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Manifestation of grief and loss in crisis-oriented psychotherapy : graduate preparation and lessons learned

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ABSTRACT

This qualitative study explores insights clinicians have gained about grief and loss through their work with clients in crisis, and their perceptions about the adequacy of their training to confront these clinical issues. Semi-structured interview questions focused on how participants work with someone in crisis, and how issues of grief and loss manifest and are facilitated in the clinical setting.

Fourteen experienced mental health practitioners in Western Massachusetts were interviewed. Their narratives revealed a strong belief that grief and loss are often part of what prompts a client to seek counseling. Participants noted that many clients are not aware of the impact of loss, particularly losses suffered at an early age, and losses that have not been recognized and grieved. Most participating clinicians revealed that they had received no substantial training around grief and loss in their academic programs and had sought out post-graduate seminars in this area. Clinicians expressed that working with clients experiencing grief and loss has been deeply meaningful and has helped develop and enhance their clinical skills. Grief and loss are seen as central to much of the psychotherapeutic work in which these clinicians are engaged.

MANIFESTATION OF GRIEF AND LOSS IN CRISIS-ORIENTED

PSYCHOTHERAPY: GRADUATE PREPARATION AND

LESSONS LEARNED

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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CHAPTER I

INTRODUCTION

Loss is universal. It is part of the human condition that everyone will suffer

multiple losses in their lives. Through death, divorce, the loss of a job, loss of personal

health, employment or significant relationships, losing something we value often triggers

a grief reaction. Bowlby (1980) described grief as an adaptational response. In his theory

of attachment, Bowlby argued that forming attachment bonds with significant others is

fundamental to survival and development. When the loss of an important attachment

relationship is experienced, grief results. It is only when an individual moves through

grief, and becomes less attached to the lost loved one, that he or she can begin to

establish new attachments to others.

In some people, a grief reaction may be delayed, avoided or can become chronic;

losses from the past can emerge and complicate a person's response to current life

challenges. Individuals may find themselves stuck, overwhelmed, ill or angry, and may

not understand "why." Clients processing grief and loss may present in any clinical

setting, and they may not be aware that unresolved losses are contributing to a crisis

situation. Covert grief and losses must be uncovered in order to help the client fully

resolve his or her current crisis situation. Grief can, therefore, be an underlying issue for a

person in crisis (Lindemann, 1944), that is, someone whose normal skills for

coping no longer adequately serve their needs.

Clinical training programs for mental health professionals are not required to contain specific content dedicated to dealing with issues of grief and loss. While grief is often central to the work of counselors, discussion of how grief, loss, attachment and adaptational styles impact an individual's responses to life stressors tend to receive no in depth coverage. In many training programs, courses that examine grief and loss in depth are elective, not required. Less than one-fifth of students in the health professions have access to a course about death (Wass, 2004). Berzoff and Silverman (2004) note that "social workers have not been trained or prepared to work with (the bereaved or) people who are at the end of their lives" (p 97). Christ and Sormanti (1999) found that "problems with teaching end-of-life curricula at master's level (in social work are)… shared by medicine and nursing" (p 95).

Without training in how to facilitate grief and loss, clinicians may bring their own discomfort into their work and remain unsure of how to respond when faced with client losses. They lack both a foundation in grief theory and an understanding of what constitutes a healthy grieving response. In a survey of social work students at the University of Wisconsin in 1997, the average student felt only "a little" or "somewhat" prepared to help a client who is grieving or dying (Kramer, 1998). Hooyman and Kramer (2006) cite a study conducted by Csikai and Raymer (2002) which found that:

> Only 31% of 390 respondents in a national survey of health care social workers agreed that grief, loss and death content of their social work programs adequately prepared them for post graduate employment (p 348).

A review of the literature indicates that grief and loss issues are currently addressed mainly in the areas of death and end-of-life care. Even in this area, a 2003 study found that "what death education is available (in mental health training programs) is inadequate. It offers little opportunity for participants to become knowledgeable about death and grief, to deal with their own feelings, or to develop empathy" (Wass, 2004).

Death, or impending death, is just one of the significant losses that may cause an individual to grieve. Parad and Parad (1990) cite a 1960's study that examined whether the loss or addition of a significant social relationship or a transition in social status such as entering or ending school, marrying or divorcing may be "crisis inducing or potentially hazardous" (p 16). The Holmes and Masuda Social Readjustment Rating Scale (1967) ranks divorce or marital separation as more stressful than experiencing the death of a family member other than a spouse.

This study investigated how clinicians who assess clients, including individuals who present in crisis, facilitate client understanding of the impact of grief and loss. It also explored whether the skills these clinicians rely upon were obtained through their professional training programs or developed through other avenues. Through a semi-structured interview I obtained narrative data regarding the clinicians' experience in aiding clients coping with losses. This qualitative study further explored how a clinician's knowledge of grief, loss, and its effect on clients has improved his or her work and enhanced his or her clinical relationships by self-report. Is an understanding of grief and loss meaningful in the psychotherapeutic process? Equally important, how has this understanding about loss and grief enhanced their work as clinicians?

CHAPTER II

LITERATURE REVIEW

This chapter provides a review of the literature related to grief, loss and crisis. Though numerous volumes have been written about these topics individually, there is no literature that explores the relationship between these elements. Since loss occurs throughout the life cycle, and significant losses lead to grief reactions, both grief and loss may be elements of a personal crisis. This review will provide brief descriptions of these elements, in order to provide a framework for investigating how clinical knowledge of grief and loss impacts clients experiencing crises.

I will begin with a description of the different types of loss and explore the factors that influence how loss impacts an individual. Next, I will define grief and describe the grieving process, including a description of what constitutes normal and complicated grief. I will address possible outcomes of bereavement and the factors that affect these results. In the next section, I will briefly present major grief theories and explore cultural differences in grief and mourning. A brief description of attachment theory, patterns of attachment behavior and how they relate to grief and loss will follow. Next, human resilience in the face of loss will be examined. The final sections will define crisis and describe the processes of crisis and grief assessment.

Loss

Loss is a natural part of the life experience. It is an element of every life transition, a shift from what has been "normal" to a state of altered reality, a new self-

concept. According to Hooyman and Kramer (2006) "loss is a life changing event that forever alters the shape and outlook of our lives" (p. 25). It is a turning point that may prompt an individual to search for meaning, to recreate their identity (Hooyman & Kramer, 2006; Weenolsen, 1988). Weenolsen (1988) defines loss as anything that takes away or "destroys some aspect of life and/or self" (p.19). Loss, like any change, impacts life with a ripple effect. Studies have found that some people who have suffered major loss "tend to report lower self-esteem, a greater sense of vulnerability, less interpersonal trust, more worry, poorer health, and lower levels of psychological well-being, even many years after the event's occurrence" (Davis, 2001, p. 137). Loss happens on several levels – primary loss, secondary losses, losses to the self and self-concept, and losses with idiosyncratic meaning (Weenolsen, 1988). It is because of this multi-level impact that the pain of loss can persist for so long.

Secondary losses include, for example, the multiple roles a partner or spouse filled in a person's life and the hopes and expectations the couple shared for the future, the loss of a neighborhood after a move, the loss of the family home after a divorce, the loss of structure and self-esteem after being fired from a job. These secondary losses also generate their own emotional reactions, which may be as strong as or stronger than the reaction to the precipitating loss. These losses, too, must be recognized and mourned, in order to resolve the grief attached to them (Rando, 1993).

Kinds of loss

Rando (1984) identified two kinds of loss: physical loss and symbolic or psychosocial loss. Death is a physical loss; symbolic losses include retirement, loss of a relationship, graduation, loss of health, loss of a dream, trust, or independence. People

tend to expect and recognize that physical losses generate an emotional response, but they are not as aware that symbolic losses also require processing (Rando, 1993). Any loss is capable of setting off a grief reaction even if it is part of the normal growth process, which is why people sometimes experience both joy and sadness when good things happen. Crying at a wedding is one example of this process.

Weenolsen (1988) notes that losses can be either "on-time", "off-time", or "time irrelevant." On-time losses are developmental. They are expected life events such as graduation and getting married. The losses associated with these life cycle transitions, such as a loss of friends and freedom, may be unexpected but are usually less devastating than other losses. Off-time losses are inevitable losses that happen earlier or later than expected, for example, the loss of a parent in childhood. Time-irrelevant losses are always unexpected. This type of loss includes accidents, rape, and serious illness. The timing of a loss in a person's life cycle matters because some losses are more profound when experienced at an earlier or non-normative developmental stage of life (Weenolsen, 1988). We are generally more prepared to deal with traumatic life events later in life, having worked through previous losses and developed a philosophic view of the future.

Ambiguous loss

Boss (1999) wrote that loss can also be ambiguous, and identified two types of ambiguous losses. Ambiguous loss can involve a loved one who is physically absent but psychologically present, such as a soldier missing in action or a biological, non-custodial parent after a divorce. The second type of ambiguous loss relates to someone who is psychologically absent but physically present, such as an individual with dementia, major mental illness, addiction, or preoccupation with work. Ambiguous loss is often

immobilizing; it is "the most stressful loss people can face" (Boss, 1999, p. 20). Loved ones do not know whether the situation is temporary or permanent, and they are often not provided with the same validation and comfort that their community extends to those who suffer more ordinary losses (Boss, 1999). For individuals experiencing ambiguous loss, something within their family has changed, and each individual member must assign meaning to their loss, redefine their role, and move forward with their life.

Factors that impact loss

Storytelling, or narrative analysis, can help individuals make sense of loss. The tradition of storytelling as a way to heal has long existed in Native American culture (Boss, 1999). Our race, ethnicity, sexual orientation, age, gender, attributional style, culture and individual value systems define us. These variables also define what loss means to an individual, and impact how we deal with loss. Likewise, culture defines the acceptable personal and public expressions of feelings and rituals for loss. Native American culture, for example, speaks of spiritual acceptance and of a circle of life. Mexican and Italian traditions speak of "destiny" (Boss, 1999).

Nolen-Hoeksema and Larson (1999) found that women are inclined to talk and to think about loss more than men do. Men tend to avoid thinking about their losses and to take on additional work as a means of coping. This difference in coping style can lead to friction and create distance in the relationships. Baum (2003) noted that several studies have found that women tend to recognize and grieve the loss of their marriage when thinking about separating from their husbands, but men tend not to acknowledge the loss until separation has actually taken place. While women tend to mourn the loss of their marital partnership, men "tend to mourn the loss of their ex-wives considerably less than

they mourn the loss of their children and of their home and family life and routine"
(Baum, 2003, p. 39, citing Jacobs, 1983; Riessman, 1990).

Findings of studies (McKenry and Price 1991; Riessman 1990, as cited in Baum, 2003) also indicated that while divorced women grieve their loss with emotional and verbal expression, men responded to loss with somatic symptoms, the use of alcohol and drugs, sexual and social activity. These results suggest that men "tend to deny the feelings of loss inherent in divorce and to distance themselves from the feelings of sadness, pain and sorrow inherent in the dissolution of marriage" (Baum, 2003, p. 41, citing Fox & Blanton, 1995; Riessman, 1990; Riessman & Gerstel, 1985). Sanders (1998) noted that in masculine grief, the expression of feelings often involves anger or guilt, and intense feelings might not be discussed with others. Men "tend to act out rather than speak out their grief" (Baum, 2003, p. 46, citing Anderson, 2001).

Religion and spirituality also provide a lens through which some individuals view their losses. For some, religious beliefs can help them make sense of loss; religion can be one source of hope and optimism when facing ambiguous losses (Boss, 1999). Other individuals may find themselves questioning their beliefs in light of their losses (Nolen-Hoeksema & Larson, 1987/1991). Because of our idiosyncratic natures, loss is a highly personal reaction.

The resources available to an individual, including their belief systems, cultural resources and social supports, help sustain them at a time of loss. Generalization about culture and religion may provide a guideline with which to open a conversation, but it is crucial to ascertain which particular traditions are important to the individual who has

sustained the loss, in order to support them in a way that is most meaningful to them (DeSpelder, 1998).

If a loss is particularly significant or painful, it can take longer for an individual to accept and integrate the loss. The most profound loss that most people experience is the death of a loved one, especially the loss of a child, spouse or parent. Death and other significant losses may bring about a grief reaction.

Grief

When we lose someone or something to which we have a close emotional attachment, we grieve (Cook & Dworkin, 1992). *Grief* is a healthy and necessary way to bring the body and mind back to balance. It is similar to the process of physical healing (Worden, 1991). Grief is the pain associated with loss. It is impossible to lose someone for whom you have had a deep attachment and not experience some level of pain (Worden, 1991). If an individual who is grieving does not work through the pain of the loss, they become cut off from their feelings. Bowlby (1980) found that people who avoid conscious grieving can develop a type of depressive illness. Grief is not an illness, but "bereavement can have deleterious effect on an individual's psychological and physical health" (Klein & Alexander, 2003, p. 262).

Grief includes psychological and somatic elements (Lindemann, 1944; Stroebe, 1987). Individuals experiencing loss exhibit great variations in the symptomology they exhibit. Affective, behavioral, cognitive and physiological symptoms may be present (Worden, 1991). There is no one symptom that typifies grief (Stroebe, 1987).

The individual who is grieving experiences grief at both an individual and interpersonal level. Their social supports, family, friends and community, for example,

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will help define an appropriate grief reaction and allow the individual to begin to understand and recover from their loss. Even with an adequate social network, the grieving process is still an isolating and lonely experience (Hooyman & Kramer, 2006). New systems, such as support groups of others facing similar circumstances, may prove to be a vital resource for healing.

Normal Grief

Normal, or uncomplicated grief was first described by Lindemann (1944) as having five significant characteristics: 1) somatic or body distress of some type, 2) preoccupation with the image of the deceased, 3) feelings of guilt related to the death, 4) irritability and anger, and 5) the inability to return to normal functioning. In addition, some individuals also take on traits of the deceased, especially symptoms of their illness, in their own behavior (Lindemann, 1944).

Lindemann's (1944) study did not record how frequently these symptoms presented in those he interviewed. He did not define "normality". The individuals he observed did not constitute a representative sample. Those he studied were survivors and individuals who had lost loved ones in the Cocoanut Grove nightclub fire, in which nearly five hundred people died. These research subjects were not only bereaved, they may have been traumatized witnesses to this disaster (Klein & Alexander, 2003). Lindemann did not state how many times he interviewed the patients in his study (Stroebe, 1987; Worden, 1991). Despite these limitations, Lindemann's work continues to be much cited in the current literature and the characteristics of normal grief he observed continue to be noticed in many distressed clients today.

Worden (1991) defined four tasks of mourning that someone who has experienced loss must complete in order to regain balance in her life. The first task is to accept the reality that a loss has happened. Maintaining a room just as someone who died has left it is a form of denying the facts of the loss; the opposite action, removing all reminders of someone who has died, is a way to minimize the loss. Accepting the reality of the loss happens over time, since both the head and the heart need to acknowledge the loss.

