic event.

Once the gravity of his partner's illness came to light, Alec preempted his own decompensating behavior by requesting meds in order to manage depression.

**Alec:** Well, he started picking lots of fights. And I was getting very frustrated. I finally broke down and went to my psychiatrist and [requested] meds. Looking back, I am so glad that I did that, not only because of how it has changed my life, but that if I hadn't, I probably wouldn't have survived the last year intact. I started taking them just before things started getting really bad.

After remarrying and relinquishing her high-powered job to focus on her new family, Claire was smacked with grief and unyielding depression:

**Claire:** People would say to me, "Oh, you get to stay home and you get to do nothing. Isn't that great?" No, I wanted to do something and I wanted to be something. My mother-in-law said, "You know, I never wanted to do anything but support my husband. What's wrong with you?" And I was depressed. We were married a couple of months and they named my replacement [at work], and I left. And that was when I grieved the loss of my first marriage. I had put way too much into my career, no question, because I had been so driven in it. So anyway, that was a loss, and it has definitely affected how I have been with clients who feel in that darkness. When someone says, "I'm depressed..." you know, I get it...I wasn't working and everything caught up. All the emotion caught up and I got depressed. And I'm talking "being in the cave" depressed. Dark, really, really down. You know, I couldn't get out of bed. Very angry...

Tori experienced depression when too many important obligations created an overwhelming logjam in her life.

**Tori:** About a year into seminary, my pay got docked from the church, which forced me to have to take up a second job, which I didn't want to. But what else could I do? I had to pay for school. I didn't want to take out a loan. And so, it was crazy. So for about 2 years straight I was working two part-time jobs. I was a full time student. Literally every single day I was working. I would wake up every single day in a panic with, "Oh my gosh, what day is it? What do I have to do? What do I have to turn in? Where do I have to go?" It was horrible! I ended up going into a pretty bad depression because of that. I didn't have any time to hang out. I made money, but I didn't have any time to spend it. I mean it was just really awful.

## Cultural Influences

Eight out of ten participants (8/10) had roots in some aspect of a specific culture, which impacted either the cause of the loss or how they responded to it. These salient stories came to light.

Eileen was a Navy wife:

***Eileen:*** We were married eleven years, and this was a Navy experience, I would say. He was a submarine officer and eventually left the Navy and came up here to Massachusetts and went to work for Raytheon Corporation. But the culture of the service, the culture is a drinking culture. It really is. And it was kind of expected. It was an expectation which I think is really wrong, and it's probably not the same as it was fifty years ago.

In the Mormon culture, sizable families are expected. This presumption hit Brylee head on when attempts to bear children were unsuccessful.

***Brylee:*** Okay, so I'm [Mormon]. My husband is, too. In our religious culture, families are generally large. Our marriages happen really young. Usually when people are still in college and children come pretty quick. And so my husband and I met in college, and got married when we were seniors. There were three of us couples that were friends. They got married the same week. We went to Brigham Young University. The joke there is that you meet someone and two weeks later you are married. And sometimes that's a reality. So we were kind of a rare couple that we dated for thirteen months and then we got engaged and then we got married three months later. And short engagements are typical for the [Mormon] community. Three to six months is the average. Any more than six months then people are like, "Why are you waiting?" Because no premarital sex is also one of our standards, expectations, and rules. And so the longer you are engaged, the harder it is to keep that. So we got married pretty quick. And so we decided we would have a baby. And so nothing really happened, but we figured, "No big deal. It will happen when it will happen." And by that point, [a few years later] one of the couples that had gotten married at the same time had four children. And another couple had three children. I include that in part of my story because we got married within days of each other.

Alec included his challenging experience of being part of the LGBT culture in his narrative:

**Alec:** I had fought for seventeen years to turn myself straight and it was my lack of faith that kept me from transforming...and then the loss of my God. Because after a certain point, I just said, "Fuck it, I'm not fighting this anymore. That, for some reason, if God didn't like us, well this was His mistake and I just don't want anything to do with Him. And that lasted for about two years. You know, after coming out I lost my mom. I lost most of my relationships with my siblings...there is a reason I am gay. There is a reason I have suffered.

On hearing news of the sudden loss of her son in combat, Norah revealed her friction with military protocol:

**Norah:** So there began our nightmare, you know. Which even looking back now, it was just a dizzying, dizzying two weeks probably of, and just the fact it was a military death and all the hoopla that comes with that. The drama. The...I want to say pomp and circumstance. The kind of stuff that they do is designed...they let you know they care and respect their dead but for the parents to be a part of that and it's your child, it feels, at least it felt to me, like someone was taking a sword and sticking it straight into my stomach. And so anything military or having to do with the Marines, we hated that and we thought they represented death. In the meantime, they sit everyone down at a big ol' dining room table at the Fisher House. So, some dude who looks like a GI Joe on steroids arrives [and says], "I'm here to report that I have accompanied your son's body back from Afghanistan and has been in my care and I have given it the utmost care." Then we met with a Navy mortician, and she started asking questions, and they let the mother make all the decisions and sign all the papers. And then finally they put us in a little van and drive us out to the tarmac. And this giant 747 jet is sitting out there by itself. We were taking pictures all over the place, and they said, "If you take a picture out there on the tarmac, we will take your camera and destroy it. You will never see it again. Because there are Navy SEALs here and top secret people here and we can't take the chance that anyone is getting their picture made." So the door of the cargo is open on the 747. The van drives out near the 747 and it's roped off with little chairs, like at a graveside service. And we get off the van and...it's almost like coming out of the mouth of the cargo. It must be two or three stories high. And it's like a big plank coming out of the cargo jet. And his casket is sitting on the end of that plank. All by itself with some fancy Marine standing next to it. It was absolutely devastating. I think they flew his body alone in that cargo jet. And so that big plank lowers to the ground level and a big truck pulls up and the Marines in their [dress uniforms] take the casket and put it in the big white truck. And it slowly, as slowly as you can drive, drives off to the mortuary. And that's the end of it.

Tori is second-generation Asian American. She enjoyed the way her elders treated her when she was a child, but experienced the loss as she grew up and this particularly changed relationships with her uncles:

**Tori:** It's one of those things that no one tells you about, and I had never experienced before because my mom and dad still treat me like that to this day. They still call me, "Baby." They still cut the bones out of my fish and fold my laundry. They still do little things like that for me. And then I remember my oldest uncle and I were really close and he had started dating this woman that no one in my family liked. It affected our relationship and we just started not being close anymore. Then it came to the point that whenever I would see him, he would talk to me like I was an adult, and not like his little niece anymore. And that really hurt me, you know. And so I became a lot closer to my younger uncle, super close with him. And he ended up getting married to a woman who is half his age and they have two kids. And I think it started to happen when they got married. Even up until that point, he still treated me like his niece, very affectionate. He would still hold my hand, rub my cheek, little things like that. After he got married, I noticed he would treat me very, very differently. He would sit there and be stern, and I wondered, "Who are you? Did I say something to upset you?" And then I realized, "No, it's because to him I'm not little anymore. I'm a grown woman."

## **Empathy**

Eight out of ten participants (8/10) shared their perceptions of how empathy has been enhanced because of their grief experience.

About increased empathy, Brylee shared:

**Brylee:** And the experiences I have had as a therapist and through my own experience, I feel like I am much more able to have true empathy for my clients, whether or not I have experienced their experience. I can feel with them where they are. And I think the depth of my ability to show empathy has increased because of my loss.

Fiona offered:

**Fiona:** So I have the ability to empathize what it might be like to be that person with the chronic illness. With the physical handicaps. What a struggle it is just to wake up in the morning and try to get your body maneuvered to the edge of the bed by yourself. And then try to get yourself up into a semi-standing position so that you can get into a wheelchair. So when we ask her to go do things we are also like, “Gosh now that we know what we are asking of her, she is going to have to get up and spend half a day getting ready.” But the invitation is what’s important. So, I think that I did not realize until my family experienced it was the impact on the family. How it does, whether you like it or not, it impacts all of the family in one way or another or multiple ways. Each family member is impacted.

Even in the face of betrayal, Alec managed the courage to say

goodbye to his former partner:

**Alec:** They told me they were terminating life support and asked if I wanted to come up and say goodbye. And I did. I didn’t stay very long. I went up and said goodbye and that was the beginning of May. There was that feeling of betrayal, but also looking back at the work that I had done earlier that year, and the work I have been doing with myself for a few years now, forgiving him was so easy. I was able to forgive him just a few days after finding out. And I was able to say goodbye.

Claire has learned to use the death of her step-father in order to help

others as they deal with loss of a loved one.

**Claire:** Watching my stepdad go through [terminal illness]...he died of cancer. He struggled with it for a long time. Yesterday I had a client who is dealing with her husband reaching the end of his life. It gave me a lot of perspective. It’s also that you’re walking with that client as you remember [your own situation], it’s hard not to. This particular client’s situation was similar to my stepdad’s progression. When she lays out the things she is considering, because he’s been given about a month, it draws me back to the last month. One of the things I remember when my stepdad was toward the very end of his life, was that my mom was not cognizant of how ill he was, even though she was the closest connected to him. She was in somewhat of a denial. So when I was with this



client, I could tell she was not cognizant of how sick her husband is. And it was easy for me to look at it and say, “You know, he’s really sick.”

Sheila shared her thoughts about empathy with her OCD clients:

*Sheila:* You will feel it. You will feel it. And you wouldn’t want to not feel it. I call this [office] room the “Hope Room,” anyway. I’m blessed because I work in an office where we are all comforting to each other and we keep a sense of humor. We love the patients. There’s a lot of compassion here. There’s an understanding of depression.

Daniel stated simply:

*Daniel:* I am able to have empathy for those who lose people, especially under those [suicide] circumstances. I’ll have that for the rest of my life and nobody can tell me otherwise, because I’ve been there, done that. It’s very real.

## Personal Therapy

Clinicians’ effectiveness, positive spirit, and authenticity are greatly enhanced by pursuing their own psychotherapy. By exploring one’s experiences of loss and grief, a therapist can grow personally and professionally (Baker, 2003; Corbett, 2011; Hollis, 2005, 2009; Rogers, 1961). Eight out of ten participants (8/10) spoke of their own experiences with personal therapy deemed necessary as a result of the loss.

*Eileen:* Eventually I went back to a therapist...that was a group therapy. I think Dr. S. had recommended that I go to a group therapy. That was hard for me, that group. It was very hard. But in some ways it was the, “Face it, Lady” kind of thing. Start telling the truth to yourself. It was really hard for me. I couldn’t face the things I had to face. I couldn’t face the money issues. I couldn’t face what was really going on. I think I was too afraid.

Brylee remarked:

*Brylee:* I remember we went to a grief counselor once about two months after we had lost Kevin, after Kevin died. And the counselor was like, “You guys have it

pulled together really well. Are you sure you need me?" It is a relief to lean on each other in a very helpful and beneficial way. And so I joined all my support groups for other women with polycystic ovarian syndrome and other LDS with infertility.