The second task of mourning is working through both the physical and emotional pain of loss. Denying or avoiding painful thoughts and memories, or remembering only the positive aspects of the person who has died, keep the survivor from completing this task. According to Parkes (1986) episodic pangs of anxiety and feelings of panic are the most characteristic aspects of grief.

The third task of mourning is to adapt to a life without the person who has died. For those who have lost partners through death or divorce, this may include being a single parent, developing new competencies, and living alone. An individual may need to embrace new beliefs since "it is not unusual for the bereaved to feel that they have lost direction in life" (Worden, 1991, p.16).

The fourth and final task of mourning is to find a way to withdraw some of the emotional energy from the old relationship, and invest in new connections. Making plans for the future and establishing new caring relationships with others does not mean that the lost loved one was not important. The person lost is gone; the survivor moves on.

Parkes (1986) described grief as "a process, not a state" that "involves a succession of clinical pictures which blend into and replace one another" (p.26). Like Worden, Parkes observed that mourning contains a realization phase and a period of

intense emotion. Parkes (1986) also noted feelings of anger and guilt in the bereaved he studied, (often with physical illness). Additional responses to normal grief include urges to search for the person who has been lost and the development of symptoms and behaviors of the lost person (Parkes, 1986).

Disenfranchised grief

In order for an individual to be supported in his or her grief, society must acknowledge that the person has sustained a loss. If the loss is not openly recognized, *disenfranchised grief* exists (Doka & Davidson, 1998) and the individual is cut off from sources of support and healing. The community may not recognize the right of an individual to grieve for a number of reasons. Non-traditional relationships can lead to disenfranchised grief because the existence an important relationship is not acknowledged. Same sex partners, non-married couples, ex-spouses and close friendships are examples of relationships that are non-traditional and which may not be socially sanctioned by friends and family. Unrecognized losses, such as the loss of a pet, ambiguous losses, abortion, or miscarriage are not always deemed socially significant and necessary to grieve. Vulnerable individuals, including children, the developmentally disabled, and those who are critically ill, may also find their grief disenfranchised (Doka & Davidson, 1998; Rando, 1993). Support might also be withheld by the community to chastise someone who was involved in a criminal act or because of embarrassment over a mode of death which might be stigmatizing (Rando, 1993). Families of those who have committed suicide or who die as the result of an accidental overdose of an illegal substance may find little support from others.

If social supports are not available, the individual can not be supported in his or her loss. Loss must be validated so that the grief can be recognized and the importance of the loss, including the secondary losses caused by the disenfranchisement, acknowledged (Rando, 1993). Mourning "requires legitimization, validation, and presence" because "grieving can occur and progress only in contact with others" (Baum, 2003, pp. 46-47).

As Lindemann (1944) noted, individuals who experience normal grief reactions move through the process over time and usually do not require clinical intervention. Grieving is, however, an uncomfortable and difficult process. Sometimes the mourning process becomes stuck and the mourner may require assistance to complete their work.

Abnormal Grief Reactions, Complicated Grieving

The most frequent "abnormal" grief reaction is delayed or avoided grief. With this reaction, a person may show little or no grief reaction for weeks, months, or years following a loss. If insufficient grieving occurs, some small loss in the future may trigger a strong reaction. Intense feelings can be triggered by a book, movie or television program in which loss is the central theme (Worden, 1991), or by the death of a pet (Rando, 1984). Bowlby (1980) theorized that the loss of a current attachment figure triggers a response to seek comfort from a previous important attachment figure. If that person is also gone, the earlier loss will also be felt. Bowlby (1980) noted categories of events known to precipitate a delayed grief reaction including:

- An anniversary of the death that has not been mourned
- Another loss, apparently of a relatively minor kind
- Reaching the same age as a parent was when he or she died (p.158).

Other abnormal grief reactions include chronic, or prolonged grief, in which there are usually very intense symptoms, insomnia and angry outbursts, and inhibited, or masked grief, where most normal grief symptoms are not manifested, channeled instead into somatic complaints (Stroebe, 1987). Parkes' Harvard Bereavement Study found that a dependent relationship with the lost person was often predictive of a chronic grief reaction in the bereaved (Parkes, 2006). Raphael (1983) described distorted bereavement, in which one aspect of loss is extreme. Distortion is seen most often with anger and with guilt. When the bereaved individual had a highly dependent relationship with the person who died, bereavement can appear as a strong feeling of desertion, intense rage and a lack of sorrow. If the bereaved feels extremely guilty, there is no anger or sadness, only self-blame (Raphael, 1983).

Ambivalent feelings towards the deceased, the loss of someone upon whom you were highly dependent, or fear of opening up wounds from the past might overwhelm and inhibit the grief process. Having had an earlier complicated grief reaction increases the probability that future grief reactions will also be complicated. Social and cultural traditions and the lack of a support network may also cause complications in grieving (Parkes, 1986; Worden, 1991). Bowlby (1979) notes that the most intense feelings in loss are caused by the fear of being abandoned and a desire to recapture time before the loss occurred. For grief to have a successful outcome, it is necessary for the individual who is grief stricken to express his or her feelings about the loss. In all of the abnormal grief reactions, there is an attempt to avoid pain, and cling to what was lost (Raphael, 1983). Bowlby (1980) found that people who have not mourned the passing of someone

important to them become dissatisfied with their lives. Relationships seem unfulfilling, especially romantic relationships and connections with children.

Bereavement and its outcomes

Bereavement is the process of grieving in the face of an unwilling separation. The separation leads to emotional distress in the same way as a child's separation from a caregiver. According to Bowlby (1980), there is a tendency to underestimate the impact and the duration of loss, including how disabling and distressing loss can be. Parkes (1986) described bereavement as:

> "one among many transitions, each of which constitutes a period of challenge and readjustment…At such times, we (the bereaved) are uniquely open both to help and to harm. We need protection, reassurance, time to recoup, and help in developing blue-prints for the future. Those who are in a position to meet these needs must expect to find the recipient of their help defensive, sensitive, vulnerable, and unreasonable. Even so, a little help given at a time of transition will often be more effective than help given at other times and, in the long run, it will be appreciated more" (pp. 12-13).

The outcome of bereavement might be a satisfactory integration of the loss. For many individuals, healing from loss identifies new strengths and allows personal growth. For others, bereavement might lead to the development of psychological or physical disorders (Parkes, 2006; Raphael, 1983). In some cases, bereavement is thought to contribute to mortality from heart disease, an occurrence which is more common in men than in women (Parkes, 2006). Bereavement might also lead to altered patterns in relationships, with individuals avoiding, impairing, or improving interpersonal connections. The way in which bereavement is resolved can establish personal strengths with which to face future losses, or may leave an individual vulnerable to stress and poorly resolved loss outcomes from future bereavements (Raphael, 1983).

Theories of grief

Theories of grief (Bowlby, 1980; Kubler-Ross, 1969; Lindemann, 1944) provide descriptive stages/phases of grieving. As Kubler-Ross (1969) cautioned, the models are descriptive and fluid. There is no linear progression through grief; grieving is an idiosyncratic process which will be impacted by, among other factors, the nature of the relationship the individual had with the deceased, an individual's developmental level and his/her cultural background (Servaty-Seib, 2004; Worden, 1982).

Lindemann (1944) wrote that "grief work" breaks the bonds of emotional connection with the deceased, allows the bereaved to adjust to life without the person they have lost, and permits the survivor to form new relationships with other people. The biggest obstacle to successful completion of grief work is attempting to avoid feeling the intense emotions that are part of the process.

Bowlby (1980) defined four phases of grief: 1) shock, 2) protest, 3) despair, and 4) adaptation. In the first phase, the individual who experiences the loss will feel numb and be unable to care for herself. Bowlby's second phase includes the mourner searching for the one who has been lost, sometimes believing she sees him in a crowd. In the third phase, despair, the individual who is grieving realizes the hopelessness of restoring the attachment with the one who was lost. In the final phase, the mourner begins to establish new attachments with others.

In *On Death and Dying* (1969), Kubler-Ross identified five stages of coping with grief and death: 1) denial and isolation, 2) anger, 3) bargaining, 4) depression, and 5) acceptance. The first stage, denial, is a common response of almost all patients. It acts to shield the individual from shocking news and gives them time to accept and integrate

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what they have been told. Partial denial tends to recur throughout the dying process, in order for the patient to continue to be engaged in living.

The second stage is anger and wondering, "why me?" Feelings of rage, hostility and criticism are often directed at caregivers and family members. The individual makes demands and complains, in part, to receive attention and to garner understanding. It is also painful to be around others actively involved in life, when your own life is slipping away. Those who are dying might also be angry with God and may see their illness as a challenge to faith that has sustained them in the past.

The third stage is bargaining. The central wish in this stage is to postpone death, or to have pain free days, a hope of being rewarded for "good behavior". Most bargains are made in secret, with God, and usually contain a promise that the person will not ask for more if this one wish is granted.

Kubler-Ross' fourth stage is depression. It is in this stage that there is the recognition of the great losses that will take place. Shame and guilt about not being able to fulfill old roles in the family may add to a patient's depression. There are also elements of preparatory grief and emotional grounding for what lies ahead.

The final stage is acceptance, as if the struggle is over. This stage is reached if the patient has had the time and support necessary to work through the previous stages. At this stage, the patient has found an inner place of peace. Words are no longer necessary; physical presence and touch is reassuring, impending death is acknowledged.

Kubler-Ross' model is based on her work with the dying. Her descriptions of the stages are based on anticipatory reactions of those who are terminally ill. The other major theorists whose works I have previously cited, Bowlby, Lindemann and Parkes, found

similar stages of grief in those who had experienced the loss of a loved one and were grieving that loss. All theories cited show a process through loss that involves initial protest, attempts at holding on, letting go, developing awareness, and accepting or resolving the loss.

Cultural considerations in grief and loss

All human cultures have mourning customs and rituals. Most societies expect that a bereaved person will be disoriented, shaken and angry (Bowlby, 1980). The models of grief cited in the literature do not acknowledge that ethnic and cultural differences impact a person's grieving. Cultural differences, such as funeral rituals, may aid or exacerbate the grief process since culture tends to define the appropriate rituals for grief and effectively determine whether a person is hampered by loss or becomes more resilient after having endured loss. People tend to rely on their cultural roots, their values and beliefs, when they are faced with a life crisis (Hooyman & Kramer, 2006).

Hayslip and Peveto (2005) researched the relationship between death and ethnicity and state that "there are no emotions that are universally present at death; rather cultural matters determine what emotions are felt, how they are expressed, and how they are understood" (p. 8). In the Hayslip and Peveto study, as in research conducted by Kalish and Reynolds (1976, cited in Hayslip & Peveto, 2005), attitudes about death and dying among four ethnic groups, African-American, Mexican-American, Japanese-American and Anglo-American, were studied. African-American respondents reported that they would be most likely look to family members and to their church for comfort when dealing with loss. Less than half of the Japanese-American participants expressed that they would be concerned if they were unable to cry over the death of a spouse.

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Mexican-American respondents indicated that they would keep young children from attending funerals and that large, family filled ceremonies were important. It was also expected that, as a sign of respect, support would be offered to surviving family members. According to funeral directors, those who attend Mexican-American funerals tend to be extremely emotional, sometimes to the point of requiring medical intervention (Hayslip & Peveto, 2005).

The Kalish and Reynolds study (cited in Hayslip & Peveto, 2005), and Hayslip and Peveto (2005) studies were conducted in specific geographic areas, Los Angeles and Texas, respectively, which may result in some regional bias to the findings. The possible bias does not, however, negate the importance of recognizing the role of culture in shaping the way individuals think and react to death, dying and bereavement. The studies also indicated that within cultural groups, participants from different age groups have differing values and biases associated with death related issues. The data suggests that changes in cultural viewpoints over time could be expected (Hayslip & Peveto, 2005).

The traditional theories of grief do not recognize a distinction between masculine and feminine styles of mourning. Parkes' research was work was done with mostly white female widows. His resulting descriptions of normal and complicated grief have a feminine bias. The hallmarks of the feminine mourning process - sadness, anxiety, and seeking social support - are found much less often and at lower levels, in the masculine pattern of grief (Baum, 2003; Martin & Doka, 1998).

Attachment theory

In order to examine loss, it is useful to understand the basics of *attachment* (Cook & Dworkin, 1992; Dunne, 2004; Leick & Davidsen-Nielsen, 1987/1991; Worden, 1982).

Bowlby (1980) described attachment as a fundamental need throughout the life cycle. By staying close to their caregivers, children establish a sense of comfort and security. When they feel secure, children are able to regulate their affect and level of emotional arousal; they learn the ability to self-soothe. A securely attached child is able to express feelings openly and view the self as resourceful. If there is insecure attachment, the child has a disturbed view of him or her self and a lowered sense of self-esteem. This child feels ineffective in dealing with his or her world. A person's quality of attachment also helps determine her ability to cope with the stress that occurs in her life.

Through their initial attachment experiences, children establish expectations of how other caring relationships will work. When a caregiver does not respond the way the child expects, the child experiences an early form of loss and cries or shows anger in protest. Adults continue to develop attachment, affectional bonds throughout their life. As adults, these attachment needs are met by connections with other adults. The need for security remains a component of adult attachment. Adults seek out individuals they expect to be "available and responsive and … for emotional and instrumental support" (West & Sheldon-Keller, 1994, p. 101). Attachment behavior is most apparent in times of crisis, when an individual is worried, ill or afraid and needs support and care from someone he perceives as stronger in order to feel secure (Bowlby, 1979,1988).

Bowlby (1979) wrote that involuntary loss can bring forth "many forms of emotional distress and personality disturbance, including anxiety, anger, depression and emotional detachment" (p.127). Individuals respond to emotional losses with a full spectrum of intensity levels. Some become highly anxious, while others appear to be barely distressed. Bowlby (1979) attributed this range of emotional intensity to patterns

of attachment formed in childhood. Children raised without a base of consistent security may develop a pattern of anxious attachment, a strong desire to be taken care of and extreme fear of losing an attachment figure. For these individuals, mourning "is likely to be characterized by unusually intense anger and/or self-reproach, with depression, and to persist for much longer than normal" (Bowlby, 1979, p.139). In contrast an individual with a pattern of compulsive self-reliance is wary of becoming close to anyone. People with this attachment pattern may develop somatic complaints and delayed mourning when they experience losses (Bowlby, 1979).

Resilience

Resilience is the ability "to maintain relatively stable, healthy levels of psychological and physical functioning" despite exposure to a highly disruptive event (Mancini & Bonanno, 2006, p. 972). As previously stated, some individuals, when faced with loss, endure years of distress; others have short-term reactions and quickly return to their prior levels of functioning. Even among resilient individuals there is "at least some yearning and emotional pangs and …intrusive cognitive and rumination at some point after the loss" (Bonanno, 2004, p. 23). For resilient individuals however, these experiences are not enduring and do not interfere overmuch with functioning (Bonanno, 2004).

Whether or not an individual is able to demonstrate resilience to a particular loss can only be ascertained in the outcome. Individuals considered well adjusted, who have high self-esteem, experience positive emotions, are able to adapt to circumstances, and who are involved in supportive relationships before loss occurs, have the greatest potential to be resilient when trauma or adversity arises (Bonanno, 2004; Mancini &

Bonanno, 2006). Resilient individuals tend to have fewer regrets and are able to feel peace and solace when thinking about their loss (Mancini & Bonanno, 2006).

The majority of individuals who experience loss are able to successfully grieve without the support of a trained counselor. Only about 10 to 15 percent of those who suffer a major loss show chronic symptoms of grief for longer than a year (Bonanno, 2004). Even in researching the aftermath of the September 11, 2001 terrorist attacks in New York City, findings showed that "although resilience is reduced at the highest and most demanding levels of exposure, it is nonetheless often still seen in up to half of the persons exposed" (Mancini & Bonanno, 2006, p. 975). The post-September 11 findings also discovered that resilience was most common in those who were young, male, educated, married and of Asian-American heritage. As a group, low-income earners tended to exhibit less resilience (Mancini & Bonanno, 2006).

McLeod and Kessler's (1990) research found that individuals with lower socioeconomic status levels tend to be more negatively impacted by stressful life events Those who have fewer financial resources are more vulnerable when economic and personal crises impact their lives. Lack of access to higher levels of education and limited networks of social support multiply the emotional impact of personal loss for those individuals. Having had a lower-status upbringing also leaves an individual with less effective coping strategies since opportunities for control and mastery have been limited (McLeod & Kessler, 1990).

Since the research appears to indicate that many individuals have the capacity to be resilient in dealing with loss, clinical interventions seem best directed towards those who can be identified as lacking in protective factors such as the availability of emotional

and material supports. Isolation after an individual has sustained a loss is solidly shown

to be related to distress (Nolen-Hoeksema & Larson, 1999). Mancini and Bonanno's

(2006) work suggests that those who "internalize their grief symptoms" (p. 977) will

benefit most from therapeutic support for their grieving. "When crisis occurs…resilience

is defined as the ability to bounce back to a level of functioning equal to or greater than

before the crisis" (Boss, 2006, p. 48). In the case of ambiguous losses, being able to

tolerate ambiguity and live with a high level of stress is key (Boss, 2006). Resilience is a

sign of healthy human functioning (Mancini & Bonanno, 2006). After a loss, those who

lack the resources and personal flexibility to keep their lives stable while redefining their

world, may become overwhelmed and find themselves in a state of crisis.

Crisis

Roberts (2005) defined a *crisis* as a period of psychological disequilibrium during

which "one's usual coping mechanisms fail and there exists evidence of distress and

functional impairment" (p. 778). There is always a stressful or hazardous event that

precipitates a crisis, and the person must also see the event as disruptive and be unable to

cope by using previous methods (Parad, 1990; Roberts, 2005). An individual in crisis

needs to learn new coping skills; they are often highly motivated to do so. Crisis can be

induced by threats such as domestic violence, by accidents, by mental illness, by

transitions such as moving, and by traumatic stressors such as serious illness or divorce.

In a crisis situation, it is common to have clients present with issues of depression

or anxiety. They may appear "incoherent, disorganized, agitated, and volatile or calm,

subdued, withdrawn, and apathetic" (Roberts, 2005, p. 12). The person in crisis may not

be aware of being impacted by feelings of grief and loss because the death or other losses they experienced may have happened long ago.

A crisis situation has five components: 1) a hazardous or stressful event, 2) the client's vulnerable state, 3) a precipitating factor, 4) the active state of crisis, and 5) the state of reintegration or crisis resolution (Golan, 1978). The hazardous event is the stressor that impacts a person's coping ability; it shifts their life off-balance. The event can be either an anticipated transition such as aging, marriage, retirement, or an accidental event such as unplanned pregnancy, auto accident or being fired. The vulnerable state is the person's reaction to the change, whether they see the stressor as a threat, loss or challenge. How the individual regards the event often determines their emotional response. Perceiving the stressor as a threat usually makes a person highly anxious. Finding the change to be a challenge brings forth some anxiety and expectation for positive change. In all responses, there is usually some anger, tension, vulnerability and confusion (Golan, 1978). The precipitating factor is the "one thing too many" that overloads a person into a state of crisis and inability to cope. The crisis state is the time frame where an intervention can achieve great results; an individual in crisis is often in a great deal of emotional distress and is seeking relief. Focused change in this time frame can produce "more effective change then long-term treatment when motivation and emotional accessibility are lacking" (Roberts, 2005, p. 18). In the resolution state, anxiety subsides and the individual returns to a pre-crisis level of functioning.

There are several inevitable events in the human life cycle. Each of these has potential to provoke a crisis in someone who is vulnerable to the stress of change and loss. These emotional crises, and accompanying feelings of grief, are commonly found in

individuals in crisis. "In the Greek language, crisis means turning point" (Boss, 1999, p. 106). During a time of crisis, an individual's orientation to the world is challenged. The person in crisis is likely to be "restless, tense, anxious and unsettled until the necessary modifications have been made" (Parkes, 2006, p. 32).

Resolution of a crisis means that the individual is no longer overwhelmed by stress and has regained the ability to cope. The clinician has helped the client understand what vulnerabilities and events led to feeling overwhelmed and why this particular stressor precipitated a crisis. The clinician has worked together with the person in crisis and has helped develop a plan for the individual to cope more adequately in the future. In a best outcome scenario, the person who experienced the crisis will begin to learn new ways of viewing and responding to their stressors in the future and thus avoid future crises.

Assessment of Crisis and Grief

Assessment is the first step in crisis intervention. The clinician needs to determine the seriousness or lethality of the client's condition and his/her biopsychosocial condition. In assessment, the clinician gathers information that will help him resolve the crisis and make treatment decisions. Elements of assessment include determining the client's current and past health status, medication use, mental status, social networks and relationships.

Through the assessment process the clinician is trying to discover who this client is, what circumstances caused his or her loss, and what is needed to resolve the crisis. A therapist needs to understand the client's style of coping, her cultural background, and

her connection to a support network. The clinician begins to resolve the loss by helping the client understand and acknowledge what has been lost (Cook & Dworkin, 1992).

Assessment of grief

Raphael (1983) developed a format for a therapeutic assessment of the bereaved, which both explores aspects of grief and helps facilitate mourning. The assessment is formed around four main areas, and may use the following questions: 1) Can you tell me a little about the death? What happened that day? 2) Can you tell me about him, about your relationship from the beginning? 3) What has been happening since the death? How have things been with you and your family and friends? 4) Have you been through any other bad times like this recently or when you were young? (Raphael, 1983).

In asking the bereaved about the details of the death, the clinician gives the client permission to speak freely about the circumstances of the loss and his or her personal reactions to it. Whether the individual was present, how he heard the news, whether the death was expected and whether the bereaved was able to attend services, are all elements that may complicate grief. The client's emotional reaction to his own narrative and his ability to talk about the loss will become clear, as will any attempts at avoidance.

Exploring the history of the relationship with the lost loved one will provide the clinician with insight to the type of attachment that existed in the relationship. Both dependent and ambivalent relationships have been shown to predict risk for problematic reactions to loss (Parkes, 2006; Raphael, 1983). It is also important that the bereaved is able to paint a realistic picture of the relationship, to recall both happy and unhappy memories of their times together.

Inquiry about how the client has been coping since the loss occurred provides information about the quality and level of social support available for him. If other stresses have arisen, they could create additional risk and impede the client's ability to cope. This area of questioning also reminds the client that staying aware of his feelings and maintaining social connections to others is important.

Inquiring about earlier losses and how those were resolved, gives a portrait of an individual's vulnerability to loss and can identify coping skills that have been effective in the past. A current loss can trigger past unresolved loss, which creates a great risk of problems in resolving the current bereavement.

Cook and Dworkin (1992) stated that seeking treatment for an issue rather than grief "indicates either a conscious defense against unwanted feelings or clients' inability to acknowledge, possibly even to themselves, what is truly felt" (p. 57). Clinicians should always ask clients about their history of losses and traumas during an assessment since previous, unresolved losses can contribute significantly to a client's current distress (Cook & Dworkin, 1992; Parkes, 2006). Signs of underlying grief can emerge from the client's symptoms. Symptoms of covert grief and loss may be anniversary reactions, or the crisis may be disproportionate to the current loss with which the client is dealing (Leick & Davidsen-Nielsen, 1987/1991).

Once the clinician has determined the precipitating event for the crisis and conducted an assessment of the client, his goal is to help the client understand the relationship between life stresses and the crisis state the client has been experiencing. In facilitating this awareness, the client may become conscious of feelings that have been suppressed. Allowing expression of these emotions may begin to reduce the anxiety the

client may be feeling. Identifying supports and alternate solutions for coping should

begin to resolve the crisis. Suggesting alternate actions for the future may help devise a

means to avoid or assist in future crises.

Summary

Themes of loss of hope, loss of self-esteem or loss of relationships are common in

therapy work. Psychotherapy could then be conceptualized, in large part, as grief work

(Cook & Dworkin, 1992). Bowlby and Parkes (1970) wrote:

> Once eyes are opened, it is seen that many of the troubles we are called upon to treat in our patients are to be traced, at least in part, to a separation or loss that occurred either recently or at some earlier period in life. Chronic anxiety, intermittent depression, attempted or successful suicide are some of the more common sorts of troubles that we now know are traceable to such experiences (p. 81).

Leick and Davidsen-Nielsen (1987/1991) suggest that "it is a reliable rule of thumb that

there is <u>always</u> grief in crisis, but there is not necessarily crisis in grief" (p. 5). When

clients move through grief they learn to adapt to a changed reality; they gain a fuller

understanding of life. Experiencing losses can "shatter hopes, destroy confidence, and

cast people into despair to last a lifetime" or "be the turning point in their lives, after

which their sense of identity or purpose was transformed" (Davis, 2001, pp. 137-138).

It is estimated that 10 to 15 percent of the people who seek treatment at the

Massachusetts General Hospital have an unresolved grief reaction underlying their

psychological condition (Worden, 1991). Similar figures were cited by Martin and

Bonanno (2006) regarding individuals who display chronic symptoms a year after

experiencing a major loss. These numbers may well be representative of the larger

population since loss is a universal occurrence in our lives. Understanding how loss

impacts us, as human beings, is one way to comprehend the symptoms with which clients present, and a powerful focus for treatment. Through developing an awareness of clients in crisis, clinicians also reach a better understanding of themselves since, in the clinical process, "we learn mutually from each other" (Hooyman, 2006, p. ix).

This review of the literature has shown that grief, loss and crisis are definitive events and processes in people's lives that are interrelated in complex ways. Resolving a crisis involves restoring a person's functional state of equilibrium. Moving through grief and out of a crisis state both require adequate support, an adaptation in coping, and regaining a sense of personal stability. Both crisis resolution and normal grieving require that a change or loss be acknowledged. Thus the skills that have been honed through work with clients in crisis can be transferred to work with clients experiencing complicated grief and other types of losses. Through understanding the connections between grief and crisis and the implications of losses of all kinds, clinicians can learn to work more effectively with clients to reduce or prevent suffering when the severe stresses of divorce, death, disaster or illness take place.

This study will focus on how therapists rely on their knowledge and comfort in working with issues of grief and loss to promote client well-being and enhance the clinical encounter. The research will explore how clinicians who work with individuals in crisis assess and assist clients in processing their overt and covert, past and present grief and losses. Through excerpts from the narrative data, this study will illustrate the powerful impact of loss and the ways therapists work with it to promote psychological health in grieving individuals who present in crisis. In addition, the study will focus on

the schooling or training that therapists receive and their assessment of its adequacy in

preparing them to engage in this critical work.

CHAPTER III

METHODOLOGY

This study focused on clinicians that work with individuals who present with

mental health crises. It explored the following questions: Is an understanding of grief and

loss meaningful in the therapeutic process? Were these clinicians adequately prepared by

their graduate programs to assess underlying grief and loss in their clients, or did they

obtain their knowledge through some other means? Has having a deeper awareness of

grief, loss, and individuals in crisis enhanced their work as a therapist? Most importantly,

how has their accumulated knowledge of grief and loss changed them as clinicians?

These questions were researched through a qualitative, exploratory study. This

design is appropriate for flexible research methods that are field focused and used to

refine understanding. Flexible research is appropriate to this study because there is little

information in the literature about the topic. According to Anastas (1999), when research

on a topic is in an early stage, "exploring…through the use of unstructured data and

flexible interviewing…seems the only way to proceed" (p. 60). This study was

conducted using a semi-structured interview guide and open-ended questions to gather

narrative data from the study participants. Content of interviews was recorded by tape-

recordings and session notes.

Expected findings for this study, based on review of the literature, were that grief

and loss issues would be important concerns for clinicians when assessing clients in

crisis. It was also anticipated that graduate training programs would not have provided

clinicians with an essential knowledge base from which to facilitate client grief and loss issues.

Sample

The sample for this study consisted of fourteen clinicians, nine women and five men, who provide mental health counseling and assessment to individuals in mental health crises. Clinicians range in age from 39 to 65 years old; all identified as Caucasian. This sample included nine social workers, three licensed mental health counselors and two psychologists. Participants have been in clinical practice from 5 and 38 years, with an average of 22.9 years in practice.

The sample was obtained using personal and professional contacts as the starting point of recruitment, including contacts made through my clinical internships. Clinicians who work in mental health centers, college counseling offices and in private practice offices in Western Massachusetts were contacted as potential study participants. Participating clinicians were asked to suggest colleagues who might be interested and available to participate in the study. In addition, clinicians whose names were suggested by faculty members of the Smith College School for Social Work were contacted. Through this method there resulted a nonprobability sample of convenience, that is, a sample of participants who met the study criteria and who were available to interview.

Individuals interested in being study participants met specific criteria. These included: 1) holding a license to practice in their discipline; 2) working with individuals who present with mental health crises; 3) having a minimum of three years of post graduate practice experience; and 4) agreeing to participate in the study.

The study was conducted using a very small sample; thus, it depends on replication logic rather than representativeness. Given the small geographic area, time limitations for the study and the constraints of the study criteria, the sample is not representative of clinicians in general. I attempted to include a culturally and ethnically diverse sample of clinicians in my study within the limitations of time and budget restrictions. My study used purposive, focal, expert sampling, that is, clinicians with three or more years of experience whose work has included assessing clients in crisis, whose insight and experience are useful to the study.

Ethics and Safeguards

Strict confidentiality was maintained as per Federal guidelines and the social work Code of Ethics (NASW, 1999). As required, consent forms, interview notes, tapes and interview transcripts are numerically coded and will be stored in a locked file for three years. At the end of this time, the files will be destroyed. Participant names will never be linked to the information they provided for the study. Demographic data were combined to describe the aggregate subject pool. Individual participants are therefore not identifiable in the final report. The data from this study may be used in other educational activities such as presentations and publications, as well as in preparation for the Master's thesis.