Fiona sought therapy for her family when her sister was diagnosed with

### Multiple Sclerosis.

**Fiona:** I took [my sister] to a therapist that I met through the University of Houston and asked for my parents to come. I wanted it to be a family situation. I requested from Alice can we go as a family and talk about what's going on. We were just trying to find answers.

The need for a variety of therapies became indispensable for Alec as a result of entanglement with his first partner since coming out.

**Alec:** In February of last year, I finally broke down and went to my psychiatrist. I asked for therapy and also started doing neuro-feedback and hypnotherapy, trying to manage. Looking back, I'm so glad I did that, not only because of how it has changed my life, but that if I hadn't, I probably wouldn't have survived the last year intact. I also did a 6-day Breath Workshop. And it made some phenomenal changes in me.

Claire recounted two very different experiences with therapy.

**Claire:** I sought counseling before we divorced, and it was a terrible experience. I was in a bad place, but it was really not a good experience.

After she had been replaced at work and felt like she had lost her identity:

**Claire:** Everything changed. So I went to therapy [with a different therapist], and I went back and grieved my parents' divorce, and grieved my mother's remarriage. I grieved. It was a season of grief. And the therapy was impactful in why I chose to be a therapist...because it really was a total life turnover experience for me.

Norah spoke poignantly about seeing a therapist who was unable to hear and comprehend her earlier losses:

**Norah:** I had hurt more over that divorce and the loss of my job when I was a newspaper writer. I loved this job and my identity was all wrapped up in that job. And that's when I first realized that, you know, "Hey, you can go through depression and grief symptoms over the loss of something that is not a person." That's when I first realized that. And I remember I was going to a therapist at the time and we would be talking about who I was dating or whatever and I remember one day going, "Wait a minute. You know you're missing something with me here. You need to know how gutted I am over the loss of my job and I'm having a hard time getting over it, you know." And so, it was like, "Whoa!" I mean I don't know. It never crossed his mind that that was affecting me, you know?

She then discussed her current therapy:

**Norah:** What I'm doing in therapy...the journey I'm on in therapy now though is I feel like someone beat my insides out with a baseball bat all the time. And sometimes I just want to scream to everybody, "I'm in massive pain!" So I go to the therapist and tell her how much pain I'm in and that I feel beat up and that some days I tell myself, "I'm sick of being alive." But I feel also that I need to go to a therapist.

Sheila noted two experiences of personal therapy at different time periods in her life:

**Sheila:** [When we moved to Spain] I had some spiritual direction counseling after my mom died. In college, I went to see a therapist for a while because I had OCD traits. And that's my specialty by the way.

Daniel received counseling with a spiritual emphasis:

**Daniel:** The suicide with my brother, you know, I have pretty much worked through it now, especially with this Jesuit priest and therapist colleague. We did some visual imagery in a very empathetic and Holy Spirit filled way... And I said good-bye to my brother, finally. He [Jesuit priest] has a strong faith and he just has that gift of healing. He helped me really kind of tie it up with my brother. Clinically it allowed me to be a little more attentive to people who are acutely, you know, "hidden."

## Loss of Identity or Sense of Self

In the upheaval of loss, six out of the ten participants (6/10) spoke of losing sight of themselves for a period of time.

**Eileen:** In that marriage there was a loss of self because I kept trying to make myself over to please him, to be the person he wanted me to be, until one day he looked at me and said, “Why don’t you be a person?”

She continued:

**Eileen:** Some things happened that were pretty tough. [My daughter] slashed her wrists and her brother found her and they had her taken to the hospital. She was seventeen. [My son] stayed home and waited for me to tell me. So that was a real tragedy for me and I never could figure it all out. But again, I go up to the hospital, and she’s in the hospital and we talk and I said, “What happened? Why? What’s happening?” It took me very much by surprise. Here’s another loss and here’s another failure and what in the world could be going on that I am not aware of anything? I’ve always considered myself a sharp observer of things. I lost my voice, and it was also a fracturing thing, you know...and the marriage was certainly crumbling, and it was a huge loss and the man I married was no longer there. But I was no longer there, either. My own self had been split off, you know.

After the stillbirth and numerous attempts to get pregnant, Brylee shared:

**Brylee:** We tried to get pregnant and nothing worked. So then I realized what I was feeling...I felt like my body was hijacked. It was like all the things it was supposed to do it wouldn’t do.

When the researcher asked, “Who listens to you talk about this?” Fiona noted:

**Fiona:** You don’t. You don’t talk about it. Because you know, because there’s that self-doubt and the guilt that comes up. It’s like, “Your sister is the one in the wheelchair, what the hell are you complaining about?” But the reality is, it is touching you. And I can’t deny it. You know, I have a trip planned for August and I’m trying to figure out, “How am I going to tell Alice? How am I going to tell my sister because another sister is going also, with her kids. It’s like, here is another trip she can’t go on. So, here I am trying to enjoy

the things in life that I can finally do, that I've worked hard to be able to do, but I just can't go and enjoy because I can't include her and feel guilty about not including her.

After the death of Alec's partner, uncertainty and loss of self was evident.

**Alec:** And so that summer [after the death] was such a blur. And you know, I went and I had known I needed to get back into therapy, and I did. And that summer I went in and saw a really good therapist and processed through a lot of this. But still so confused. And I didn't see any clients for...well, I say I didn't see any clients. I didn't see any clients for two weeks. And then I told my colleague that I needed her to supervise me, but that there were a couple of clients I couldn't just *not* see.

In the course of the interview, it became clear to Claire what she had indeed lost in leaving her work.

**Claire:** We got married and I got off the hamster wheel. I wasn't working and everything caught up. I was in a position of power and had a staff - all these things - so all of a sudden, what should have been the happiest thing for me became the most difficult. I felt like I'd lost my identity. Yeah. That was it. I'd lost my identity. We were working for the same company and we made the decision that since his career was going up and I'd step out of the way and be his support. And that for me was incredibly hard...

Tori verbalized the often imprecise and unrecognized losses of childhood.

**Tori:** And then I realized, "No, it's because to him I'm not little anymore. I'm a grown woman." It was okay, but at the same time, I'm still his niece. It was so conflicting and weird. And so it was this loss of not being a kid anymore...but I'm still a kid in a way, you know.

Leah's unresolved pain and loss of self persists.

**Leah:** I don't know if I'll ever feel like I'm okay. I guess that's the biggest...I walk around wondering, I'm not really okay. I feel broken. I feel like there's something wrong...something not quite right. It just hurts.

## Post-interview Comments

Post-interview reflections were unexpected and invaluable, with six out of ten (6/10) responding positively.

When asked several days later how the interview with Brylee had affected her, she stated:

**Brylee:** I felt so much peace after our conversation. I really felt good. And I was so much more present to my clients afterwards.

Fiona laughed:

**Fiona:** And so from the standpoint of getting to talk about it, I love getting to talk about it because it's like my therapy session. It's like my special therapy. No, it's my bitch session. Listen to this how this is impacting my family.

Claire remarked:

**Claire:** Thank you! Every therapist likes to talk about themselves for a while.

Several months later, she emailed a thoughtful and powerful statement:

**Claire:** Something recently came up regarding our interview on grief. I realized that I really hadn't responded other than to say that I really enjoyed it, and it helped me process things. Perhaps one of the most enlightening things to come from the session was the realization that I had resolved the grief related to my first marriage and divorce. I remembered how surprised I was that it didn't come up in our conversation sooner, and it was a great realization that I had, in fact, moved past it.

Norah expressed her feelings:

**Norah:** You've been awesome. I want you to be my therapist. You're much better than the guy over at the Vet Center...I was looking forward to it because I need people to tell my story to. I really do. I just feel like such a burden most of the time.

Leah revealed:

**Leah:** Well, I can say now I feel lighter. I almost feel like I've gotten some of the burden off. It's nice to have somebody to share that with...just to be heard. Thank you for giving me an audience for my pain. One thing I know is that very few people really understand or "get" that pain. My experience is that most people don't want to deal with that which is uncomfortable. It isn't fun. It isn't possible for them. It isn't. Yeah, it's like it's a downer. "I don't want to hear that," you know. It's not a downer. It's part of life. But we go through life only wanting to experience things on "this" side. And so how can you really enjoy this part if you don't understand the "this" part? I mean, the greater the pain, the greater the love, right?

Sheila stated:

**Sheila:** You've given me a different perspective on this today. You are making me think. You really are making me think. I had one therapist friend tell me, "You know, I see my therapist once a month just to talk about little ol' me." I would like to do this again, I really would.

## Self Care

Attempts at self care and coping varied among the participants, depending on how they experienced loss and what resources were available. Six out of ten (6/10) made special mention of how this manifested.

**Eileen:** I was thinking about experiencing the fractured self. Because all of that came out of that experience living with an alcoholic and using denial as a way to survive. It's always a coping mechanism and not being able to face what was really there.

Several years later, she became involved with a group of supportive women.

**Eileen:** I belonged to this wonderful women's group and we were together for two years. I did not miss one meeting for two years. Some people might

occasionally miss a meeting but we met for two solid years and then peoples' lives started getting together and they moved off to other things.

Brylee realized her medical situation would make full-term pregnancy nearly impossible.

**Brylee:** And so [pregnancy] has been kind of on the back burner. This Merina is a five-year Intrauterine Device, so it's like I've got five years. I decided to go back to school. I'm going to figure out what I need to do with my life and will not make any permanent decisions. But I know I don't have to worry about it. I don't have to feel the pressure...

She continued:

**Brylee:** I don't go to baby showers. That's just really hard. And I don't babysit. Because I had someone [from LDS community] tell me, "Well, you don't have children and it's your responsibility and your job to take care of those of us who can have children and you have to watch our children." And I ended our friendship.

Fiona opined:

**Fiona:** So, how do I take care of myself? I really felt like it was a huge relief when I did move because I physically wasn't there and didn't have to feel guilty about not physically being there to help her clean house or get bossed around and told what to do. I know that I can't fix her and I can't change what my parents do and I'm not going to be the one who tries to fix it. *They* have to say, "I want something different. How do I go about it?" I can put my 2 cents in and say, "You don't deserve that. It's wrong. You should think about speaking up." So how do I take care of myself? It's truly part of the mental, cognitive process saying, "You can't fix this. This is not your life. So you have to do what you need to do yourself." And other people may not agree with it. It may not suit them as far as the role I am going to play or not play. But I have to do what I can to take care of me. I have learned to become more selfish...and maybe it's not selfish.

Regarding concern for having had a partner diagnosed with AIDS, Alec admitted:

**Alec:** You know I had to make an appointment with my doctor. I couldn't get in for a few days, and got tested and then the way the Veteran's Administration does their HIV test is it [result] is at least seven days later.