Potential benefits to study participants included the opportunity for participants to reflect on how they work with issues of grief and loss in crisis contexts, the chance to contribute to the knowledge base of how mental health clinicians obtain and utilize insights about grief and loss in their therapeutic work, and the opportunity to acquire feedback regarding how other clinicians in comparable settings do this work, through

dissemination of study results. Risks for participants were minimal. They included the possibility that some of the study questions could trigger disturbing thoughts, feelings, memories or personal grief reactions for the study participant. This is unlikely since the questions focused on the grief and loss experiences of clients, not clinicians. A list of grief and loss reference information was created and provided to participants at the end of the interviews. A copy of this resource information is included as Appendix E.

Data Collection

After receiving approval from the Smith College School for Social Work Human Subjects Review Committee (see Appendix A), contact was made with potential participants who met the study criteria. Clinicians were contacted by email or by phone to assess their interest and availability to participate in this study. A copy of the recruitment email is included as Appendix B. Once a clinician who met the selection criteria agreed to participate in the study, an interview appointment was scheduled. Interested individuals were sent copies of the informed consent form for their review prior to the interview date. The informed consent detailed the nature of the study, risks and benefits of participation and the ways in which confidentiality would be maintained. A copy of the informed consent form is included as Appendix C.

One-on-one, in person interviews were conducted and lasted approximately one hour. Interviews were audio tape recorded and focused by semi-structured, open- ended questions contained in the interview guide. Additional questions were posed during many interviews, in order to further probe and clarify the themes that arose. Participants responded to questions with personal content and were able to ask questions about the interview, ask for clarification of the interview questions, and inquire about the use of the

data. Interviews took place at the offices settings in which participating clinicians practice. Interviews took place between February 13 and March 28, 2007.

Prior to the start of the interview, participants were asked sign a copy of the informed consent form if they had not already done so. They were also asked to provide demographic data including their age, gender, license and field of practice. The sample size is too small to provide reliable data on subgroup variations. This information was requested to see whether any trends emerged which might suggest a need for further study. The data provided also help to substantiate the credibility of the study participants.

Questions in the interview guide were clustered around the following themes: 1) questions about what training in grief and loss clinicians have received (i.e. Did you receive any specific training in your graduate program on how to work with clients around grief and loss?; 2) thoughts about and techniques used when working with clients in crisis (i.e. How do you engage with a client in crisis?); 3) questions regarding loss and how it manifests in crisis (i.e. How often do you discover that there is an underlying loss or grief issue fueling a client's crisis?; 4) questions about grief and grieving (i.e. Are you comfortable talking about grief with clients?); 5) questions about the clinical implications of working with grief and loss (i.e. Can you do crisis work without an accumulated knowledge of grief and loss?); and 6) suggestions for students and training programs (i.e. What suggestions would you offer to students in graduate programs about how to prepare to work with clients experiencing loss? The complete interview guide is included as Appendix D.

These questions, which arose from a review of the literature, provided data that addressed my research questions regarding how clinicians who assess clients in mental

health crises obtained their skills and how a clinician's deeper knowledge of grief, loss and its effect on clients has transformed his or her work and enhanced clinical relationships.

To enhance the validity of the study, two experienced clinicians reviewed the interview guide and provided feedback regarding clarity and relevance of the questions before it was used by participants. The instrument was piloted with one crisis clinician who was not included as a part of the study. The feedback from this test of the initial interview design allowed me to further refine the phrasing of questions and flow of the interview for its use with study participants (LaTerz, 2006).

Knowing that personality and the quality of the interaction can bias the research, as the interviewer, I attempted to maintain neutrality. Since cultural background and standpoint may in some way bias the data collected, I will refer to this possibility in the discussion section of the study. As suggested, a log for self-reflection was kept during the research process (Anastas, 1999).

Data Analysis

The interview was chosen as my method of data collection since this study explored an area not previously studied. According to Anastas (1999), "the informant's knowledge and experience of the phenomena of interest should guide the dialogue" (p. 353). My literature review has shown no prior investigation of the role grief and loss issues play in the presentations of clients in mental health crises.

The interviews conducted for this study were audio taped. The audio tapes were fully transcribed by myself and an individual hired to assist with this process. The paid transcriber signed an agreement of confidentiality before beginning the work. The

answers to each interview question were grouped by subject heading and question. Data

from this study were manually analyzed. Written transcripts were compared with the

audio tape recordings to verify the accuracy of the transcription.

The data from this study were reviewed and organized using theme analysis to

probe the resulting transcripts for relevant categories of information. Records were kept

of the process of comparisons that were used in coding in order to track my process of

analyzing the data as suggested by Anastas (1999). "Carefully chosen excerpts from the

data verbatim" have been included in Chapter IV, Findings, "in order to ground concepts

and results in the words of the research participants themselves" (Anastas, p. 67).

CHAPTER IV

FINDINGS

This chapter details the findings from interviews conducted with fourteen licensed mental health professionals who provide mental health counseling and assessment and whose practice has included work with clients in crisis. Participants were initially asked to respond to questions about whether their academic programs had provided training in the areas of grief and loss. Interview questions then focused on how clinicians work with clients in crisis, questions about loss and how loss manifests in crisis, questions about grief and grieving and the clinical implications of working with grief and loss. Participants were also asked what they would like to share with graduate students and graduate programs about preparing to work with these clinical issues. Clinicians were then given the opportunity to add any other thoughts on this material that had not been covered in earlier questions.

The major findings of this study revealed that across varying mental health disciplines, clinicians did not receive substantial training regarding crises, grief and loss. Through their years of clinical work, participants have come to recognize the importance of grief and loss as underlying many of the reasons that individuals find themselves in crisis or seeking mental health services. Clinicians found that vulnerabilities to loss and patterns of responding are often created by losses at an early age and tend to resurface and resonate if they have not been previously resolved.

The data from these interviews are presented in the following order: demographic data of participants, academic background and training of participants, ways clinicians work with clients in crisis, how issues of loss manifest in crises, how clinicians assist clients dealing with grief, clinical implications and suggestions for students.

Demographic Data

The study was comprised of 14 participants: nine women and five men. All participants are clinicians who practice in Western Massachusetts. Participants range in age from 39 to 65 years old, with twelve participants age 51 or over. All participants identified as Caucasian, with one naming European American heritage and one listing Spanish heritage.

Participants were trained in the fields of social work (n=9), psychology (n=4) and one participant holds a Masters degree in Education Counseling. Two participants also listed training in family therapy. Training in the field of social work emphasizes working with a person in their environment, looking at all aspects of a person's life. Professional training programs in psychology tend to focus more on counseling and therapy.

Individuals included in this study have from 5 to 38 years of clinical experience with the average participant having 22.9 years in practice. Participants estimated the percentage of their time spent with clients in crisis ranged from 5% to 100% per week. One participant did not answer this question. Eight participants estimated that they spent 50% or more of their professional time working with clients in crisis.

Participants work in a variety of settings. Six clinicians work in mental health clinics; three of those clinicians also list hospital emergency rooms as a setting in which they normally practice and one clinician regularly sees patients on the medical floor of a

hospital. Three participants work primarily in college counseling offices; two participants work in private offices. One participant is a university professor; one participant practices in both a college counseling setting and a hospital psychiatric unit. One participant lists psychiatric facilities, community and state hospitals, and agency offices as the settings in which she normally practices. Two participants co-facilitate cancer support groups in addition to their clinical practice. Two participants mentioned that they worked as crisis responders in New York City after 9/11; two did work in the geographical area impacted by Hurricane Katrina.

Training

Because the clinicians participating in this study were trained in multiple mental health disciplines, it was necessary to query whether preparation for facilitating grief and loss work varied between programs. Individuals who hold LMHC and LICSW licenses have completed master's degree programs and a minimum of two years of supervised post-graduate clinical work. Clinicians with Psy.D licenses have completed doctoral level training. All mental health professionals adhere to a code of ethics and pass state licensing exams.

Seven individuals trained as social workers hold independent social work licenses (LICSW). One social worker indicated that she holds Board Certified Diplomat (BCD) credentials in addition to an LICSW. This distinction means that a clinician has demonstrated a high level of competency in this field. Other participants included three licensed mental health counselors (LMHC), two psychologists (Psy.D) and one social worker who holds both LCSW (licensed clinical social worker) and LMHC licenses.

Participants were asked three questions regarding what training they have undergone around issues of grief and loss. First, had they received any specific training during their graduate programs to prepare them to work with grief and loss? If they had, they were asked how extensively the material had been covered in their coursework. Second, they were asked whether they had taken any post-graduate courses, workshops or in-service trainings related to grief and loss and if they had, what had prompted them to do so. Finally, participants were asked whether they had received supervision or on-the-job training that prepared them to assist clients dealing with issues of grief and loss.

Coursework in graduate programs

Of the fourteen participants in this study, one clinician had taken a specific course on death and dying within his graduate program. More than half of the participants (n=8) recall some courses that "touched on the subject" or in which it "came up" or into which the topics were "integrated" but only one participant reported that grief and loss "was covered quite extensively, in all aspects" in her program. Several clinicians (n=3) remember doing some reading and one participant recalls that they "reviewed stages of loss and grief (Kubler-Ross)…in a case specific way." One participant spoke of a teacher who showed their class a video of work she did with a family whose father had terminal cancer. From her study, a documentary was made, "I guess she's sort of famous for it." Clinicians trained in family therapy (n=2) recall "a section" on grief and loss. Four participants recall no coverage of grief and loss at all in their graduate training program. One participant enrolled in a course on grief and loss at another school while she was a graduate student since her program did not offer coursework with that content. While content about grief and loss seems to have been integrated into participant training

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programs, most participant clinicians report that they received no substantial training to deal with these issues during their academic instruction.

Internships provided participants with their most memorable and in-depth training about grief and loss issues. One participant completed a field placement as an emergency room social worker. He states:

> People were being brought in who had been shot, stabbed, tried to kill themselves, had been raped. So I had to know a little bit about grief and loss to be able to help these clients or their relatives with what had happened. But it was pretty rudimentary compared to what we know about grief and loss today. I had to get a lot of training since then.

Another participant reports doing independent "papers and journal work" around grief and loss related to his internship at an AIDS hospice. He was prompted to acquire more knowledge because "I was experiencing a lot of loss through that job as well, so it was good for me to kind of review what the processes of grief were." Other participants report working in pediatric oncology and volunteering at a medical center and with Hospice.

Post Graduate Training

The vast majority of participants (n=12) have been motivated to take courses or trainings related to some aspect of grief and loss after they completed their degree programs. The reasons they cite for doing so vary. Several participants (n=3) stated that they didn't get the training or depth they felt they needed from their coursework. Half the participants (n=7) took trainings driven by the work they were doing. These are sometimes prompted by client demand such as "a lot of issues of loss for the children", or "a number of people going through significant loss" and by their own perceived need to enhance their knowledge in an area of personal interest. One participant stated that she takes "at least one conference or workshop per year… I have taken a lot because that is

one of my specialties." Another participant with an interest in crisis response work states that "because to do that work effectively I need to understand the dynamics of grief and loss, I've had to focus on that as part of what I'm knowledgeable about."

Clinicians also cite the relevance of grief and loss to clinical practice, that it is "an important part of the human experience." One participant states that "I think a lot of depression and a lot of anxiety disorders are actually grief or loss, being sensitized to that, and also perhaps the anticipation of that happening again in the future." Another clinician points to the training inherent in her clinical work:

> I've done additional trainings, workshops on grief and loss, and I have to say most of my training has come from (the) individuals themselves. I can't get any better training than I have from people. I have gotten from them something that I haven't been able to get through any formal class or seminar. And that's personal experience.

Participants report that they have taken courses and workshops on a number of grief and loss related topics including: helping survivors cope with the loss of a loved one, geriatric issues, thanatology, recognizing and managing the expected reactions of grief, loss of a child, mind/body conferences, disaster response trainings, critical incident training, hospice trainings, grief and loss for college students, cultural aspects of grief and loss, and self-care in grief work. Clinicians (n=5) also report that they have educated themselves through "lots of reading" about grief and loss and all aspects of responding to people who are dealing with loss.

Of the two participants who have not taken post-graduate courses or workshops on grief and loss, one points to financial reasons when she states that ""I usually take my courses with what I'm interested in and am I going to get a CEU and financial match." The second clinician states: "(the setting I work in) is not real helpful in providing

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training. And I think that I just get caught up in what I do here. It's not something that's really struck me as terrible necessary."

Since issues involving grief and loss arise for a wide variety of clients across the clinical setting, clinicians identify this as a salient area in mental health counseling. The majority of participants have been motivated by the needs of the clients they work with to enhance their skills through professional workshops and trainings.

Supervision or training in the work setting

The majority of participants in this study (n=9) recall case-specific supervision that explored some issues of loss which, depending on the setting in which they practiced, ranged from "a tiny bit" to "that was a lot of what we talked about." Individuals who have been trained in critical incident debriefing (n=2) describe receiving extensive "on-the-job" training to do that work.

One clinician who worked in substance abuse services recalls:

> They were good about…we had a fair amount of clients that would die. And every time somebody died, we would be called in, as a group, not just an individual counselor. And we would process it as a group.

Another participant recalls supervision that was helpful to her while she was involved in personal loss:

> Actually, during my supervision when I was in my Master's program, my husband was dying of cancer. So I was getting supervision at that time and so a lot of it, coincidentally was about the job but certainly, a lot overlapped with my own situation with the loss of a spouse dying. That was kind of opportune that I was in such close supervision at the time that I could get kind of personal help and knowledge and growth.

Three participants recalled no focus on grief and loss in the supervision they received. As one clinician stated:

I have available to me supervision but the people that I have accessed as supervisors - most of them within my job function - have not had it, formal training for grief and loss. So sometimes I've actually looked for some support or supervision from people specifically who deal with grief and loss.

Her thoughts were echoed by a clinician who observed:

…grief and loss was not the focus of supervision. Understanding the journey of the self would be the focus of supervision …So I think what happens with anything that hasn't been researched or under supervision, if you're dedicated to helping the people you serve, you just keep persevering, reading, getting as much knowledge and exposure and understanding as possible to construct the paradigm by which you face the person and have the conversation with compassion.

As this statement illustrates, working with clients about grief and loss requires both self-knowledge and insight. Most participants indicated that they were provided with no specific training in these areas through their professional training programs. Clinicians have sought out other avenues through which to obtain and enhance the skills they need to work with this important clinical element. The next section explores how clinicians use their skills and training to assess and assist clients in crisis.

Working with Clients in Crisis

Questions in this section were focused on working with clients who present in crisis. Clinicians were first asked to state their own definition of a crisis. They were asked to describe their process of assessing an individual in crisis and what, if anything, they focused on that was not usually included on a mental health assessment form. Participants were asked to describe how they engage and whether they normally explore relationship patterns and social supports with clients who present in crisis. Finally, participants were asked whether they inquire about whether these clients have experienced major life losses.