In caring for herself, Claire returned to graduate school with the goal of earning an MBA, and teaching at the college level. When asked how it was for her to begin to find her identity, she replied:

*Claire:* [I began to] open myself up to other possibilities, other dreams, to begin to be able to see I could do something else. I didn't have to be...to begin to look at the path as though the path didn't have to be straight...and that was this path that I was on. It was very straight. I was in a mode of progression and everything just moved in a sequential order. And then to be able to adjust and go, "Wait! I could do something different. And I could take a different road." And I could still have an identity. And I could still do something, and still be a supportive wife and mother. But I did have to recognize in the loss was that I might not be able to be – I've never attained that similar position of authority in a position where I was in a career-type role. So I adjusted. And from that point forward, I definitely made my career decisions and my adjustments based on where my family was. But for me it was to really be able to reassess and recapture a different dream. What I went through at that time was to say I would love to teach at a college level. And so, that's it. It was finding another goal. It was moving toward another goal and doing some work on some of the unhealed wounds.

Sheila's self care involves watching re-runs on TV:

*Sheila:* I love the "Golden Girls" and I think at the end of the day, to me, the best way to end my day is not with the news, not with CNN. I turn on the "Golden Girls."

## **Spiral**

Literature previously cited in this work revealed several references to the mystical manifestation of a spiral. Detecting this metaphor within the participants' narratives validated a most exhilarating discovery. Six out of ten participants (6/10) spontaneously used this whirling image.

Eileen confided:

**Eileen:** That's what grief will do and that's what rage will do. The grief, losing Al, and [life] just spinning out of control that way...

When Alec learned his partner had been lying to him all along, he lamented:

**Alec:** Who am I with? And who was this? Was anything he told me true? Or was nothing true? And there were so many griefs swirling around in a tornado together with me just caught in the middle and not able to go anywhere.

He continued:

**Alec:** At a more meta level, I know that there will be more grief. Because that's just the way life is. But I am not afraid of it. Grief is one step on that spiral of life. And no matter how many times we go around the hill, grief will always be there.... And then we will go around and we walk through something else. And we will climb another level and then grief will be there again, and it's a part of what life is.

After a replacement was found at her job, Claire fell into a deep depression:

**Claire:** I spiraled into darkness, like I fell off the face of the earth. And that was when I grieved the loss of my first marriage.

At the news of her son's death, Norah responded:

**Norah:** And I instantly...I just remember wailing. Just like you see in the movies. Somebody screaming, "NOOOO!" I felt like I was in a tunnel or a cyclone or something...like I was in a vortex. It was like a dream...like being swirled around on a roller coaster. I felt a fight or flight weird feeling, but I had nowhere to run. I had to stay there in that vortex, you know. There was no place I could run to get away from it.

As she began her story, Leah commented:

**Leah:** I will tell you my story of how my life spirals downward.

Daniel spoke of his father's struggle with news of the suicide:

**Daniel:** I lost my brother under those circumstances. I don't wish that on anybody. It was a heavy hit. I can't imagine what it did to my parents. Probably put my dad into a spiral with his lymphatic leukemia. But he didn't die until two years later. He had tremendous mental power and I think that helped him stick around.

## God

Five of the ten participants (5/10) mentioned God's presence and influence

in their lives:

**Brylee:** [regarding her miscarriage] So we went through this big grieving process...I was thinking, "I really do want to become a parent." This was something I was looking forward to. And so I felt that [miscarriage] was something that God had provided me to open my eyes to how beautiful it could be...God can use me. In a way, I am free to be His instrument. Whatever He needs I can do. And so I have the time to put into helping ease people's suffering. Also it is something I felt like I should do for a long time. I felt like He was leading me to that, and it's not where I expected. I am not living the life I expected to live. But I have been finding that it has been a blessing in my life in much more rich ways than it would have...and so, it is definitely for me a story of loss, yes. Grief, definitely. But I feel like He has opened the windows of heaven in ways that I wouldn't have known to look for.

After Alec rescinded the "Do Not Resuscitate" order in the Intensive Care Unit, relieving him of responsibility for his partner's care, he recounted:

**Alec:** I got a call from the ICU nurse saying he had just coded...you know, I just kept seeing God's grace. If I had not done the Breath Work I would not have been in a place of... peace isn't the right word. Just a sense of unity with God, and the universe around me. But I still believe God is sovereign...I may not like or understand everything that happens...I don't believe He causes everything to happen, but that He allows things to happen for a reason. And I see that that reason, in my life, is to allow me to be a healer...There is a reason I have suffered. There is a reason that I have been where I have been and that all of those things...I truly feel that all of those things serve to make me the healer that I am.

Claire put her faith in context of her work:

**Claire:** Part of that [loss] has to do with where I am with my faith. To me, my faith really entails giving things over to God.... I did have a miscarriage before I had my son. I worked downtown at the time, and I would see these families with 10 kids parading around. And I would think, “God, what is it that you are depriving me of? And that woman has 10 you know, that are all at the bus stop.” And I would think, “What is it, God?”

Leah shared how her faith has sustained her in the midst of horrendous physical, sexual, and emotional abuse:

**Leah:** I always felt like the only reason I had to live was because God had a purpose for me. I said, “I have a dad. I have a Father in heaven. That’s the only parent I really had that I know I could count on.” So that is really what kept me going.

Daniel remained troubled about his brother’s suicide, vis-à-vis his very strong Catholic faith. Suicide is considered a grave sin against God.

**Daniel:** I know God in His loving goodness, compassion, and mercy and I firmly believe, and it’s in my heart and mind...He, more than anyone understands Mark’s state of mind. I’m sure He had mercy on his soul. I’ve had some very fine people in religious life indicate likewise. But you know, there’s always this doubt. The bottom line is God in His justice, kindness, and goodness will determine what happens to Mark forever and ever. But I will tell you that as long as I am living and breathing, I will pray to God with words in my mind and me externally with my voice, that God will pull him from wherever he is and bring him to Himself, so that he will be with God forever and ever.... And until this body is shed, I will operate within those limits and I will continue to pray and think of my little brother...

Although Norah did not mention God, she offered:

**Norah:** I am not very religious. I’m very spiritual. But not organized religion.

## Resilience

As surmised, the interviewees were invested in responding to the strong desire to grow a bigger, more meaningful life. Participants dwelt in varying states of resilience, likely dependent upon where they were on the continuum of their own resolution of grief. Four out of ten (4/10) participants commented specifically on positive changes in their lives.

Despite the turbulent early days of her adult life, Eileen pulled herself together, earned advanced degrees, and built life-giving networks. During this time, she met and married a brilliant therapist.

*Eileen:* We bought this house, which I wasn't too sold on, but eventually I began to love it. It had a full basement which we finished off for his office, and a beautiful deck all the way around with stairs. And so his office was there, and we taught and did group therapy together. We had a wonderful time doing that. Pairs, couples, groups. That was a marvelous experience with him. One of the things he taught me was to stand up for myself. And when I started being mouthy he winked and said, "I created a monster!"

Brylee thoughtfully created new, exciting plans for her life:

*Brylee:* I decided I needed to stop and take care of me for a while. And so I had some really extensive [reconstructive] work done on my foot and I was on bed rest for four months after that. And then I decided I was going to move on with my life. And so I decided to go to grad school. And I had been wanting to be a therapist for a long time and I had put it off. Going to grad school was really a quick decision for me. I knew it was something that was in my future. And so one of the things I did halfway through the first year of my program was get on birth control. And the thing that I love about it is that I love being a woman again. I don't have pain. I don't have all those crazy cycles. I love it!

Alec was asked the question, "Have you begun to love life in a different, deeper way?" He observed:

**Alec:** You know, I think that's a really good question. It's not that I love life because it's happy and it feels good. It's that I can now love life unconditionally. I can love it unconditionally knowing that it's good, it's bad. You know, it's kind of like when you have children. No matter how much they frustrate you, no matter how much they hurt or disappoint you, you still love them. And I think that going through all of these things last year, I think that's how it's changed my paradigm on life. It's like the love is bigger than everything else.

Leah recounted:

**Leah:** So, you know, every day is a gift and I am fortunate to be where I am. I have amazing children who I love and I know they love me. I have broken the pattern of abuse in my family. It stopped with me. And so, if nothing else, I was able to do that.

The researcher anticipated two topics which might arise, in light of literature regarding loss and grief, particularly Kübler-Ross (1969, 1974). Curiously, these notions, “guilt” and “denial,” were rarely mentioned by the participants. They are here incorporated as a theme *by virtue of their relative absence*. One may question preconceived notions that guilt and denial necessarily accompany loss.

## **Guilt**

While only three out of ten clinicians (3/10) noted feelings of guilt, their stories were introspective and compelling.

Brylee remarked:

**Brylee:** Sometimes I feel guilty [not having children], like I'm not doing my part. We don't look the way [other LDS] families will look. But I have come to a lot of peace with that.

Fiona recounted her personal struggle with guilt:

**Fiona:** The guilt part is huge for me. I feel guilty when something good happens in my life. It robs me of my quality of life. I feel guilty when I tell my sister about all these wonderful things my husband just did for me and he went and

bought me this and we went to this restaurant. He's just showering me with love and then we're going to go on a trip to Italy, and it's like I want to be excited about it. And I deserve to be excited about it. But I have to fight for that. I still have to give myself permission to feel happy.

Understandably, Daniel took his brother's suicide very hard, and he felt

laden with guilt:

**Daniel:** The irony is I'm Chief of Mental Health and my brother goes. I would have turned over every stone under God's heavens to have stopped that, had I an inkling. And of course I guess there was guilt involved afterwards. What could I have done? And the mind then goes really bizarre. I mean, my mind was going every which way from Sunday, I was wondering you know, "Hey, Mark. Was it really Mark? The mistake was not ID'ing. I could have done it. I have enough strength to have ID'd. And someone in the family needed to do that because it was a closed casket funeral and nobody, you know, had the assurance that that was Mark. Whatever was bothering him, he did not get it out on the table. Because if he had, I think I would have burst his bubble and he would have been okay. Had the gun not been there, which he had recently purchased, he would have been okay. He would have gotten past that. My little brother. My baby brother. So much going for him.

## Denial

In this study, only one clinician clearly admitted denial although it may have been a transient factor in others' narratives. Eileen was ambivalent about continuing her marriage. She had not anticipated divorce, yet her husband's behavior was increasingly violent.

**Eileen:** Yes, the storm warning flags were up. But of course I don't want to see that. I don't really want to see the impact. I don't really want to see what's going on fully. This is how alcoholism affects you. So after the gun incident, it was very clear to me that I couldn't run away from it anymore. I couldn't pretend that everything was fine, which is what I did. I thought maybe we could get back together but I don't think Al ever really thought that.