Defining crisis

When asked how they personally define crisis, four clinicians responded "that's a good question." Perhaps the most concise statement says:

> I define crisis as a situation that is acute and that temporarily overwhelms a person or person's ability to mobilize their usual resources - their usual coping resources and assets and strengths.

The elements of "overwhelm," of "acute stress," "extreme intensity," of being "all worked up," of displaying "extreme emotional affect or lack of affect," feeling that "their life is collapsing or it's happening at a rapid rate" are mentioned by participants (n=10). A few clinicians noted that crisis can be precipitated by either internal or external reasons.

Some participants (n=5) noted that it is up to the individuals themselves to define what constitutes a crisis since "it's the person's crisis that I have to look at" and that finding the meaning, why this is a crisis for this individual, is key. As one clinician stated:

> … Clients at times tell us what a crisis is, even though it doesn't necessarily fall within our definition. It can be an overwhelming experience of any kind, of any magnitude I suppose, dependent on any one individual's ability to manage whatever it is that's causing the overwhelming sense. So some people who have… virtually no coping skills are, I think, more susceptible to a "crisis", than somebody who is a little bit more well adjusted. And there are a lot of factors that are involved in that - support systems, family, friends, and, you know, one's own capability to handle stuff and I think that's different for everybody.

In their definitions, only one participant specifically mentioned the element of hope or a future orientation as lacking in an individual experiencing a personal crisis. As he stated:

People's usual mechanisms for solving problems and believing that they are in a safe place … (their) belief that they can manage things in the world (that) they're not going to be overwhelmed and overcome - is breaking down in the crisis. There's been too much coming over and their own personal ability … to manage the amount of affect that they're having is being overwrought. And so it's interfering with their sleeping, their eating. They're getting a lot of intrusive thoughts. They're not able to rest. They don't feel like they can turn it off. And they don't see hope. That's pretty important. They don't sort of see that this will work out in some way. They really don't have a future orientation around that so that's what crisis is.

Assessing a crisis

Crisis is not always an emergency. Clinicians seeing clients in crisis assess whether there is a need for immediate action. As one participant stated "people encounter crisis every day. It depends on the continuum whether it's a problem or whether it's an emergency." All participants surveyed assess the client's level of risk and how the client is functioning by looking at, as one clinician stated, "their ability to manage their own self-care and access support, and things like that."

Sometimes, it is not easy to determine what the crisis really is. As one clinician stated:

Often times I think people who come in say one thing, you know, it's usually a lot bigger than what it is. So I spend a lot of time trying to define the other factors that are contributing to things. And kind of teasing out from them what it is they are really experiencing. And often times I think people … don't always know specifically what it is. They'll know what the precipitant is but it takes time to … tease out what exactly the crisis is. And how that's reverberating, cause often times, it's not a single event. Sometimes it is, but most of the time it seems that it's quite a bit of things that have boiled up and "the straw that broke the camel's back" kind of thing, rather than a particular single incident.

Another participant describes:

I think the easy ones are the ones where the people are saying to me that in fact, they are at their wits end…can't take it anymore…The more difficult ones are someone who may be brought in by someone else and might be sad or tearful

even and unwilling to truly describe what is going on. And yet you can clearly see
by their demeanor that, in fact, things are not well for them.

Other participants suggest that determining "is this an anniversary of something?" and

assessing whether the client is "using too much drugs or alcohol, or other kinds of

experiences that numb what they're feeling" help them determine the client's level of

crisis. Having respect for the client's assessment of their own situation, determining what

they think will help reestablish balance, and normalizing client responses to their

situation also help to establish trust and rapport. One clinician mentioned that she tries to

find out whether there are things that have been helpful for this person in the past so that

those can be accessed again or expanded upon. Only in the case of an extreme situation

will a clinician take charge, as in this statement:

> But if I can hear they're in shock, I will say you need to come in. So it's a
> combination of my own assessing the facts of the situation, hearing their
> emotional experience, hearing their own assessment, and deferring to their
> wisdom. Again, unless they're in shock. Then I would take charge of them.

> Some of the participants (n=5) stated that they focus on the individual's affect

when making their assessment. As one participant shared:

> If…somebody's here because somebody broke up with them, or they had a
> relationship loss or whatever and they're seething - that tells me a lot more than if
> somebody's got a tear running down his cheek…. It's not something that comes
> off the form. You have to talk to people, listen to the inflections in their voice,
> look at how they're reacting, their physical reaction.

Many clinicians (n=9) spoke of using their intuitive clinical sense in making an

assessment of the client's state. In the words of one participant:

> I think in therapy and in clinical social work we're always using our intuition. So
> we're not just leaning on the words but we're hearing, listening for defense
> structures and ego functions in the answers. So lots of our work is in the ether
> between the questions and the answers. A lot can't be said in words, I think. But I
> think that's what makes our field so unique, that we're not robots. That there is

much more to human energy than meets the eye. And as you develop the capacity to see it and to relate to it and interact with it and you develop your capacity for compassion, the dimensions of the human self reveal themselves to you. So it's not on a form. That's why I think non-clinicians don't know what we're talking about.

The "intensity" or "frantic-ness" in the way a client presents, their strengths, their thought process, their "ability to be grounded," body language, and the direction that they seem to be moving in are other factors which provide clinicians with important information for getting a true sense of the client's state. The client, through the symptoms they describe and the behaviors they exhibit, will help determine the level of care a clinician needs to provide. Determining the full nature of the crisis, rather than just the precipitating event, is important in helping the client begin to cope with their situation. Listening to the client's words, noting their reactions and filtering these responses through the lens of their professional training allows a clinician to assess the situation and begin to assist the client.

Engaging with clients

Participants described that they use their customary clinical skills with clients in crisis, perhaps with slightly more intensity "being more there," listening to their story with "total attention, open mind, open heart" and attunement to potential risk factors. Time, for the most part, stands still; the fifty-minute office hour "doesn't count any more." Clinicians listen carefully and respectfully to the client's story. They validate clients; they give "permission to people to be in crisis." Clinicians "try to meet people where … they might be" based on age and the way they present themselves, using humor or maintaining a "by the book" approach depending on how the client presents.

Participants report that they are "not afraid to ask those hard questions" or to be "there with the person in that state…offering them some possible way out of that or some possible scenario that resolves the crisis." One clinician describes her process:

> You need to be steady. You need to be a steady presence. You need to be transparent and quite simple in your communications. You have to instill a sense of hope, of calmness and of containment.

Another clinician describes the skills he employs:

> I let them know I care about them. I comfort them. I demonstrate compassion and empathy. I seek to form a relationship very quickly by letting them know I care, that I'm concerned and that I'm knowledgeable about crisis situations…And that I want to help them. And that I want to work with them together to try and figure out what they need and how they can be as resilient as they're capable of. I try and offer them hope.

Exploring relationship patterns and social supports

All participants (n=14) stated that they ask individuals in crisis about their patterns of relationships at least some of the time. Half of those interviewed (n=7) state that it would depend on the crisis or the circumstances. If a relationship were part of the presenting problem, they would focus on that in the session. Relationships can be part of the crisis; they can also be "a potential source of support or hope." Half of the participants (n=7) stated that they always explore relationship patterns. As one clinician stated:

> I think you have to explore relationship patterns all the time because we don't live in isolation. So to understand the meaning of a crisis, you want to know if their support structure's there. Is there any body to talk to, or anybody to be there? Or is the person totally alone? How do they relate? - I think (those) come out over time…I think when people are really in acute crisis you can't ask all these questions because they can't cope with all of the questions…(but) as you see the coping can take the questions, then you ask them.

Another participant responded:

> I don't do that immediately. First I'm assessing the crisis. I always look at relationship patterns. I'm by training and inclination a family therapist. So I always look at relationships and systems. But I don't do that immediately. First, I look at the immediate person. But when I start talking about their support systems that are there for them, to help them get through the crisis, I certainly address the issue of relationships.

One clinician, who does work with children in foster care, discussed her focus on

relationships, not only in the present, but in a person's past:

> I also, when I'm asking about relationship patterns, ask about current, past, also if there are people in their life that have been important that they no longer have contact with. And sometimes with that I think that that's when you hear where some of the struggle might be. I think discussing about relationships is very important because (for) a lot of the people that I have contact with, it's a central factor. And that's the loss of relationships whether it's with parents or guardians, or some of the children I work with (who) have had multiple placements. And one of the things I realize is that these children and these families grieve when there is a move. And it doesn't get acknowledged.

Every participant interviewed indicated that they explore social supports with

clients in crisis. For someone in extreme crisis, having a support system sometimes

"means the difference between somebody going home or somebody going into a higher

level of care." Crisis work seeks a disposition, that is, the best place for the person in

crisis to be at this time. As one clinician stated:

> I would explore social supports, especially if I'm not sure where the person goes after this meeting with me. That's the limitations of therapy and something in between hospitalization and therapy is the person's social system. So I would certainly investigate that, maybe even have contact with those people, encouraging them to stay close to this person.

If a person is in acute crisis, the evaluator becomes even more active in connecting the

client to their supports. As one clinician described:

If a person is a danger to themselves or others or they're so disorganized that their judgement is grossly impaired… It truly is the responsibility of the crisis evaluator to mobilize that social support. And to involve them. And to get them connected in some way in order to get that person who is in crisis involved with some … connection with another human being. And…you're now part of a triangle in getting other information, other observations. Getting people reconnected is absolutely critical. It's part of the assessment...it's absolutely *critical* as far as quality crisis assessment.

Major life losses

Nearly all clinicians (n=13) indicated that they inquire about major life losses

with clients who present in crisis. The question may not, however, be posed that directly.

As one clinician explains:

If they're in crisis, we assume that they have had major losses and sometimes it's brought out by asking the question – is this an anniversary of anything? Are you in a relationship? And usually, if you develop any kind of rapport with these folks, they'll often say yeah, I've been with my girlfriend for two years or no, my boyfriend left me a month ago... People who come in looking for substance services usually will just lay it right out there. My daughter died in a fire. My father raped me. My spouse left me. I'm homeless. They'll just tell you everything right when you walk in the door. You don't even have to say your name. Not always, but lots of times they'll do that. So with other people sometimes it's teasing out and trying to ask the right questions without really coming out and saying it that way.

Clinicians ask about losses of any kind – losses by death, relationship losses, job losses,

current and past. They also, as one clinician explains:

…are listening for…upsetting things in their life….I might go down an avenue of toward sexual abuse or sexual assault…I may well do a genogram and get at it that way.

Another participant takes a different line of questioning:

What I ask is – have there been other events in their lives where they have felt like this? Have there been other times…when they felt overwhelmed or not able to cope? …What I'm trying to assess is, is the current crisis tapping into other unresolved big events in a person's life? So…if someone was sexually assaulted, does this tap into something that happened to them before, where they weren't protected? Or where they were assaulted? If somebody lost somebody in a

disaster or is experiencing death, I would probably explore other losses, other deaths that have been meaningful to them. So, I don't just do it as a routine thing. I am always interested in how the past is activated by the present.

The importance of this exploration is explained in the words of another clinician:

I want to know if (they have major life losses) now and I also want to know if that's the case in the past, to assess sort of how they work that out. What's the pattern that they showed in the past? Cause that may give me some information as to how they're gonna handle this now. I'll also, along the lines of major losses early in life, think that if… that's the case, sometimes…the person's coping is gonna be damaged. For instance, if a child loses a parent early in life, I think damage…in terms of trust of the world, can be such that that's why they're in crisis now. It's because they think that things happen out of their control, there's nothing they can do about that. So I'd want to know if they had an experience like that in order to tie in perhaps, to this current crisis, some crisis early on. And hopefully, hopefully, bring in more realism now because if you're a child who loses a parent there's not much you can do with that, but as an adult, you can do a little bit more, hopefully.

The words of another participant illustrate the importance of probing for all types of loss:

Many things are experienced as a loss that may not be as specific as a death, like parent's divorce or moving from one's hometown, or even moving from home to college. And I find that I'm often explaining to people that if they had a hard time around some of these issues, that they may have an extra vulnerability. But that anyway, one loss resembles another and it doesn't have to be the same kind of loss to tap into some of the grief feelings. So I think I talk about that a fair amount with people.

The recognition of client coping skills and vulnerabilities as mentioned by the last two clinicians is important in all clinical work, not just when working with clients in crisis. The following section will take a more in-depth look at indications that loss plays a role in client difficulties.

Role of Loss in Clients' Crises

This section focuses on how issues of loss present in crisis situations. Questions explore how loss is defined, how underlying loss might manifest in a client in crisis and

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how often grief or loss fuels a crisis situation. The types of losses that clients mention and do not mention are also explored.

Defining loss

Participants defined loss in very broad terms. For all, the definition included some form of saying that there is "something missing" or "some change happens" and an ending results. Several clinicians (n=4) noted that loss is subjective and is based on what is significant to an individual because, as one clinician noted "you can lose some things and it doesn't matter. It's when it matters, that it becomes loss." As another participant recognized, the magnitude of loss depends on the amount of emotional resonance.

Clinicians included the following in their definitions of what might be significant losses: people and places, relationships, security, possessions, animals, ideas, job roles, sense of self, physical integrity, photos and personal history, quitting smoking or drinking, loss of a home through moving or fire, loss of hope, loss of time, age, energy, wisdom and loss of a role in the family. Some (n=5) participants noted an element of grief, sadness or longing in their definitions. As one clinician noted, significant loss does not have to be the loss of something large.

> I think loss can come in many, many forms. It can be tiny; it can be huge. It could be tiny but very pointed at an important part of their self-identity. But I think it's when anything has disturbed the order of health for the person.

One clinician explained that some losses are more likely to be explored:

> I think that the more minor losses are harder to catch and I think that that's where the empathy part gets difficult. It if is something that might not seem like it would be a big loss. And sometimes you have to ask more questions to determine if it is. And sometimes I might not think to ask. Well, you just quit smoking. Well that's great, you know? And not look at any changes and what that could mean for the

person…Where does that leave you now? It is not always something that is seen as a good thing, may not be something that is followed-up to assess what the meaning of that is. And what replaces that habit in your life?

While most participants gave a broad view of loss, one person spoke about loss as a constant in the human experience. She mentioned less obvious losses that might bring someone into therapy, but not necessarily cause them to present in crisis.

> I think everybody is experiencing loss on some level. So for example, let's say it's a marital situation. And sex is slowing down or disappearing or the quality of it is changing. Or the person isn't spending enough time with them any more, or isn't regarding them with the same dignity they were regarded with earlier in the marriage. Those are losses. And while that's not the same construct as if somebody left the marriage, so the whole thing is gone, so there's gradations of loss…I don't think that there is a time when people aren't experiencing some kind of loss. But again, how important the loss is varies.