Denial was a protective element as Norah boarded the plane to Little Rock immediately after hearing two Marines would meet her at her home once she landed. Before takeoff, she texted her boyfriend:

**Norah:** I [wrote], “Oh my God. You know my daughter just called me and said two Marines were at our front door. I have no idea what’s going on.” So you know I just had that hour long flight not knowing anything of what was going on, and I’m just sitting there thinking, “Well, this is really bad.” I was in shock, I think. And when [my boyfriend] met me, we just started talking about it. What could this mean? What’s going on? I don’t know. Let’s not make assumptions, you know.

### **Unforeseen Themes**

The interview process was generally reflective, and participants were most eager to share their personal experience. In the course of data collection, an interesting discovery arose. As stories of loss were told, it became clear in all ten cases, two or more types of loss were concurrent within the same narrative. This confirmed an unpredicted and quite intriguing finding. The following are examples of this dynamic:

**Brylee:** And so we decided to...umm...he was...[our son] was cremated and he was buried in the hospital plot where other babies were stillborn. And we thought that was a good place. And since we would move around... I don’t know. I didn’t want to bury him here until like I was going to have a connection here. And he was born there. So, that’s what we decided would work best.

This heart-rending story is woven with threads of ambiguous, nonfinite, and disenfranchised losses. Ambiguous loss: knowing they would be moving around, and they had no real connections in San Antonio, where would be the best place to bury their son? Nonfinite loss: loss of a child gives rise to unending grief. Disenfranchised loss: the death of a stillborn affords little recognition or social support.



Norah's story reaches the depth of grief as the cause of her son's death was revealed in a most unfortunate way:

**Norah:** There's more about the grief and loss part. There's a whole other piece to it about my anger and disgust with the military and my struggle with that. I have a love/hate relationship with that. It's gone from total hate to love/hate. Because I meet the individuals and I love the individuals that I meet. But two weeks after my son's death, I found out through a newspaper reporter that he was killed by friendly fire. There was a newspaper reporter embedded with [my son's] group when he was killed and he wrote a story about it, the friendly fire death. And that's how I found out about it. And that just set me off. And it made me feel like I could not trust them to tell me the truth. So I became kind of obsessive about getting the facts. And I would get the facts any way I could.

She continued:

**Norah:** To me, he exists in my heart and in my memories and that's where he is and I feel him with me all the time. I think about him all the time. I think of him four to five hours a day probably.

Ambiguous loss: the love/hate struggle suggests ambiguity. Disenfranchised loss: although there was substantial public acknowledgement for this combat-related death, when the ensuing truth came out, the social support waned as she sought answers to her burning questions. Nonfinite loss: the searing pain of a mother who has lost her son is without end.

Leah shared her story:

**Leah:** My parents had never once told me they were proud of me. I've always felt like nothing I ever did was enough or good enough for my parents. I just so desperately was the over-achiever. I won everything and did everything. Had a 4.0. Won every competition. Was California's this and whatever. Never heard that I did a good job. Even when I graduated with my undergraduate degree at 44 with a 4.0, and I was missing a spouse. I sent my parents a graduation announcement. And they never said anything. Never sent me a card. Nothing. They completely disregarded it as if nothing had ever happened. And that would be very indicative of how my life has always felt. It didn't matter what I did. I am an insignificant being to the people who should have loved me the most.

Ambiguous loss: feeling uncertain and unimportant to those who were her primary caregivers. Is she *in* the family? Or not really a part of it? Nonfinite loss is evident in the absence of synchrony with Leah's wishes and expectations, and her hopes of the world as it "should" have been for her. Disenfranchised loss in this case, Leah's experience cannot be openly recognized, mourned, or validated.

### **Artifacts**

Participants were invited to include any artifacts as they told their stories.

Five out of the ten (5/10) either showed their personal artifacts, or discussed them in great detail.

Eileen brought out her wedding album, and together we viewed each page as she shared stories of that special day in 1956. Rich memories came forth as she laughed and reminisced.

***Eileen:*** "I'm so glad I showed you these pictures!"

Brylee shared several ways she honored her tiny son and dealt constructively with her grief.

***Brylee:*** We had his memorial and planted a tree in Colorado. My family has some land up in the mountains. Just a little hunting cabin on it. A Douglas-Fir and a whole bunch of wildflowers around it. The Boy Scouts often use that land and that cabin for a scout camp. And so every year the scouts go, they do a service project, and they keep building up this area where this tree is. And it is really special. They have made this little path and they have lined it with river rocks. This year, they are talking about building benches. To me, it's the more special thing. His tree is kind of our memorial place.

The nurses at the hospital had given Brylee a small, round hand-painted box

for items pertaining to her baby boy.

**Brylee:** In there they included some pictures of [him]. Someone had taken pictures at the hospital which I had no idea and which, at the time, I was thinking, “I don’t want to look at this. I don’t want to be reminded.” And so, we didn’t take any pictures. But those are some of the most special mementos to me. It took months before I felt that about them. And so I wouldn’t have thought to take pictures, but Denver now has an organization of photographers that take pictures at stillbirths. My picture is like a snapshot and then they decorated the outside to make a card out of it and then they put his name and his stats and his information. Like a birth announcement, but very sensitive. Also, they have this little seashell that they filled with plaster and they imprinted his feet. And so I have his little footprints. And they have his little handprints and his little footprints on top of his birth certificate. And there was a little nightgown that when we held him that is what he was wearing. With a little cap and a little crocheted blanket. It was what we held him in. So, the little nightgown actually has some blood or fluid on it from when he was wearing it. So, I don’t get that out very often. I don’t want to wash it. I used to get out all the mementos...like I have ultrasounds when we found out it was a boy and I have the pictures and all the printouts from the ultrasound machine and I started a layette...I [also] wrote a lot of poetry to him on Mother’s Day. Two years ago, I had been thinking I really wanted a soft, fluffy baby blanket because I felt like that was still missing from his layette. And so I found the sweetest, softest Winnie the Pooh blanket and contributed that to his layette. And so that was finished. That time when I opened [the layette box] up there were some roses...dry roses from the memorial. And some little bug had drilled holes through the roses and so it was crumbled on everything in the box. And I just broke out crying and have not opened the box since then.

Alec began to paint in the midst of his loss, and his stunning paintings hang on his office walls:

**Alec:** [Painting] has been very transformative for me. This is what came out the first time I ever painted!

Norah prepared a video for her son’s memorial service:

**Norah:** All I had to do was plan a video. And that’s really down my alley. And I wanted it to be the kick ass video of all time. I spent at least twelve or fifteen hours the day before the memorial service working with someone who edited and did video and I thought we came up with a really awesome video.

Later in the interview, she spoke of a dinner he and his girlfriend made for her before he left for Afghanistan the second time:

**Norah:** God, it was fantastic! It was exactly what I would have chosen for myself. Like a really nice, fancy salad with strawberries in it and goat cheese and arugula and tomatoes and grilled chicken and candied pecans. I still have the candied pecans in my refrigerator because I won't throw them away. They candied them themselves. So every time I come to San Antonio I see those pecans in there, I'm like, "I'm never getting rid of you." That was a very special night.

Regarding the special jewelry she wore:

**Norah:** Today I am wearing a very small display of my son's stuff. I wear the green bracelet because we had these made. It's in camouflage colors and it has his name, date of death, and US Marines on it. We gave those out to everybody at the memorial service. And then I ordered a metal bracelet with his name on it and that he died in the Enduring Freedom Conflict on that date. And then the Marines gave me this bracelet which has his name and Afghanistan 1987-2011. And then I have my gold star pin on my jacket, which I try to wear every day, which is issued by the Defense Department to every member who has lost a loved one in the war. So right now I feel very much like I'll [always] be wearing all this stuff. I ask myself, "Why are you wearing all that stuff?" You know, "What's it for?" I don't know the answer just yet. But right now I feel so much love and so much pride about him that I don't know. It's just kind of an outward expression of my love and pride, I guess.

Leah held back on expressing her grief until she felt her 10-year-old daughter had resolved the loss of her father:

**Leah:** So at about the third year mark is when I felt like I had moved through enough of it and then [my daughter] and I actually created a memory box. We ordered an urn. And she chose what she wanted on her brass plate. And we asked people to write letters that would help her better know him. And we put little trinkets in like the very first pair of shoes he bought for her. Just little special mementos. At that point, I had remarried and my current husband had adopted her and he wrote a beautiful letter to her and thanking her dad for bringing such a beautiful little girl into the world, and that he would do his best to raise her and honor him in raising a daughter that he would be proud of. [She] has never read any letters. She tucked them into the box. A lot of people send pictures. We made copies of them and put them in the box and we sealed it. And so we make a little time capsule. It's in her closet. It's a real marble urn just like you use to put ashes in. Because she doesn't have anything else, and I wanted to do that before we left Napa because that's where all of her memories of her father were. So, I felt it was important for her to have something to take with her.

### Themes Arising from Impact on Therapy

The second research question was: “How has your personal experience of loss and grief impacted or transformed your work with clients?” In analyzing data, it became clear each individual revealed an “Impact Profile” emerging from their “Loss and Grief Profiles.” From these intensely personal, heartfelt stories, participants ascertained and described how the essence of these conscious, lived experiences has influenced their work as therapists.

Table 4

#### *Results of Impact Profile Analysis*

<b>Name</b>	<b>Increased Awareness</b>	<b>Increased Empathy</b>	<b>Return to School</b>	<b>Increased Sensitivity</b>	<b>Increased Ability to Share Emotion</b>	<b>Willing to “Go There” with Clients</b>	<b>Expert in their Own Loss</b>
Eileen	X		X				X
Brylee			X	X		X	X
Fiona	X	X	X	X		X	X
Alec	X	X		X	X	X	X
Claire	X	X	X		X	X	X
Norah	X				X	X	X
Tori		X		X			X
Leah	X		X		X	X	X
Sheila		X		X		X	X
Daniel	X	X				X	X
	7	6	5	5	4	8	10

**Eileen**

Becoming a divorced, single mother, after eleven years of marriage, Eileen quickly learned she had to grow beyond her role of being a stay-at-home mother. She dreamed of becoming an educator, dealing with children and teaching adults how to care for them. Unquestionably Eileen needed to enhance her education in order to provide for her children, as she could not depend on support of any kind from her former husband.

*Eileen:* I had started back to school...but I didn't have my degree. So I said, "Well, I think I'll do something. I'll move on [after the divorce]. Get my degree so I won't have this happen again."

This was a very difficult time in her life, caring for four children and attending classes for her degree. Eileen sought personal therapy and joined a women's group for support. Here she became interested in the positive influence therapy had on her as well as how she could be of support to others. She persevered, eventually earning two Master's Degrees, and finding enterprising opportunities to work as a therapist. The impact of Eileen's losses compelled her to improve her situation through obtaining higher education, and out of this has surfaced a vital interest in encouraging others to do the same.

**Brylee**

After her miscarriage, Brylee decided to put pregnancy on hold for five years. She is currently in the middle of that time period, and at peace about this decision. Meanwhile, she returned to school to earn an M.A. in MFT, and has poured her heart into creating a vibrant therapy practice, nurturing others by helping them heal.

**Brylee:** So to heal me, so that I could be a whole person, I needed to have something beneficial that I could give back to the world. And so doing therapy is something that I can impact and influence people by such a powerful and meaningful way. Like a mother who influences the life of their child. That is when I was inspired to do therapy. We talk about how we never get over our grief. You just learn to make it not as painful. It's always going to be a part of us and it makes us who we are. But the pain associated with it can change. I find it interesting that over time as we distance ourselves in time from the event, the aspects that stand out to me shift. And we didn't know to expect that. What that doctor said really helped make a horrible situation better. It was like such a powerful sentiment to me...how meaningful that was! We have been able to heal in different ways than we expected...One of the things I found as a therapist is that we talk about how we validate each other's experiences and one of the other things of a therapist is we learn to become more aware of what our clients are experiencing whether or not we have experienced that. And so we are sensitive to it.

As with Eileen, the impact of Brylee's loss led her to self-improvement through higher education. Resilience manifest as she learned to distance herself from the pain, and at once acknowledge its existence. Increased awareness and sensitivity towards others fostered meaning in her loss.

### **Fiona**

Fiona admitted the issue of having a sibling with chronic illness has collateral repercussions for each family member. The impact of this illness has sensitized her not to make assumptions regarding each individual's perception of what is occurring and to become responsive to those who suggest "all is well" within a system encompassed by chronic illness, when circumstances may indicate otherwise. Fiona is aware of her experience, which spawns curiosity about others in similar situations.

**Fiona:** The one that I can think of as far as personal and family impact that I have experienced was a huge education for me. The impact on the family and the dynamics with a member that has developed Multiple Sclerosis. Everything changes. What the family does. Where the family can go. Is it wheelchair

accessible? I don't make any assumptions for what it is like for the other person or persons. I can see so many people that come in the therapy room who I know in the past without this knowledge that they sat there when you ask them a question they say, "Oh, everything's fine. No, no, it's fine." They don't always own up to this personal struggle that they are having, this internal struggle because they're feeling guilty. So how has this helped me with clients? Number One: in all ways make my effort not to assume how that person might be impacted by something or what the experience is like for them just because I know what it might be like for me. It's for me to have a greater respect but not assuming what it's like for that person who's just told me whatever experience they share. This is my reality. This is what I feel. This is my experience. Chronic illness. It increases my curiosity around others with a family member who has a chronic illness. So I might be more inclined to ask questions about their experiences and relationships in family dynamics that they might not be so aware of. But just to start the conversation and explore areas they really thought were problematic. It could give them insight and validation.

## **Alec**

Alec's "Impact Profile" indicated his profound loss was at once the worst and the best experience of his life because it was so transformational for him. He realized by having firsthand experience with loss, he was much more able to identify with clients in their suffering. Facing his own pain and fear, he pursued personal therapies and other avenues of healing, which deepened self-knowledge and refined clinical skills leading to him becoming a much more accomplished therapist than he was before his experience of loss. Awareness of personal vulnerability became a strong force from within, thereby enhancing his empathy for many types of loss.

***Alec:*** Well, 2011 was by far, the worst year ever in my life. Worse than coming out. Worse than losing my family. 2011 was worse than being homeless as a kid. 2011 was the worst year of my life but yet, in some ways, it was also the best year because it was so transformative. That seeing my clients and talking with them, I see times where I am sitting with them and I say to myself, and then I say to them that this, right here what happened today, has made everything in my life that has happened worth it. And the things that I went through and the way that I processed and the way that I grew last year have allowed me to be an exponentially better therapist. Before I got into my own therapy, I was a decent therapist. Got in my own therapy, and did some work and some hypnotherapy



and I was a pretty good therapist...If you are not willing to experience the pain, you will never experience the pleasure. Because we can't selectively numb ourselves. If we numb ourselves from one emotion, we numb ourselves from all emotions. And so I chose to dive into the pain head first. And walk through that fire and that cold and darkness because I had lived so much of my life numb that I was never going to go back there...And you can never take a client where you haven't been. And I am sure there are places in the future where I will be that I haven't been yet. But by choosing to be vulnerable and choosing to face all of that pain and fear and loss head on, it has allowed me to have such peace, even though there's such misery in myself and the world around me. Having such a visceral grief has really allowed me to enhance my empathy for all kinds of grief.

### **Claire**

Awareness and identification with the client's anguish appeared in Claire's "Impact Profile," as well. Empathy and willingness to be open to the other's experience of loss joined with sharing her own human emotion resulted in validation of the client's experience.

*Claire:* There's a parallel experience with the client and with your own experiences and losses. And so I think that's something I have to be cognizant of, or I have to both be cognizant of and suspend it at the same time...because at times I don't want my experience to overshadow the client's experience. My approach with clients isn't, "I'm the almighty expert." I take some things from my experience but then I learn a great deal from my client's own experience because obviously her perspective, her reality, her context, her shoes are different from mine. I definitely can remember I cried with her. And she was like, "You're showing your humanity - I'm so glad!"

### **Norah**

Prior to her son's tragic death, Norah did not spend much time talking about grief with her clients, since her own exposure to loss was minimal. The "Impact Profile" magnified by his demise became a significant piece of how she sees herself. Like Claire, sharing her own emotion helps others to be genuine with theirs. Because of this profound

loss and ensuing grief, her insight and openness expanded and she now readily discusses these issues with her clients.

**Norah:** At my office I have a wall of framed pictures and flags and things to represent him. And, as a therapist, I think I want everyone that comes to see me to know that I lost my son in the war. That's a huge piece of me now. It's almost like...umm...I am a Marriage and Family Therapist with a PhD, my son died in the war. To me, it's like such a huge important part of who I am as a therapist now... I haven't spent that much time talking about grief and loss in my practice. Mainly because up until this, except for my divorce, I've never experienced this level of pain due to the death of a person. And so this becomes part of my repertoire of experiences on which to draw from to help my clients.

### **Tori**

Tori recounted the time her beloved dog had to be put down due to worsening seizure activity secondary to a brain tumor. This experience impacted her work with clients as she became more sensitive to others, especially those who have lost a cherished pet. She reported heightened compassion and empathy because of this personal loss.

**Tori:** It absolutely helped me become sensitive to others who have lost a pet. And I really believe if I had not experienced it, I would totally not be [sensitive]. If someone else said, "I'm putting my dog down..." I'd be...you know, I really don't think I would have the same level of compassion or understanding, by far. I so get it now.

### **Leah**

Leah lived through a wide breadth of loss that increased her awareness of how mothers often do not seek therapy for their own healing. Like Fiona, Leah learned to be responsive to family members who may have difficulty expressing their pain. As with several previous "Impact Profiles," she has become able to "go there" with clients, and not avoid this important subject matter. Empathy evidenced in the client's belief that the

therapist truly understands. Similar to Alec, Leah never wants to “not feel” her own pain, as it represents life’s realities.

**Leah:** Dealing with people who have loss, really any kind of loss...it could be a pet. It could be a lot of things. And those things I have dealt with in the therapy room. I suppose a real keen awareness to the fact that parents (specifically mothers) often will not seek their own healing. They aren’t doing their own work because they’re protecting their children. And so I understand when a mom will come in and say, “Well, she’s had this loss and I need this help for her.” And immediately I’m thinking, “And where are you? And how are you doing in this process?” I recognize it is a very difficult thing for a lot of people. They don’t know what to say, and so they don’t say anything. And so I feel really comfortable in going to that place that can be very painful to people. I know how important it was for me to go there and it was much easier with a counselor who was okay being in that with me and not avoiding it...it feels good for the person who’s grieving to know that you really get it and that you’re feeling that pain, that you, too, are suffering, or you, too, are hurting just even hearing their story.

She continued:

**Leah:** So many people have loss. They have huge loss. All kinds of loss. And just wondering how connected they are to that and how they are processing that loss, and do they think of that as something as, “Okay, well it’s just over and I need to get over it.” And I don’t know if getting over it is a very functional or a healthy thing to do. I don’t ever want to get over this [loss of her husband]. I don’t ever want to not feel. I’m okay feeling sad. I’m okay feeling loss. I’m okay hurting. It’s part of the spectrum of living a full life for me.

### **Sheila**

Sheila referred to her diagnosis of OCD, a condition with which she has struggled all her life. As a child, she knew she was different from others because of her drive for perfectionism. This situation impacted her work as a therapist in that she focuses on working with children suffering from OCD and other anxiety disorders. She empathizes with them because of her own agonizing experiences, and works to decrease their

anxieties. She has furnished a special office just for seeing children. Everything in this room is diminutive, thus providing a safe place where a child may feel in control.

**Sheila:** That's my specialty, by the way, OCD. Much of my work is with children. When you have OCD, especially as a kid back when I was young, you didn't even know what you had. That wasn't really a diagnosis. You were just told you were a perfectionist and da da da. Then, as I got older and went to school I go, "Ahh! There's a name for what this is!" And then you find out you're not alone with it. So, I love working with children who have a diagnosis of OCD. We look at the brain and understand it needs more serotonin. And not necessarily put kids on meds right away. I always say we have to figure out, (because it's anxiety) what in our life we're not too contented about that we want to put in order. And they'll usually name whether it's a sibling, or something in the family, like maybe they worry about dad's health or mom, schoolwork, anything.

In discussing her approach to OCD therapy, Sheila stated:

**Sheila:** I think that's why we come to counseling. Because we're going to pull out what doesn't work... You want to know where the loss was? Having to be flexible and not having things in the order I wanted them to be in. That was a transition. So, the loss... you're dealing with someone that has to adapt something differently to their lifestyle because they've taken on other things, so they can't do it all, you know.

## **Daniel**

Daniel's "Impact Profile" indicated finely-tuned awareness of others who may be contemplating suicide. Like Leah, Daniel is not afraid to "go there" with his clients, and he has become more attentive to those who may have trouble expressing their despair. Similar to Alec, Daniel finds meaning in profound loss by attaching a reason to having experienced it.

**Daniel:** Since then, the impact on me professionally, clinically, is that I've always had a second or third antenna for anybody who is suicidal. To a few colleagues I've said, "I have an extra antenna and this is the reason." I'm not afraid to talk about my brother's death. To other people listening for the first time it's very impactful. But you know, I've had years to make this adjustment and to

work through it. Over the years, it has done me well in the sense of my antenna resonated with anybody in the suicidal range, and believe me, there have been a lot of people. I don't think I've lost anybody in my immediate care over the years, thanks to the goodness of God and His direction and enlightenment. Clinically, it allowed me to be a little more attentive to people who are acutely or, you know, "hidden." I get at these nuances of talk or whatever that can allow me to get that [message] out, and then we go somewhere with it and hope we stave off the impending sensation. It has been helpful to me over the years, but for that reason that I lost my brother and under those circumstances... When all is said and done, what is the intent? It's been to help and to make things a little better for somebody else.