Underlying loss

There is no specific universal symptom or behavior that would prompt participants to consider that grief or loss was an issue in a client's crisis. Some clinicians spoke of symptoms that are characteristic of the stages of grief. Sadness was, in fact, the symptom mentioned most often (n=4). Decline in an ability to function or enjoyment of life, slowing of thought process, depressive symptoms and anxiety would prompt many clinicians to probe further into a client's history. Client behaviors may not indicate to us that something that has changed. One clinician explains:

> I think that can be extremely varied and very individualized. Some people can be appearing to be quite fine when in fact they are experiencing a tremendous amount of grief. And for other folks, they can be angry or sad or agitated. They could be assaultive. They're in business. They could become more demanding, have higher expectations of those around them. And sometimes that's a change for the individual and if you don't ask what's going on with them, you might not realize that it's driven from loss. So it can be extremely varied. It's not just, you know, the five stages of grief or loss - the anger, the denial. It's *much* more *complicated* than that.

Even in childhood, loss and the importance of it to a particular individual will vary. In the

words of one participant:

> In grade school, kids are always gonna get excluded. How badly that hurts may
> relate to whatever losses are also occurring. Or if there are no other options for a
> kid to develop who they are and the one option that seems to be available to them,
> they get kicked out of, then that loss is larger for that child than some other child
> who has everything pretty much intact but they're being excluded from one
> particular group.

Unresolved losses from the past, whether from childhood or later in life, might be

resonating with the client's current situation and surfacing now. Tying the current loss

back to the client's history can clarify the diagnostic picture for the clinician and inform

the client in a new way of looking at loss. Clients may not be in touch with how far-

reaching loss may be, as this clinician explains:

> They may come in with – this is the problem – but what I've discovered is that it
> may be an issue that was unresolved many, many years ago. And by asking is this
> the first time that you've ever felt this way, is a good way to introduce another
> kind of thinking about loss…for themselves as well as my thinking.

One participant cited two examples of how unacknowledged grief and loss may manifest

in clients, which help to illustrate two ends of the continuum. In her first example:

> This was a client that was considered a long-term mental health client … some of
> her behavior appeared to be very strange and one of the things that this individual
> would do, they would go and camp out in the local cemetery…not at a particular
> grave, just in the cemetery. And people would get sort of in a frenzy about this
> person behaving strangely…the individual was perceived as just being somebody
> crazy and psychotic …but the reality was that this person had had a …
> miscarriage. So there was no gravesite, there was no ritual, there was not any of
> that. But this happened repetitively and it would happen around the anniversary of
> the conception, the miscarriage and the perceived birth of the child.

The second client she described provides a less extreme example. This is a young woman

who is finding it difficult to make decisions about what to do after college:

If you didn't do a deep enough intake, and help her go to a comfort level of being a) aware of the loss and b) able to feel the feelings of the loss…you could perceive that she was just being resistant about not making a decision...behaviorally she looks stuck and when she initially discussed her parents getting divorced…she was not emotionally connected to that.

Symptoms or behaviors do not necessarily indicate the presence or absence of grief and loss issues. Asking clients about recent changes in their lives and exploring important losses from their personal history helps to provide clinicians with a more complete framework for the client's current difficulties.

Loss as a fuel to crisis

Nearly all clinicians interviewed (n=12) believe that an underlying loss frequently fuels a crisis. Several participants (n=4) estimate that loss is present 98-100% of the time. Many types of loss impact an individual; as one clinician stated "it's always a change." Sometimes the loss will be a death. Loss can also be loss of function, loss because of a medical procedure, "loss of independence or feeling like others might be making decisions for a person," loss of a relationship. As one clinician stated:

I think there are always underlying losses, all the time. Going through life is difficult. And life is all about development and having different needs and seeking different achievements or elements in life for happiness. So nothing in life is disconnected from the rest of life. What happens in the inner self is connected to what's happening in the outer self. And nobody has it all. So loss is always present. Now how huge a loss is… will vary with how much pain. But I think underlying losses are always something that must be looked at in all therapy.

In response to this question, two participants spoke about clients who experience psychosis. As one clinician described:

The schizophrenic with their first psychotic break - from my reading …I have an understanding that when they can clear from that experience, they are at the

highest risk ever because they realize something … has changed and they begin to look at their life… in a different kind of way and…wonder – what is going to happen to me? What just happened and how can I avoid this from happening again? Because they're losing everything that they ever knew about. So even within that …it's there. And if I know that people that have those kinds of experiences have loss, I know that everyone …also experiences that at some level. So it's always present, present and prevalent.

The losses clients speak about

There are many losses that clients in crisis will speak about. Losses relating to relationships were most common, with all participants (n=14) identifying at least one type of interpersonal loss that their clients frequently name. It is not only a loss of someone through death that creates this level of crisis. In fact, only half (n=7) of the clinicians mentioned death in their response to this question. The losses mentioned more frequently were "when someone has left," "break up issues," "leaving home," "loss of marriages, separations from children, close relationships that are physically apart." Along with the loss of relationships, there is often an accompanying loss of "safety, housing, or money" or the loss of a job, which adds to the intensity of the loss.

The age of a client in crisis will sometimes give rise to the issues that are causing them difficulty. Children and young adults will often experience the loss of a cherished pet. They will deal with the death of a grandparent. When families move, or parents divorce, children may be enrolled in a different school. Children lose "the ability to have relationships with people they were originally around." Teenagers who don't feel like they're fitting in may experience "kind of social losses at school." Young adults heading off to college may find themselves breaking off romantic relationships. As one participant states:

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> With college students the loss issues tend to often be break up issues. And they have a sort of displacement of a certain sadness…even though it's an exciting thing to leave the parental home and get out in the world (there is) a certain sadness about that, the new found autonomy and the loss of childhood. So often there's a displacement onto a more acceptable object like your boyfriend, your girlfriend… Loss of pets is big in the college population, for I think similar reasons. You know, about how a family focuses on the pet and the pet starts to represent the family.

In slightly older clients, issues of loss may begin to have some focus on life expectations rather than strictly the current situation. One clinician explains:

> …Singles in their twenties or around thirty. Several times in the recent past I have had someone who is around thirty think they have losses because they are not married already, they don't have children already, and their cohorts in that same age bracket are already at that point. So they are running out of time…they feel their time, their hourglass is running out. They're thirty years old! So I mean, in one sense it is a distortion, but I think that thirty is a significant number.

Adulthood is a time when looking at loss can also be finding "that you never got." One clinician finds that "people will explore what they feel like they didn't get from their parents," which is a loss of nurturing.

Another clinician speaks about a broader sense of loss:

> I think the crisis becomes the loss of a dream…I think that we all have hopes and dreams but when they're lost I think that a lot of people will find themselves in some hopeless state. And hence the crisis. It's angst. It's something kind of existential in a lot of ways … to say that we are here to create and the question what am I here for and what am I going to do? And that's all a part of some kind of a dream that we all have, I think. As I say, I believe it's innate. So that's huge, the loss of a dream.

The loss of health, the loss of body parts, the loss of autonomy and mobility are other major losses that clinicians mentioned. In the elderly, a "loss of function… loss of the ability to drive and things like that" are often crisis-inducing issues.

Ambivalent feelings about someone with whom a relationship has been lost can also impact how able a person is to speak about their loss. There might be "feelings of relief or real anger at that person" which might complicate the grief reaction and precipitate their crisis.

The clinicians who have participated in disaster response work also mentioned that the loss of property is "very important to people." The sense of belonging and the symbolic items which people display in their homes and offices are irreplaceable. As one clinician shared:

> I see the world at large only hearing about the loss of individuals as being grief driven. I don't think that people are accustomed to thinking a little bit more globally about what loss actually is…With a lot of disaster work you go in and you are standing there and the loss is just tremendous. You're standing there and there is no longer a home. You have a slab. So it's the loss of community, it's the loss of friends; it's the loss of your history. It's the loss of being recognized as living at 118 Elm Street. Your street no longer exists.

Of the nine participants who mentioned the loss of an animal, most spoke of this loss in relation to children or adolescents. The impact of the loss of an animal remains significant throughout life, as illustrated in this example from a participant involved in disaster response:

> There was a man who survived (Hurricane) Katrina who had a dog. He was holding on to a tree in a raging river all night to survive and the dog held on to him. And at one point, he had to push the dog off of him or else he would have come off the tree. And he felt really guilty about that, and that was probably the most distressing thought he had that kept coming back to him about what had happened. And he didn't even know the dog. It just was a living thing.

Even in this example of someone experiencing multiple and intense levels of loss, it is a relationship issue which has a devastating impact on this individual.

Unspoken losses

Since loss occurs on many levels and can have a far-reaching impact, participants

were asked what types of losses clients were less willing or able to talk about. The most

common response (n=4) was the experience of some type of abuse whether by rape, child

abuse, domestic violence or sexual abuse. Participants find that with sexual abuse "a

person has to really feel they're comfortable enough…with the therapist and with

themselves in order to tell that story." Most individuals don't readily identify the

intangible losses, a "loss of a sense of self, loss of a dream," "loss of faith, loss of a kind

of assumption about the way the world is" as loss. Things that "people attach a bunch of

stigma to…can be glossed over at times" including drug and alcohol related issues, and

severe mental health issues "so oftentimes, you have to ask probing questions" since

"those are things that people tend to not want to talk about." One clinician shared a

dramatic example of loss in a young chronically mentally ill individual:

> The dream of going to med school. Realizing that you're too ill…Asked to leave
> med school. Asked to leave graduate school because they're too ill. The shame.
> Those are the things that they don't talk about. Their secrets. Their voices…I
> really think this is the anniversary of the death, the loss, of one of them who was
> in medical school. She killed herself. And she wouldn't talk about it. She was
> asked to leave medical school. That's what they don't tell you about…They don't
> want to tell you. It'll go on for years before they'll tell you.

Several clinicians (n=3) mentioned that losses early in life or the loss of

innocence tend to be downplayed. Most therapy is short-term and more focus is placed on

"a here and now thing." Childhood trauma, being bullied or scapegoated or being

unpopular "certainly comes back up throughout a person's life and they grieve maybe for

not having had a childhood." Those losses may not be "an immediate precipitant, but that's certainly in there." Another clinician states:

> I think people will minimize the effect of early losses in their life (that) probably I need to remind them of. Let's say divorce as a child, would be a significant loss. You lose the life that you imagined would be the case. You lose access to a parent in one way or another. Loss of a parent early. Sometimes clients are up front with that but many times the early losses, I think, get buried. And then they're focused on the crisis, on the here and now, without seeing that those early losses sensitize them to either see something or to proceed in life in a particular way, to try to avoid that loss in the future. They don't see how that's changed their lives.

A parent who has lost a child through death will "typically not talk about it." The participant who shared this observation stated that it "reaches the core of a parent" and is often too painful to bring up. College students might not talk about feeling "a level of sadness and homesickness about leaving home" or "the loss of a peer through either a car accident or suicide." Individuals who have been in the foster care system often don't talk about being "removed from their homes, from their families" even if they have had multiple moves and had to "address having to leave a family you've become connected with to move to another and to another."

As one clinician stated, "the crisis is usually an accumulation of incidents," a "number of events that happened." Those who have not effectively dealt with other losses "keep coming back. It's like a ghost that follows them around." He states that:

> I think (that) oftentimes people just lose themselves in a crisis. It's like they forget where they are, who they are, what their sort of grounding element is. And that can be precipitated by a lot of things.

By all accounts, the significance of a loss and the amount of pain that accompanies it will vary greatly among individuals. Interpersonal losses, those involving relationships, were noted by participants as losses they most often discussed with their

clients. Intangible losses and any losses that can be stigmatized are difficult for people to talk about, even in therapy. The following section explores how clinicians work with grief and grieving clients.

<div align="center">*Working with the Grieving Client (Grief)*</div>

The questions for this section asked the participants to share the process of how they assist clients dealing with grief issues. Clinicians were asked whether they felt comfortable talking about grief and how they acquired their level of comfort. Questions focused on how they work with clients to resolve grief including any strategies or rituals they suggest and whether their own religious beliefs guide their work with clients who are grieving. Participants were also asked whether grief and loss complicate the resolution of a personal crisis and how frequently overt grief causes a client to present in crisis.

Comfort level – talking about grief

Nearly all of the participants in this study (n=13) stated that they are comfortable talking with clients about grief. The one clinician who did not answer with an unequivocal "yes" stated that "I'm getting more comfortable as time goes on." Approximately half (n=6) of the participants cited dealing with "my own losses" as one of the ways in which they have come to their level of comfort around grief. Personal characteristics such as being "very interested in people's feelings and emotions," having a "high tolerance for intense emotion" and wanting to do "meaningful work" drew some clinicians into volunteer work and then to clinical practice. Growing up in a family that was comfortable talking about death and that recognized that "death was part of the life cycle" was important for some participants. One clinician stated: "We always talked

about the people after they died, for the rest of our lives…so it wouldn't matter how long a person was dead." Another clinician cited her Spanish heritage and the rituals of the Day of the Dead as developing her comfort with grief from a young age. Reading about grief and dying, meditation, and personal therapy were also cited as ways of increasing a tolerance for sitting with a client's grief.

Many participants cited their years of clinical practice as developing their ability to bear witness to a client's grief. They referred to: "just plain old experience", talking about "grief and loss and end-of-life issues" with individuals and in support groups, "going through the experience" with clients, "allowing people, just giving them permission," and "truly coming to grips with (the fact that) grief is real and that in some way, it has to be okay." A few participants cited experiences of clients being murdered, losing children or committing suicide as some of their most humbling, painful and profound clinical experiences.

One participant shared his belief that people try to avoid grief and the strong feelings that grieving evokes in them. He explains that he regularly discusses grief with clients in his clinical practice:

> I think grief is such a natural wired in program that we all have for dealing with loss and when it comes on people, they don't understand it. And so they try to anesthetize it, or step away from it, or they think they're going crazy when actually quite the opposite is true. They really need just to trust their brains and trust their souls that their brain knows what to do including cry, yell or scream. Especially in this country, we avoid loss. We think loss is a failure. Rather than in other cultures where perhaps, they understand that loss is inevitable…In this country we definitely view that a death is a failure and that illness is a failure and we should do everything to stop it. I think that that supports a view that somehow this is bad. And I think it doesn't get played out in terms of people talking about loss, talking about death. So I think just bringing it up and making it a part of really, everyday life and that people have the mechanisms to deal with this is important.

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Helping resolve grief

The way that nearly all participants try to help a client resolve their grief is "by listening, by being able to hear what they have to say." Sitting with a client as an attentive listener, "making it possible for them to talk" and "acknowledging the feelings" helps the client tolerate the emotion and recognize that "they have a right and a need to feel those feelings deeply." As one clinician states:

> I think what helps them is being able to talk about it. People find when they're going through grief that other people don't want to talk about it. They don't want to hear about other people's losses…I really think that what therapy mostly does is allow people to say what they can't say anywhere else.

Participants spoke of letting the client know that "I'm willing to go wherever they want to go", that "I can handle it and I'm prepared to", that there's "nothing that's going to be so hard for me to deal with that they have to…not go there." One clinician described a client he met with at a hospital emergency room:

> …just being there with them and letting them do what they have to do. I'm thinking of a case where this man suddenly lost his girlfriend to an overdose. She just died. And he came into the ER one night and he was all over the map. He was screaming. He was sobbing uncontrollably. He was lying in a fetal position. And I just reassured him that he was doing exactly what he needed to be doing. And that he was safe and I would be here with him and just allow that process to take place. And it seemed to help.

Other clinicians "try to explain what grief is" and try to "normalize" it. They explain the stages of loss that some people experience. They try to "guide people away from…self-destructive, self-defeating internalizations." Clinicians attempt to "be a sounding board", to "let them gain enough tolerance and comfort so that they can accept that it is going to be grief, and it is going to be painful" and "give them the hope to stay with it" so that the grief can be resolved. One participant observed that:

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> I think that sometimes people feel they don't have the language. I think they feel there are things they're supposed to say. People seem to doubt themselves a lot around loss. I don't think I'm doing this the right way. I haven't cried; I think I should be crying.

Another clinician explained how educating clients about the grief process could help them move through it:

> Natural emotional reactions are understandable and it's all part of the brain just coming to terms with grief. There's a psychiatrist out in California who said that… grief is coming to terms with reality. The reality is this person, this situation, is gone and you have to come to terms with it and grief is that process of … letting the information in…assessing the world in a different way. And letting them know what that process is so they're not fighting it, I think, is what sets them up to at least go through it. And then you just get out of the way.

Clinicians all recognized that the client is the only one who can resolve his or her own grief and "grow a new self." Much like when "the crocus come up out of the ground…it's gotta crack through the surface and shift what's there", the client needs to experience his or her own internal shift and growth.

Strategies and rituals

Nearly all the participants in this study (n=13) would suggest some form of rituals or journaling to clients to in order to help them resolve issues of grief and loss. Clinicians cautioned that the suggestions were always made with the individual in mind since:

> It depends on the person. Some people, rituals are very important, and some people hate them…Some people it opens up wounds. And for some people, it's very healing. Some people need to write in a journal and say their good-byes that way and some people it would just totally send them off the edge. So it's getting to know the person.

Some form of writing, journaling or writing letters, is the suggestion that was most frequently mentioned (n=12). Letters can be burned, as a "way of sending the letter

to the other side" and also are a release because you "externalize it, first by writing it and secondly sending it." Keeping journals or a diary helps to track emotions and record memories of the person who is gone. Writing can also be helpful in other ways:

> Anything that gets the grief out in some way is a good idea whether it's a ritual, going to the cemetery, writing things. Anything that brings feelings to the forefront to me can be very, very helpful. And also if a person is in a complicated bereavement situation where it's clear that they're not actually flowing through grief, we actually have to immerse them back into it. So going through writing about it or going, depending on how difficult the issue is, getting them back involved in the process through some ritual may be important.

Encouraging clients to talk about loss with other people in their lives, including friends, family or professionals, attend a support group or a grief group, use their own support network, "not isolating, not internalizing," was mentioned by nearly half the participants (n=6). Basic healthcare such as eating nutritionally, exercising, getting "a good night's rest" are important to maintaining good mental and physical health and minimizing possible symptoms. Allowing emotion to surface "to not block it" but to "let grief at whatever intensity they have just exist" allows the natural process to evolve. More than anything, allowing time to pass promotes healing.

> The brain knows what it's gonna do. It's gonna need a certain amount of time to do it and you really can't change that. And so big losses are gonna take time; little losses take less time.

Letting people know that grief "is a process that moves on, at different paces for different people. But it will move on" can be extremely helpful. Sharing some awareness of the stages of grief with the client, "what can happen when one is grieving" was thought to be beneficial by a several participants (n=4). The extreme symptoms of grief

can be a frightening and overwhelming experience for people who might otherwise be "afraid that they're going crazy."

Rituals such as candle lighting, creating a memorial space, mock funerals, placing items in a casket for their loved one to "take with them," taking a "final picture" at the funeral parlor and setting a memorial place for someone who has died at a holiday table were also mentioned by participants as suggestions they have used with grieving individuals. The lone participant who does not suggest rituals to the clients he sees stated: "I do crisis work…it's about the intervention…I believe in …those kinds of tactics, but I don't usually introduce them in this kind of work."

Grief and loss in crisis situations

Participants were asked if the presence of grief and loss created any additional challenges to resolving crises. Many clinicians (n=8) stated that once the person is safe and/or stable, the underlying loss "could potentially destabilize things again" and make a person "more vulnerable to crisis." The crisis would not be resolved; it would "cycle again and again" in a "repeat of particular patterns." "Unidentified grief is a problem" and "getting them to the point where they can even recognize that sometimes can be tricky." As one clinician states:

> People who deny the loss will stay in crisis their whole life and never know why. And that's what makes it so difficult to work with adults who have been traumatized or had some losses of different kinds early in their childhood. They now are adults and they've learned in a maladaptive way, to cope. To get to that place with them is very, very difficult.

Several clinicians (n=4) stated that they believe "grief and loss and a crisis go together" and had difficulty thinking about a crisis that did not "involve grief and loss."

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Participants confirmed that "grief and loss take time" and that often, the focus in clinical work is on the "immediate response", kind of putting "a Band-Aid on the problem" and helping to "get people hooked up with appropriate services." In many cases, "it's not being recognized as grief and loss", "that grief part doesn't get acknowledged" which one clinician noted as "a huge disconnect."

One participant acknowledged that there are some situations where people "can't grieve for one reason or another" because they believe "it will upset some other situation." In those cases, a person may need to grieve in private; they are not "free" to grieve because of the expectations of the people around them. Potentially, that situation could destabilize the person's world. Another clinician noted that grief and loss could raise a challenge of "differentiating the diagnosis" and may "overshadow or overlay" issues of a client's clinical presentation.

Religious and spiritual beliefs

Most of the participants in this study (n=11) believe that their spiritual or religious beliefs help guide their practice with a grieving client at least "a little bit." For some, this influence prompts them to ask a client what religious beliefs they hold, "what that means for them and how that is helpful or not helpful." Participants may ask clients what they believe happens when a person dies, if the death of someone is part of the reason they are presenting. In a crisis situation, has the crisis shifted their religious or spiritual foundation? Do their beliefs still offer them solace? What spiritual supports "whether it's a Bible or a priest or a person, can they potentially access?"

Clinicians referenced their own spirituality and a "sense of the universe as having a sense of continuity", order, and "energy… that doesn't die even when an individual

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dies." Religious beliefs help participants to "have a comfort level with death and dying" and see it "not as the end of everything." One clinician cites his spiritual practice as benefiting his clinical work in the following ways:

> My ability to face death, my ability to face a lot of things that are not pleasant in myself, through meditative practices, I think, strengthen my ability to be present with other people and for other people, for whatever they are going through.

Another participant shares:

> I think we continue to be reborn whether it's here on earth or in another place or in another dimension …I guess in that sense I have a level of comfort with the idea of death. And for myself I find that reassuring.... I think it lends a sort of steadiness to what I'm saying… So in that sense that does guide me and I tend to want to help people see the beauty in whoever's life it was that has passed. And that they haven't really gone anywhere. We just don't see them any more. But they're around. And that they live in our hearts.

More than focusing on their own spiritual or religious beliefs, clinicians report that they ask their clients about their religious affiliation and spiritual practices since "most people have some kind of belief system that they operate from." The person's beliefs, if they have any, "are guiding their work" and "they are certainly not going to take any suggestions from therapy that do not line up with their spiritual beliefs." Spiritual beliefs "are an extremely important part of some people's lives." As one clinician recognized:

> It is important to have those discussions. And in those discussions, what you find is the guiding philosophy and theology that the person has based their life on. Or you will find that they are in an existential crisis because that's breaking apart. Any living system that breaks apart has the elements of reconstructing itself… the psyche has within itself the capacity to reconstruct itself.

In terms of their own beliefs, most participants (n=11) stated that they hold a broad or eclectic view. Some say that the seed of their beliefs is from an organized religion, but they draw from their own experiences and do not necessarily practice within

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an organized religion today. Energy work, the twelve-step model, therapeutic touch, physics, holistic health, mindfulness meditation, nature, mind-body-spirit work, world religions and shamanic studies are some of the fields that have influenced participants' spiritual values. One clinician cited Elizabeth Kubler-Ross' speeches and other workshops about near-death experiences as influential in forming his beliefs about work with grieving clients. He shared the idea that:

> Probably when people die it's okay. They're fine. And the grieving is for us and most difficult because we don't really know...I don't tend to focus on the person who has died. I focus on us being separated from them as being the most painful and difficult (part). And I say well, since all theories are equal, why not believe that they're at a party somewhere? … So I think spiritually I add this sort of "better part of the story" around people who have died and hopefully that releases them from worry about the person who's departed…it makes it easier to let people go. And I think people feel better when they hear that.

Overt grief and crisis

When asked if overt grief often caused clients to present in crisis, many participants (n=9) stated that it did not. Individuals at the beginning of the grief process "are not ready for counseling. They're not ready for any healing process. They're holding on to those memories." As one clinician describes:

> My experience has been that people in overt grief rarely present in crisis. They will migrate towards their loved ones first, which is the most natural process and I'm thankful for that. It's after it persists for a period of time, when it begins to cause problems beyond what they anticipated, when we see them. So it's not the initial grief. It could be weeks, months or years afterwards that that's when we see them.

Several participants (n=4) remarked that while the percentage of clients for whom grief is the presenting issue is small, that "there's a lot more grief than is expressed overtly." Issues like "the fight with the partner" or "a kid who just went and punched

somebody at school" might be driven by grief, but the grief may be underlying. As one participant explains:

> A person can look exteriorly like they are contained and interiorly be broken apart…So what a person presents overtly is only part of the story. And I think a therapist's vision and empathy has to reach beyond the surface of presentation. Because we're living in a world that does not allow you to walk around with it all hanging out…So people have to have internal ways of dealing with whatever they're in. And so they come to therapy because they're bursting sometimes, on the inside. And they need a place where they can dump it.

Another participant recognized that clients sometimes "deny what's going on" or "lack awareness of how grief may be running things in their life" because "you get funny messages about grief from society."

Two of the four clinicians who practice in college counseling settings found that overt grief was the main presenting issue "fairly frequently" or about "50% of the time." They cited the death of a friend or grandparent and breakups with partners as commonly presenting issues for students. One participant referred to the work he does with disaster relief and related that, in that setting, overt grief is "one of the biggest areas that they're struggling with" that lead a person to seek help.

The clinicians in this study felt comfortable working with grief and loss in part, because of the experience they've acquired in their years of clinical practice. Through their professional work, participants have attained a level of comfort for sitting with clients who are experiencing strong emotions. Clinicians have also dealt with their own personal losses. They recommend that clients use tools or rituals to assist them in their grieving, especially those that allow emotions to surface. Grief or loss that is not dealt with tends to resurface and create additional crises in the future.

Having explored with participants how clinicians work with grief, and how often grief is an issue in the clinical setting, the next section will examine how issues of grief and loss impact clinical practice.

Clinical Implications

The questions in this section focused on the clinical implications of working with grief and loss. Participants were asked about the importance of grief and loss in the clinical setting and whether an accumulated knowledge of grief and loss were necessary for a clinician to work with clients in crisis. The final questions in this section asked participants how their clinical work has been enhanced by working with clients in crisis and what has changed in the way they sit with grief and loss now from when they first began their clinical practice.

The importance of grief in the clinical setting

Nearly all participants (n=12) noted that "acknowledgement" of grief in the clinical setting is perhaps most important. It is "a way that we can connect" and "validate" people. If clinicians lack an awareness of the impact and pervasiveness of grief, they "miss an opportunity" to work with it and the chance for "someone to have some resolution."

Grief might bring a person into a clinical setting. If it does, and they are in crisis, "they're open to change" and "willing to look at themselves" which "can mean growth." Grief can be "a turning point." As one clinician stated:

Grief is really about one's relationship to one's self and to the world. And if you think of clinical work as sort of trying to optimize the relationship between self to self, and self to the world…it's very much a part of it.

Grief is seen as "as much of a person's life as everyday living" and so "when a person comes in with a problem, you have to find out what's going on in their life. And you have to assume they lost." People may not have thought about what they have lost in their lives, the things that they are grieving. Grief "is the source of a lot of upset" and can be happening "rapid speed" in the world today.

One participant observed:

Unexpressed grief, unresolved grief. I think it's something to keep in mind. I think it's a large percentage of what we see at least in outpatient settings. And in inpatient as well.

Grief tends to be underestimated and "one grief tends to reawaken another." Clinicians suggest being "incredibly respectful" of what the person is going through and of "the many, many different ways that people manage their grief." Work with grief and loss is "just bearing witness to pain" and you have to "be there and just listen". Participants who have experienced their own grief process recognize that grief is a "very painful but also a positive experience" in which people can become "really clear on what is meaningful."

The importance of loss in the clinical setting

Nearly half the participants (n=6) believe that it is most important that clients understand that loss is a normal and inevitable part of the human experience. People tend to try to avoid loss and the intense feelings it creates. One clinician explains:

Trying to hold in abeyance the feeling of loss actually gets in the way of taking in the positive things that life can offer. And again, I think that this is true about any intense emotion. I often say I think that we try to protect ourselves from what we consider negative feelings. And the problem is, that if you have a filter on feelings, it filters all the feelings. So you feel less bad, but you also tend to feel less good. And I really, really believe that. So I feel its important to help people understand that if they can somehow experience their loss then they're also opening themselves to the possibility of joy.

Another participant offered this view of loss:

Some people are frightened of it, some people don't understand it. I think it's a large reason why people get involved with drugs and alcohol, why they're running for antidepressants, because they're frightened of it. Our whole society is very frightened of pain in general…What I think is important about it is to teach people to tolerate loss…as a part of life. And to learn from it and hopefully be enlightened by it rather than running from it. I think it's a major, major problem in our society and why people are drawn in to therapy is because they feel very weak in the face of loss…They don't…see that it can transform them in ways that, make them better people. They think that there's something wrong. It's been pathologized.

Other clinicians noted that clients need to understand that processing loss takes time and affects not only the "whole being" but also "how we view things" and "how we interact." Three participants noted that they view grief and loss as parallel issues.

Knowing about grief and loss, working with crises

Many participants (n=9) do not believe that a clinician can effectively do crisis work without an accumulated knowledge of grief and loss. Some note that through doing the work itself, you quickly acquire experience "by the hour." As one clinician shared: "I think it's very difficult to work in this field for one day without getting accumulated knowledge of grief and loss."

Every person has lost something so even novice clinicians bring basic understanding to their practice. Acquiring "basic knowledge and clinical skill" can begin

to prepare clinicians for the work. One participant noted however, that "if you just focus on the practical then you're doing the client a real disservice." Others stated that "the issue has to do with empathic attunement" and "if you're going to be effective, you'd have to be able to address these issues with people…You have to look for it, identify it and connect it with the current state of affairs." Some clients deny grief and loss and they can be challenging to work with. As one clinician describes:

> It can be very difficult, moving people from denial… Sometimes, we meet people that have layers and layers and layers of grief and loss and injury and betrayal and all kinds of things. So we're trying to meet out what's going on here – what do we have left after we dig through this rubble? Who's in there?