### **The Researcher's Journey**

This dissertation would be incomplete without careful analysis of the researcher's own pathway through this initiative. In the following section, I will describe my own lived experience as I collected and analyzed data, as well as the essence of self-discovery.

After receiving permission from the Institutional Review Board, I eagerly anticipated the data collection aspect of this project. Once the word was out, clinicians quickly volunteered to participate. This sparked excitement as I began to journal my experiences and feelings. With digital recorder in hand, I set out to interview Eileen.

This elderly woman was very much looking forward to sharing her story of loss and its impact on her life and work. Eileen had taken thoughtful notes beforehand, and said, "I think it would be good for me to tell my story. I have never done it like this before, and certainly have not talked about it since [my husband's] fairly recent death."

As she spoke, I was freshly aware of the need to bracket *my* innate tendency towards compassion and beneficial pursuit of a thought or feeling. I discovered a key aspect of this type of research: I was *not* there to do therapy, but simply listen actively

and determine the essence of what Eileen was sharing about her loss. This was a new approach for me, and I became conscious of it early in our interview. As a result, I felt rather stiff and restrained, focusing on the narrative and holding back on interactive therapy.

The interview lasted nearly two hours, and she could have continued, further detailing her story. I was bound by time constraints, yet grateful to have a structured and necessary ending. A few hours after the session, I felt emotionally and physically spent. I took a very rare nap. From my journal:

My heart is heavy. I am sad about her stories of loss and that I was/am unable to “process” them with her. The grief seems lighter (for me as therapist) when I can help to work through it and move towards healing. I need space from this interview, yet I look forward to analyzing it.

Brylee eagerly volunteered to be interviewed, almost hoping I would ask her. Although I looked forward to hearing her story, as the scheduled time approached I became a bit anxious, remembering my exhaustion after the previous interview. Knowing the subject matter was loss of a stillborn baby piqued my maternal instincts. I had never before spoken with someone in depth about this type of loss.

Her office was simply and beautifully appointed, creating a welcome sense of calm. She began by telling me no one really wants to hear her whole story. Brylee has divulged only bits and pieces to others, but not the story in its entirety. This interview allowed for recounting her complete narrative, prompting tearful moments united with poignant inner strength and determination on her part. The issue of bracketing was much reduced from the previous interview for me and I felt comfortable and present to her as

she spoke. Active listening alone became more natural with diminished inclination to “do therapy.” Empathy remained, focus sharpened. I began to learn the difference between researcher and clinician. From my journal:

Always a relief when these interviews are over. This was intense, but no headache or fatigue this time. In both sessions I see overlap in the types of loss and grief....this is something to watch for...

The third interview proceeded with even greater ease. It was less emotional than the previous two narratives. I felt more self assured and able to bracket my own lived experiences, and began to see more clearly how this data collection process works. The balance between creating a therapeutic relationship and maintaining the investigative distance of a researcher clarified. I centered on helping the participants to “really feel understood” during their narratives. Fiona demonstrated more anger than sadness throughout her interview as she spoke of her frustrations with her chronically ill sister. From my journal:

Perhaps the most poignant moment for her was when I asked, “Who listens to *you*? Who hears *your* story?” Fiona blinked back tears and reached for a tissue. Today I clearly feel less emotional drain – maybe because she didn’t exactly demonstrate passion or emotion herself.

It is understandable therapists are requesting to participate in this study. For many, there is a need in life to disclose one’s disquieting stories of loss with someone who truly cares and have those sorrowful experiences validated. Equally important, they explore lessons learned from that loss and the meaning found within.

By the fourth interview, my confidence as a qualitative researcher had expanded. I felt assured with my interview skills and potential themes began to materialize. From my journal:

Alec revealed yet another sorrow distinct from the previous participants. I am struck by the multi-faceted dimensions of grief...all very different stories, yet common themes are beginning to surface.

There was no inclination to slip into a therapeutic role, and despite this very tragic narrative, I felt energized by the notion that to me this is becoming important research.

As momentum gained in data collection, I began to anticipate meeting with the participants who were inspired as they recalled surviving their losses. Each reflected on using personal experience of loss in empathic ways to help them navigate their clients' loss and grief.

Claire's interview was somewhat confusing; nonetheless it offered a new twist in my understanding of finite loss. She had forgotten to mention her divorce as a loss in her life until well into the session. Leading up to this disclosure, she appeared detached and vague. I worried this interview was "going nowhere." Perhaps the audio recording made her nervous? When Claire finally revealed the divorce and realized it was one of two huge losses in her life, genuine surprise and insight triggered the notion that for her, this loss was unequivocally over. From that lively moment on, the narrative became more honest and my tension dissipated.

I was aware of Norah's loss before our meeting, as the death of her son, who was active duty military, had reached local and national news. She was keenly interested in telling her story and our session lasted nearly two hours. In great detail she described the



agony of her loss, recalling minute facets, feelings, and thoughts during this ordeal. From my journal:

This was another excellent interview. She began by talking about the photos and awards belonging to her son which adorn a wall in her office waiting room...like previous participants, Norah states personal experience has carved within herself greater empathy for her clients, as they grieve their own losses. She believes her openness and willingness to allow others to ask about her loss sets the stage for clients' expression of compassion and understanding.

Despite emotional intensity in this interview, I maintained the stance of a curious yet caring researcher. I felt very present to her, and even though it was simply an interview on my part, Norah stated it was meaningful and therapeutic for her to convey her story.

Tori was the youngest participant, and brought her limited life experience to the interview. While her losses were no less important to her, they illustrated commonalities with others in early adulthood: loss of a grandparent, a pet, moving away from home, and the end of childhood. My initial impatience dwindled when I realized her perspective was valuable in this study since it brought a fresh look at losses long forgotten by older adults.

The interview with Leah was impassioned and filled with turbulent tangles. It was the first time she had ever told her entire story, and she ventured in many different directions. My head spun trying to follow her lead as she recounted a variety of traumatic losses beginning early in childhood. Leah was perceptibly nervous beginning her story, however in the course of the narrative, she felt safe enough to continue and expand details. The session lasted nearly two hours, and its intensity left me faintly unsettled. Maintaining a bracketed attitude helped preserve my perspective, knowing I was not present as therapist, but as a researcher. Remarkably, Leah's own outlook

changed as she began to identify and acknowledge resilience and find meaning in her losses. From my journal:

Some of the participants have “tried” to find an example of each loss: finite, ambiguous, nonfinite, and disenfranchised losses in their lives. I have encouraged them simply to recount their story of loss. That seems to free them up to share the unadulterated narrative. I am beginning to regard loss as a crystal, with many facets...also noting the “layering” of loss upon loss...I hadn’t expected these discoveries at all!

Interviewing Sheila was somewhat frustrating as her evasive tendencies came through into our conversation. It seemed as though she was not taking our interview seriously as she launched into the loss of certain television personalities and shows. Disparate facets of Sheila’s story emerged. Nonetheless, it was her account of loss and commanded respect and attentiveness on my part. The challenge for me was to collect divergent story threads and weave them into a cogent understanding of the essence of her personal experience of loss. From my journal:

This was another interview where I wondered about the substance and seriousness of what she had to say. Yet who am I to judge another’s grief? On the other hand, does anxiety prevent a person from taking this subject matter seriously enough to express it?

By the final interview, my confidence as a researcher expanded, comfortably maintaining the necessary balance between investigator and caring individual. From my journal:

It appears to me that telling one’s story of loss and grief needs to take place in the presence of someone who is educated in the nuances of loss and grief, and who can effectively process this loss with the griever. Daniel welcomed opportunity to recount the story of losing his younger brother to suicide, albeit nearly forty years ago. His memories remained clear and narrative flowed with little prompting on my part. I am increasingly aware of the positive dimension in telling one’s story

of loss: no matter how long ago loss occurred, it still “feels good” to disclose one’s sorrow and have resilience validated.

Conducting interviews was personally rewarding. I grew as a researcher, refined my interactive skills, learned anew the value of balance, and appreciated the wholesome feeling of putting the puzzle pieces of this study together. Worthy of note: a particularly frustrating event occurred with nearly every interview. Once the session ended and I turned the recorder off, the participants more often than not shared some true and heartfelt “gems” of thought or emotion, and this would not be documented. After departing, I would scurry to my journal and note the essence of what was said. Following the first few sessions, I learned to anticipate this recurrent issue.

## **Discussion**

The concluding section of this chapter will explore findings uncovered as a result of this research.

### **Findings in Relation to Theory and Literature**

Data collection and analysis effectively elucidated four theories of loss and grief examined in this study. Careful scrutiny of every interview determined *most* participants mentioned *each* of these forms of loss in their narratives. Least noted was finite loss, while ambiguous, disenfranchised and nonfinite losses ranked equally across the study. Likely, finite loss was less referenced because by nature, *it is ended* and does not persist in producing emotional pain. Ongoing, unsettling discomposure characterizes ambiguous, disenfranchised, and nonfinite losses. For some people, all loss may be finite. Their worldview involves moving on to the next person, dream, challenge, or

deed, without due deliberation. They are not stronger than their peers; they simply view life through a different lens. These individuals rarely seek grief therapy. For others, loss may devolve into a dull ache following searing emotional heartbreak and seemingly unending woe. It is for these people therapists need refined knowledge and skills to assist in healing.

Data analysis led to discovery of two major foci: “Loss and Grief Profile,” and “Impact Profile,” further elucidated below.

**Loss and Grief Profile.** This analysis was generated from Question 1, wherein participants simply shared their stories of loss and grief. Twelve predominant themes came to light from these accounts. Topics and the frequency in which they occurred are detailed in the above section.

**Impact Profile.** Refinement of the above themes evolved into Question 2, the investigation of impact upon each clinician’s work. Due to the personal nature of individual narratives, impact analysis resulted in a loss profile unique to each participant.

**Spiral as Symbol.** In previous chapters, the powerful image of a spiral emerged from literature chosen to be included in this work. Ancient Celts believed all creation was composed within the dynamic spiral systems of the universe. An astonishing mystical influence materialized when six out of ten participants described their grief experiences using the image of a spiral! For the author, this has become an exhilarating finding within the research suggesting cosmic interconnectedness beyond imagination.

## **Findings in Relation to Rationale for the Study**

Four main points comprise findings in relation to the rationale in this inquiry:

(1) From the outset, the need and desire for therapists to process their personal experience of loss and grief with someone who is knowledgeable and caring was astounding. Once word of this study entered the therapeutic community, clinicians fervently expressed their desire to participate. The author maintains a growing waiting list of therapists who wish to join in future research. During post-interview feedback, participants described telling their story of loss as a very positive and rewarding experience. Many expressed desire to share more at a later date.

(2) When asked to speak of how personal losses have impacted their work, without exception each participant noted their therapeutic “grief specialty” with clients correlated directly with the loss they sustained.

(3) While each clinician was somewhat knowledgeable of Kübler-Ross’ (1969, 1974, 1982) [finite] five-stage model of grief, only a few were vaguely familiar with ambiguous, disenfranchised, or nonfinite losses. This is highly significant since finite loss was least noted within data analysis. According to the narratives, ambiguous, disenfranchised, and nonfinite losses far outweighed occurrences of finite loss. This inversion is likely due to the fact that Kübler-Ross set foundational blocks for studying loss and grief in the second half of the 20th Century, from whence many current therapists and university professors learned the subject matter. Little has changed to update clinicians and students to new and valuable information on loss, grief, and

resilience. Interviews frequently gave rise to participant “Aha” moments as the researcher labeled their loss leading to greater understanding of their grief.

(4) Although distinct differences among ambiguous, disenfranchised, and nonfinite losses exist, they were recurrently found to be confluent and overlapping. These losses frequently coexist, though this is not a consistent pattern. The image is not unlike observing different facets of the same crystal. Once the category of loss is precisely identified, seemingly interminable grief may be parsed and assuaged.

## CHAPTER V

### SUMMARY, IMPLICATIONS, & RECOMMENDATIONS

Life is a series of gains, but it is also a series of losses; *failures to grieve* loss and disappointment openly, honestly, will rise again, as unbidden ghosts from their untimely burial, through depression, or as projections onto objects of compelling, delusive desire, or through captivation by the mindless distractions of our time. Failure to incorporate loss into our lives means that we have not yet accepted the full package life brings to us. (Hollis, 2009, p. x)

Hollis' cautionary statement is at once a warning and an invitation to live life to the fullest. It is also the statement which puts tooth and rigor into the depth of this dissertation. This final chapter circles back throughout the previous four chapters: (1) to summarize observed grieving patterns, (2) to examine impact of this grief on therapists' work, and (3) to provide suggestions for future research. This triplicity: observation, qualitative analysis, and recommendations for the future, demonstrates solid potential for advancing the state of scholarship within the therapeutic culture.

The subject matter for this dissertation was born out of the researcher's keen desire to understand the questions of her own loss and grief. Words of reassurance from others often fell short of her desire to be understood and have her loss and resilience validated. At times, the researcher/therapist herself felt unable to effectively help those suffering agonizing loss, as well. This launched the quest to better understand the personal experience of loss and resulting insight among therapists to whom individuals entrust their deepest, most life-changing heartache, hoping they will come through the liminal space with spirit intact and energy restored.

## Summary

The purpose of this study was to investigate how loss and grief affect therapists, and whether this encounter prompted personal transformation, specifically in their clinical work. The guiding premise of this study postulated that the ability to work in a therapeutic setting with individuals overwhelmed by loss might be impacted by a clinician's own insight into their lived experience of loss and grief. This research explored whether experiencing personal loss helps a clinician better serve grieving individuals. Unless the therapist possesses an incisive sense of awareness and willingness to "go there" with the grieving client, healing will not likely take place (Doka, 2002; McBride & Simms, 2001; McCabe, 2003).

The "Literature Review" in the second chapter explicated four models which conceptualize current thinking on loss and grief: finite loss (Kübler-Ross, 1969, 1974, 1982), ambiguous loss (Boss, 1999, 2006) disenfranchised loss (Doka, 2002), and nonfinite loss (Bruce & Schultz 2001). In addition, the vocation of therapist was examined, elucidating commonalities across the profession in order to further define the population chosen for this research.

The third chapter, "Methodology" discussed the research techniques used in this qualitative inquiry, which was conducted as a heuristic phenomenology. This method provided the framework through which the researcher could best understand therapists' experience of loss and grief and how it impacted their work with clients. Clinicians' perspectives were captured as they shared their stories, while at the same time the researcher discovered more about herself and gained insight into her personal experience



of loss. Interest in this research grew throughout the local therapeutic community, and clinicians readily volunteered to participate. Criteria used to determine adequate sample size for qualitative research was based on saturation of themes, which was achieved with ten participants. Use of MAXQDA, a computer-based software program, was valuable in storing, organizing and codifying information for further analysis.

The fourth chapter, “Results” provided a brief description of each participant including stories of their loss. Two profiles were established based on the research questions. The “Loss and Grief Profile” detailed twelve themes emerging from participants’ accounts. These were arranged according to frequency in which they occurred.

Question 1 became the bridge to understanding the import of Question 2, which generated the “Impact Profile.” Explication of clinician’s loss and grief narratives provided the ground upon which Impact Profiles were developed and analyzed. Due to the personal nature of individual narratives, impact analysis resulted in a “Loss Profile” unique to each participant.

Key research findings led to the following four observations:

(1) Participant response indicated a need to process one’s loss, whether the wound was forty years old or freshly dealt, or somewhere in between. Verbalizing what and how one survived provided a unique opportunity for self-discovery and growth, proceeding on the spiral of life.

(2) The type of loss sustained by the participant became their “grief specialty” in working with clients. These clinicians were highly cued in to clients suffering *the same*

*or very similar* experience of loss. For example Daniel, whose brother committed suicide, is acutely aware of clients who may be considering taking their own lives.

(3) Each participant was acquainted with Kübler-Ross' (1969, 1974, 1982) notion of five predetermined [finite] stages of loss, but had only vague knowledge of ambiguous, disenfranchised, and nonfinite losses. When these types of loss were identified by the researcher during interviews, participants grasped the knowledge and embraced the insight. Of specific note was that while each participant had some knowledge of Kübler-Ross' (1969, 1974, 1982) finite model, this was by far the *least* mentioned experience of loss disclosed. This indicates a discernible gap in therapists' current knowledge and education in the domain of grief therapy.

(4) Despite intrinsic differences, ambiguous, disenfranchised, and nonfinite losses were recurrently found to be confluent and overlapping. These three forms of loss are at once similar and yet very distinct, describing different facets on the same crystal. In particular, they share the *unending* element of loss.

### **Implications**

The opening quote by Hollis (2009) asserts if we do not face our losses and grieve them wholeheartedly, they will return to aggravate us in unfinished, unforeseen ways. Likely, the root need of most therapy is identification of one's personal loss and accompanying grief. Addictions, depression, and unsound behaviors spin off unsettled and murky reactions to unrecognized loss.

The researcher views a well-educated therapist as one who stands in the liminal space between brokenness and healing, and is trained to guide those seeking

interpretation of their emotional pain and suffering. Regrettably, few clinicians appear truly equipped and confident in dealing with another's deepest sorrows. The sheer magnitude of certain losses may make a therapist's willingness to go the distance with a client downright intimidating. This research ascertained a confounding dearth of knowledge in therapists' recognition and understanding of loss and grief. Each therapist in this study was relatively familiar with finite loss, as though Kübler-Ross' (1969, 1974, 1982) paradigm was the gold standard. Surprise and validation noted during interviews when clinicians' pain was specifically identified and acknowledged vis-à-vis all four models of loss, demonstrated two seminal points determined by this research:

(1) Unless we are clear about the nature and identification of our own grief, we will be unable to truly understand our losses.

(2) Unless we are in touch with and truly understand our losses, we cannot help others effectively through their own loss and grief.

Identification of loss precedes ability to grieve well. Ability to grieve well yields personal growth, insight into self, and plausible potential for finding new meaning through one's own lived experience of loss. The more self-knowledge and understanding a therapist possesses, the more helpful and valuable therapy will be for the client.

By its nature, this awareness will grow from within and ultimately become part of one's worldview.

## Recommendations

This study generated sound and durable recommendations for both clinical practice and future research. The staggering differential between what student therapists are taught and the existing body of knowledge needs to be diminished. Educators must seriously begin to create programs which incorporate the in-depth study of loss and grief using insights from a variety of literature, including poetry, fiction, film, ancient and modern philosophical accounts, as well as those authors and references aforementioned in this work. Within these programs, students may be encouraged to investigate their own lived experiences of loss and grief, thereby initiating a level of self-discovery which has likely not yet been tapped. The topics of loss and grief may also be covered in a variety of settings, conferences, organizational luncheons, round table discussions, and lectures within the community.

This specific body of research momentarily resides in the liminal space, the point of tangency, standing between this freshly completed dissertation and the future of therapist-centered study of loss and grief. That many more clinicians request to participate in this study is no small thing. Potential for expanding this research and adding to the current state of knowledge is replete with possibilities. Widening the sampling base to include other caregivers, nurses, social workers and clergy may be a logical and valuable next step. Diversifying gender participation would also enhance the quality of the sample. Investigating gender differences around grief would provide yet another portal for discourse and study. As with the magnificent spiral, there is no discernible end to where this research may lead.

### **Researcher's Final Perspective**

This experience of being a researcher in my chosen field of study has broadened and deepened my knowledge and awareness of loss and grief. Each interview kindled both newness and familiarity, enriching my perspective as an investigator and as therapist. Above all, the essence of my personal lived experience has advanced to new heights and enhanced meaningfulness.

In an impassioned lecture given in 1940, at the Seventh Conference on Methods in Philosophy and the Sciences, Gregory Bateson (1972) described what he learned from his father, a geneticist:

I picked up a vague mystical feeling that we must look for the same sort of processes [as his father unearthed] in all fields of natural phenomena – that we might expect to find the same sort of laws at work in the structure of a crystal as in the structure of society...this bit of mysticism was important because it encouraged me to expect these ways of thought to fit in with very different fields of observation. It enabled me to regard all my training as potentially useful.  
(p. 74)

It is in the spirit of compelling mysticism that this dissertation is composed.

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## Appendix A – Cover Letter

**St. Mary's University****AN INVITATION TO PARTICIPATE  
IN A RESEARCH PROJECT**

Dear Colleague,

My name is Molly O'Phelan, and I am a doctoral candidate in the Department of Counseling and Human Services at St. Mary's University, with a degree in Marriage and Family Therapy. For my doctoral dissertation, I am conducting a research project entitled: **A Phenomenological Exploration of Therapists' Personal Experience of Loss and Grief and Impact on Therapeutic Approach**. The purpose of this study is to capture clinicians' perspectives as they share their personal experiences with loss and grief, and how these events have transformed their therapeutic approach. I invite you to consider participating in this important research.

The study will describe four current views of loss and grief. Those who wish to participate will identify and tell the story of the type of loss they have experienced (see below), and discuss how it has impacted their work with clients. The interview may last from 60-90 minutes, and will be digitally recorded, transcribed verbatim, and verified by the respondent. From this information, common themes and relevant patterns will be ascertained and combined with the stories of other clinicians.

Should you decide to participate, please contact me at ophelanm@gmail.com to arrange an appointment time at your convenience. From this pool of willing clinicians, participants will be randomly selected for the study. Each person is encouraged to include any relevant poetry, music, prose, or artwork which has been helpful in processing this grief.

In order to preserve anonymity and confidentiality, participant identities will be assigned numerically. This systemization allows me to determine common themes without identifying the participant. There will be no remuneration for this endeavor; however potential for advancing knowledge and healing in our profession provides a meaningful venue for giving back to the community.

**Four Current Views of Loss and Grief to be Considered:**

**Finite Loss:** This type of loss has a clear beginning and end. It may or may not be a vast, life-changing event, but is significant enough to cause an emotional reaction (Bozarth-Campbell, 1982; Westberg, 1962). Examples include the loss of someone not

very close personally, but who has influenced you in some way, loss of a pet, not achieving something wished for like a club or social group.

**Ambiguous Loss:** A distinctive kind of loss for which there is uncertain closure; the status of a loved one is considered either “there” or “not there,” with no acknowledgment of it being a true loss. This type of loss has an undefined beginning and an undetermined end (Boss, 1999, 2006). Examples include the situation where an individual is physically present, yet psychologically absent, as with Alzheimer’s disease or brain injury. Conversely, those physically absent such as in an unwanted relationship break-up, prisoners of war, or victims of natural disasters namely flood, tsunami, or tornado, are often very much psychologically present to those who await and love them.

**Nonfinite Loss:** Bruce & Schultz (2001) state, “we use the term nonfinite loss to refer to losses that are contingent on development; the passage of time; and on a lack of synchrony with hopes, wishes, ideals, and expectations” (p. 7). It is the loss of “what should have been,” referring to dreams and expectations of life, couched within a person’s past, present, and future worldviews, and is especially influenced by one’s specific fears and anxieties (p. 7). Examples include having a child with developmental or emotional disabilities, infertility, diagnosis of a life-threatening illness or deteriorating health, loss of someone by war, murder, or disappearance.

**Disenfranchised Grief:** An expanding concept developed by Doka (2002), which addresses various sectors of our changing society. “Survivors are not accorded the ‘right to grieve’.... for many reasons, such as the ways a person grieves, the nature of the loss, or the nature of the relationship...grief is not openly acknowledged, socially validated, or publicly observed” (p. 5). Examples include the loss of someone with whom one is having an affair, suicide, miscarriage or stillbirth, loss of a pet, job, or religious identity, loss within a gay relationship.

If you have experienced any of these types of grief, please consider sharing your story with me. I see no physical risk to participants in this study. However, sharing one’s grief story may spark difficult or unhappy memories, which may be long-forgotten, yet trigger unexpected impact. Should you wish to pursue further therapy for grief resolution, a list of qualified therapists will be provided.

**The data collected from this inquiry will be used for education and publication purposes; however it will not be identified with you personally. Any questions about this research, or any related problems, may be directed to the Principal Investigator, Moonyeen (Molly) O’Phelan, MA, RN, LMFT-A, Department of Counseling and Human Services (210) 438-6400.**

**ANY QUESTIONS REGARDING YOUR RIGHTS AS A RESEARCH PARTICIPANT MAY BE ADDRESSED TO THE ST. MARY’S UNIVERSITY**

**INSTITUTIONAL REVIEW BOARD HUMAN SUBJECTS (210) 436-3315. ALL RESEARCH PROJECTS THAT ARE CARRIED OUT BY INVESTIGATORS AT ST. MARY'S UNIVERSITY ARE GOVERNED BY REQUIREMENTS OF THE UNIVERSITY AND THE FEDERAL GOVERNMENT.**

Thank you very much for considering participation in this study. It would be my privilege to hear your story of loss and resulting change, and weave it into words of insight and inspiration for working with our grieving clients, as well as enhanced self-care for clinicians. Please contact me at: ophelanm@gmail.com if you have questions or would like to join in the research.

Sincerely,

Moonyeen (Molly) O'Phelan, MA, RN, LMFT-A



## Appendix B – Consent Form

St. Mary's University

CONSENT BY THE PARTICIPANT FOR PARTICIPATION  
IN A RESEARCH PROJECT

**Title:** A Phenomenological Exploration of Therapists' Personal Experience of Loss  
and Grief and Impact on Therapeutic Approach

**Principal Investigator:** Moonyeen P. O'Phelan, MA, RN, LMFT-A

Department of Counseling and Human Services

ophelanm@gmail.com

**Associate Investigator:** H. Ray Wooten, PhD, LPC

Department of Counseling and Human Services

210-438-6400

hwooten@stmarytx.edu

I am being invited to participate in the above-mentioned research study. My participation in this study is entirely voluntary and I may refuse to participate, or may decide to cease participation once begun. Should I withdraw from the study, which I may do at any time, or if I choose not to participate in the study, my decision will involve no consequences, penalty, or loss of benefits to which I am otherwise entitled. I am being asked to read the consent form carefully and will be given a copy of it to keep, if I decide to participate in this study.

I was told the purpose of this research is to elicit clinicians' perspectives as they share their personal, lived experiences with loss and grief, and how these events have transformed their work with clients. I was also informed about the following procedure:

Therapists will be invited to take part in this research through an email sent to their professional address. In this email, a brief description of each form of grief to be studied will be defined. Those who wish to participate will respond by identifying the type of grief they have experienced and contacting the researcher to set up an appointment. From this pool, a minimum of 5 and up to 25 clinicians will be randomly selected. Respondents who have been chosen will be interviewed at the location of their choice, bearing in mind the need for privacy and confidentiality during the session. There will be no alternative procedures or accommodations for this interview (i.e. no phone interviews, videoconferences, or chat rooms). I have been advised that the total anticipated time commitment for the interview may be approximately 60-90 minutes, and will consist of telling my story of loss and grief, and how this experience has impacted my work with clients. This conversation will be digitally recorded and transcribed verbatim. I will be asked to review it with the investigator, at a later date, for content and meaning. I have been invited to include prose, poetry, music, or other artifacts (video excluded), which have been helpful in processing my grief. I have been informed there is nothing experimental about any of the procedures within this study, and significant findings in this research will be shared with me.

I have been informed the investigator will report any child abuse or sexual misconduct by a mental health professional to the proper authorities. I have also been instructed that the researcher will not pursue information that puts me at legal, ethical, or moral risk.

I have been advised that while there are no physical risks associated with participation in this study, I may experience some discomfort in reviewing my personal feelings, experiences, and opinions. Sharing my grief story may spark difficult or unhappy memories, which may have been long-forgotten, yet trigger unexpected emotional impact. If this becomes problematic, terminating the interview may be warranted. Should I wish to pursue further therapy for unforeseen issues or further grief resolution, a list of qualified therapists will be provided.

I have been advised that I will receive no direct benefit from my participation in this study. However, my contribution will aid the investigator in better understanding how experiencing loss and grief affects the work of the therapist. This, in turn, will yield improved educational training for clinicians in the areas of grief therapy and enhanced self-care.

Every effort will be made to maintain the confidentiality of my records. I have been specifically told the information gathered in this study will be coded so as to protect my privacy. This will be accomplished through a procedure whereby the data I provide will be referred to by my participant number alone. The list, pairing participant names and

participant numbers, and the consent forms will be kept separate from the data and will only be available to the principal investigator. I have been advised that the data collected from the study will be used for educational and publication purposes; however, I will not be identified by name. The confidentiality of the data will be maintained within allowable legal limits. I have been notified the information gathered during our interview will be stored in sealed envelopes, within a securely fastened file cabinet, in the researcher's office, and retained for 5 years. Thereafter, the records will be shredded. I have been assured the researcher has a firm understanding of and solid commitment to confidentiality.

I am aware that no financial remuneration will be offered for participation in this study. I have been told the investigator has the right to withdraw me from this study at any time. The investigator has offered to answer all my questions. If I have additional questions during the course of this study about the research or any related problem, I may contact the Principal Investigator, Moonyeen (Molly) O'Phelan, at ophelanm@gmail.com. In addition, I may contact the Department Area Representative for the Institutional Review Board, Dan Ratliff, Ph.D., at dratliff@stmarytx.edu.

In the event of injury resulting from this study, St. Mary's University does not offer financial compensation nor absorb costs of medical treatment; however, necessary facilities, emergency treatment, and professional services will be available to research participants, just as they are to the general public. My signature below acknowledges my voluntary participation in this research project. Such participation does not release the investigator, institution, sponsor(s), or granting agency(ies) from their professional and ethical responsibility to me.

**I HAVE READ THE INFORMATION ABOVE AND HAD MY QUESTIONS ANSWERED TO MY SATISFACTION. I VOLUNTARILY AGREE TO PARTICIPATE IN THIS STUDY. AFTER IT IS SIGNED, I WILL RECEIVE A COPY OF THIS CONSENT FORM.**

---

Name of Research Participant (Please Print)

---

Signature of Research Participant

---

Date

---

Signature of Witness

---

Date

---

Signature of Principal Investigator

---

Date

ANY QUESTIONS REGARDING YOUR RIGHTS AS A RESEARCH PARTICIPANT MAY BE ADDRESSED TO THE ST. MARY'S UNIVERSITY INSTITUTIONAL REVIEW BOARD-HUMAN SUBJECTS (210) 436-3315 or toll free: 1-800-FOR-STMU. ALL RESEARCH PROJECTS THAT ARE CARRIED OUT BY THE UNIVERSITY AT THE UNIVERSITY ARE GOVERNED BY REQUIREMENTS OF THE UNIVERSITY AND THE FEDERAL GOVERNMENT.

## Appendix C

## VITA

**Moonyeen P. O’Phelan**  
**MA, RN, LMFT-A**

**137 Paloma Drive**  
**San Antonio, TX 78212**  
**ophelanm@gmail.com**

**EDUCATION:**

Ph.D. Candidate, Marriage and Family Therapy, St. Mary’s University  
M.A. Marriage and Family Therapy, St. Mary’s University, 1988  
A.A.S. Nursing, St. Mary’s School of Nursing, Minneapolis, MN, 1979  
B.A. Theatre Arts, University of Minnesota, 1974

**LICENSURE:**

Registered Nurse – currently licensed in Texas  
LMFT-A – since October 2010

**AFFILIATIONS AND MEMBERSHIPS:**

Minnesota Jung Association  
San Antonio Association for Marriage and Family Therapy

**OCCUPATIONAL HISTORY:**

Currently working as a School Nurse at Lackland AFB Independent School District  
Marriage and Family Therapist – Lutheran Social Services, San Antonio, TX 1987-1990  
Registered Nurse – Humana Women’s Hospital, San Antonio, TX 1988-1990  
Registered Nurse – St. Joseph’s Hospital, St. Paul, MN 1979-1985

**AWARDS AND RECOGNITION:**

Yellow Rose of Texas 2009 – awarded by Governor Rick Perry  
Volunteer Excellence Award 2009 – awarded by Air Force Chief of Staff  
Outstanding Volunteer Award 2008 – Lackland ISD Board of Trustees

**COMMUNITY INVOLVEMENT:**

Board Member, Texas Children’s Choir – 2011 to present  
Teacher, Adult Education Department, St. Luke’s Episcopal Church 2006 to present  
Volunteer Staff, Alpha Home, San Antonio, TX