Participants state that an assessment is not complete without focusing on the grief and loss issues impacting a client. One clinician cautions that:

> I think that if we are going to be able to do this work, a lot more needs to be done in academia to include talking about this as a life process instead of a beginning and end and that's the end of it. For people to be able to ask more about people's life situations and hear what is and is not going on in people's lives, that may in fact be grief. And our educational systems aren't quite there yet.

Another participant suggested other ways that novice clinicians can accumulate knowledge about issues of grief and loss and improve their efficacy:

> I would hope that they get supervision, consultation and further training where they are able to process that. Now I don't think you can do grief and loss work without getting in touch with your own grief and loss. So I think that therapy can also be helpful to people, or something that helps put them in touch with that and helps them to face their own issues with that. If somebody hasn't resolved that, and none of us has ever resolved it perfectly, but it's really a source of, like it's a no-go area. Or you get so stirred up that every time you sit down with a client you want to cry because they're crying. It gets in the way of your being an effective helper. So I that think it's important to do one's own work with that to be an effective crisis intervention person.

Enhancement to clinical practice

Clinicians spoke of several aspects of their work that have been enhanced by their practice with individuals in crisis. Confidence in their ability to help people and to handle any situation that they clinically encounter was a common thread. Clinicians also found that they are more able to "be in the here and now" or be "more grounded" and aware of the issues they are dealing with on their caseloads. Participants found that their "capacity for understanding", their level of tolerance, their "capacity for empathy" and their "ability to make a connection" or develop a "stronger alliance" have been enhanced by work with clients in crisis.

Clinicians cite improved interview skills and being sensitized to probe for issues such as grief and loss beneath the surface, increased openness to collateral work, and using more confrontational approaches with clients. One participant spoke of "precipitating crises" with some clients by encouraging them to be "very honest" about what's going on in their relationships or to do something that's "risky or scary" for them because "sometimes people won't consider other possibilities unless they're in crisis." As one clinician stated:

> I think (working with clients in crisis) gives you a range of experience. To see somebody who's fully, fully in crisis gives you more of a perspective of the landscape of human response. And I think it helps you locate people at various points. It also helps you with being more aware of when things are really about to go very badly with your clients in regular treatment. And to help you shift into different kinds of interventions knowing where things can lead if you will.

Clinicians shared that they have learned a lot from their clients, that "there is not one individual that I have not learned something from", that "every client has made me grow as a person." Four clinicians stated that this work has not only made them better

clinicians, it has made them "a better person." As one participant stated, the skills he has obtained through this work "have enhanced my life, not just my clinical practice."

How participants' work with grief and loss has evolved

Clinicians were asked what has changed about the way that they sit with grief and loss now from when they first began their clinical work. Most participants (n =11) related that they were in some ways more able to tolerate sitting with grief. Participants in this study cited both their own experience of personal losses and their years of working with clients in helping to develop their capacity to allow and work with grief in the clinical setting.

One participant noted that "it was more theoretical and abstract before my husband died." She cited that going through that experience "has built my compassion…and understanding that losses are not simple little losses." Another clinician stated that she has "a greater sense of the notion both of the amount of psychic pain that someone can experience, as well as the sense that you can get through it."

Examples of comments from different participants include: "I can sit with it more…I'm not afraid of it… I can get right in there. I can be with them…I have clearer boundaries. I'm just more mature…I'm much more confident. I'm much less volatile, stirred up, overwhelmed by it. I understand patterns and dynamics of it much better than I used to…I can manage my own reactions more effectively…I don't try and problem solve…I'm very comfortable and allow silence. I can tolerate waiting and just being with an individual, truly being with them." One clinician observed: "I wish I had me helping me when I was twenty-five because I think I could have helped me."

Even after years of practice, clinicians still struggle at times with their own reactions to client grief and loss:

> I'm not going to be the one to alleviate what they're going through. And sometimes that's hard to sit with because it is so profound and it presses all sorts of my buttons. There's countertransference stuff that happens at times and to be conscious and aware of that because there's some people you just want to put your arms around and grieve with them. But I think that for the most part I see my job as being rather sober. And I don't mean sober in a sense of unemotional or unattached, but sober in a sense of being able to see the bigger picture and to be a sort of a positive light in the grieving process.

Some clinicians stated that what had changed from when they began their practice was an awareness that grief and loss is quite prevalent in the clinical setting, "more than just the obvious." These clinicians try to point out connections and possible vulnerabilities to clients so that they can talk about and feel supported regarding their losses. Clinicians might be "more likely to bring it up" even though talking about loss might be uncomfortable or certain types of losses might be "hard to talk about." Many people don't understand grief and loss "and how you deal with it" and present in therapy because "they're not managing grief and loss in some way." Providing education around grief processes and validation that some individuals are incapacitated by grief can be both supportive and mobilizing.

These participants view grief and loss as inevitable parts of the human experience. Encouraging clients to recognize and grieve their losses allows them to move through the clinical process and regain a sense of safety, mastery and control. Clinicians recognize that working with grief and loss not only allows their clients the potential to change and grow, it also enriches the clinician, on both a personal and professional level.

Overwhelmingly, these participants indicate that grief and loss are important issues be aware of and work with in a therapeutic setting. The final section looks at what suggestions experienced clinicians would offer to students and academic programs to prepare individuals entering the field of mental health counseling.

Suggestions for students and training programs

The questions in this section offered the opportunity for participants to make suggestions to individuals and the training programs that prepare them to enter into clinical work. Clinicians were asked whether they felt that coursework in grief and loss would have been beneficial to them when they entered into the field of mental health counseling. They were asked whether grief and loss should be given the same level of importance as other course material in a graduate program. Finally, participants were given the opportunity to add anything else about working with grief and loss that they had not shared earlier.

Suggestions for students

A number of participants in this study (n=5) suggested that being "in touch with your own feelings and beliefs" around grief and loss is "really, really important." Doing some "soul searching" can create a "comfort level around death that allows you to put it aside" and "feel solid" so that you can be "fully present" with your clients. Using whatever means necessary, whether through journaling, "in therapy, through a spiritual practice," or "reviewing my life and those dramatic points …and really exploring what my reactions were again" helps provide a sense of what loss really is. Being willing to

"work out your own values and your own attitudes about it" is really important "because they will be there and be part of the process."

Some participants (n=5) also related that supervision can and should be a place to work through issues that come up "so that you don't project that on to your client." In the view of one clinician, "supervision is as important as anything." For those working with grief and loss however, there is a belief that "good supervision…is lacking a lot for this kind of work." The importance of good supervision, especially for a new clinician, is illustrated in the words of one participant:

> Hopefully you have a good supervisor. Because if you have a good supervisor you're going to be able to deal with it. You're going to be able to grow with it and become a better clinician with it. If you don't have a good supervisor, then you might want to pay for a supervisor, especially when you first start out, because it's just invaluable.

Finding a way to be sensitized to loss, through movies, through reading, is also suggested by these clinicians. Speaking with people who do grief work or having conversations with people who have experienced loss in order to learn what has been helpful to them, can also inform clinical work. One clinician offered this advice:

> Go get help for whatever you need. You can't be an expert on everything and *don't do everything just by the book.* Read the books but listen to the spaces between. Listen, a good musician knows how to hold the pauses between the notes. That's what makes good music. What makes good therapy is the same thing - that balance between listening and speaking and knowing and realizing you don't know. Don't think you can get out of the gate being an expert. Because you know what? It shows. And clients know it.

Having an intellectual understanding of the theories of grief, the processes and the phases was mentioned by several clinicians (n=4) as being important. Even more value is placed on understanding the meaning of the loss to the individual client. The client needs

"to be able to feel that somebody else can tolerate grief with them", and that they have your "undivided attention." As one clinician states, "it's all about being there for people."

Even clinicians tend to want to "protect ourselves from the intensity of emotions that come with this sort of thing" so you "have to somehow let it wash over you and accept it and not get frightened by it." As one clinician advised:

> You need to separate yourself in some way that it is their grief and loss, not your own. And you would better serve the individual if you keep that in mind and not get caught up in the sadness of it completely, so that you're now not thinking and concentrating clearly. So always understand it's their grief and loss so you don't get pulled into it.

Grief and loss is "a part of many, many problems" and "should be…a major point of assessment and intervention." Asking about how clients have dealt with loss and paying attention to what it means for the client is extremely important in the clinical process.

Would coursework on grief and loss have been beneficial?

More than half of the clinicians in this study (n=9) stated that they would likely have benefited from a course dealing with grief and loss in their training programs. Some stated that while experience is most beneficial in this work, at a time when they had less life experience, being introduced to the themes of grief and loss and how pervasive those are in the human experience would have helped them in their earlier practice. Covering the area of cultural differences in dealing with loss is one specific area that was suggested as important to discuss if a course were offered. One clinician mentioned that he wished:

> …that I could have sat with someone who had some experience with people that were going through this and that they could talk to me about it. Because I would learn more from that than reading some words in a textbook. But no matter in how in depth they may speak about it, it's still the experience that you have to go through to gain the knowledge

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Rather than a specific course about grief and loss, one clinician suggested that a course about the human experience "where people are likely to have crises: birth, death, transitions, losses…the whole continuum of human experience" would have been "enormously important." She also stated that "there should be more emphasis on boundaries because we all go through these experiences as well as our clients."

The one clinician who had taken a course during his training program stated that he "barely remembered it" since it was many years ago. Other trainings he has taken since have been beneficial but he indicated that what he draws on the most is the "physical resonance" of his own grief when listening to people "because that means I understand it much better than just intellectually."

Many clinicians in this study (n=9) felt that a course dealing with grief and loss would have been helpful to them as beginning clinicians. Participants also pointed to other resources such as self-awareness, mentors, and knowledgeable supervisors as paths to inform clinical knowledge.

The level of importance of content on grief, loss and crisis

Nine of the clinicians stated that grief and loss are important and are probably not given sufficient attention in training programs. Participants believe that there is already too much to do in graduate school and noted areas that were not covered in their training that probably should have been. Some participants felt that there is too little time spent on "what actually happens in sessions", "the real spirit of what we have to deal with", "what actually happens to people in life and under what circumstances will they be showing up in therapy" and that clinical applications should be weighted more heavily.

Clinicians did state that grief and loss were important, possibly of "paramount importance" and should be woven into other course material "because it doesn't occur in a vacuum." Those with the strongest opinions on this topic stated the following:

> It is extremely important. It's a part of our human condition and it gets horribly neglected and should be incorporated into our institutions... I think that there are some people who really are expert at this work. And if they are given the opportunity, there's many areas that you could even do internships, with hospitals and hospice, and being a support to other people who are doing this work… along the way, you're gonna need to deal with it. And if we're trying to do things better then this is one area that definitely needs more focus

> I think probably it's not given sufficient importance. And probably on some level it's again because of the fact that a lot of people teaching and planning the courses are not necessarily good about grief and loss. Either they don't understand it or they can't deal with their own grief and loss. As I was saying to you, I think that it's so central and to be able to face death, grief and loss is so important to feel confident in working with people who are experiencing crises, that it needs to probably be given more attention than it's given. And in particular the broad way that you were talking about so it's not just about death. It's not just about dying.

Other thoughts on grief, loss and crisis

At the end of the interviews, participants were given the opportunity to add anything else that they wished to share about grief and loss. Most of the clinicians who did share insights offered words of wisdom that apply to both clients and clinicians.

One clinician affirmed that "bad things will happen to us but we don't know what they are" and that "what's gonna make our lives feel better is really experiencing it fully." Focusing on what makes life meaningful, which has to do with relationships, will "put us in danger of further loss" but "it's worth the risk." Learning about yourself and others helps minimize those risks and puts you in tune with your feelings.

Another participant shared:

The people that I become most concerned with are the people who are expected to be the survivors. They're supposed to solve everybody else's problems. They're supposed to be the doers. They're supposed to be the achievers, and something happens that sort of knocks the wind out of their sails. What happens then? Who's looking out for them?…So lots of times I'll have high achieving clients and you really have to listen to when they're no longer taking care of themselves. The most important thing that I think that I could probably suggest is - take your own advice. Cause as clinicians we forget that… It can be tough work. It can be wonderful, joyous work, but it can be tough too. So take care of yourself. And listen to yourself. Listen to your advice. And have fun. You know, try to find the fun in it too. Building relationships with peers. That can be very rewarding.

Clinicians also revealed that they have, on occasion, made a judicious use of self to let a client in crisis know that they were not alone with their experience. Another participant shared the story of her husband's final days and how having a Hospice physician normalize his experience was amazingly helpful to both her and her husband. She observed:

That's what made me realize how important normalizing it is. Because you really do feel - it's so extreme and so dramatic and so painful that you do feel like you're coming apart. And you really aren't coming apart. And that's what's helpful, I think, for people to realize that. Now again, some of the people we see it's complicated by multiple losses, by mental illness, by lack of support, by poverty, by physical health problems. So when you're talking to me, I'm thinking about the patients that I had in private practice or myself, who go through grief and loss but they aren't complicated by all these other factors. That's a whole different ballgame.

A participant noted "most people heal" even if they don't get any help, which "is always important to keep in mind." He recalled that:

I've dealt with children who have had to kill their parents, I've dealt with parents who have lost their children, I mean some of the most horrific, terrible losses that human beings can experience. And yet, for the most part, I've seen people come back from that and be able to move forward with their lives. And I think to know that, is really important for the helpers to know. It doesn't mean that there aren't people who get blocked or stuck or who can't resolve it more quickly or less painfully and there are people who go in a circle, like if they have PTSD where they can't get out of that circle and they can't move along. But I just think it's

important to remember that grief and loss is part of the human condition and most people experience it and deal with it and have their own resources to be able to cope with it. It's a lot about resilience. And that's why it's so important to focus on resilience in doing this kind of work and not pathologize a normal life process, just like we shouldn't pathologize birth. We shouldn't pathologize grief and loss.

Summary

This chapter has presented the findings from questions asked to fourteen mental health professionals on the topics of grief, loss and crisis. These clinicians have been trained in various disciplines in the field of mental health. They work with clients across diverse settings.

Participants agreed that a "crisis" includes an element of intense feelings and pressure to resolve what, to a client, seems like a paralyzing situation. Assessing the crisis includes determining levels of client risk, the availability of social supports and the inherent strengths of the client to cope. Exploration of past losses and how those were dealt with also helps to illuminate the client's potential vulnerabilities in dealing with present and future losses.

Grief and loss were identified as important issues to be mindful of and to address in any clinical setting. Participants strongly believed that unresolved and underlying losses can fuel a crisis situation. Interpersonal losses of important relationships through break ups, separations and divorce were mentioned more frequently than deaths as reasons an individual may present in crisis. The participants held a broad view of grief and loss, not just as an end-of-life issue. Several clinicians stated that clients do not understand that they experience this diversity of losses or recognize the impact that multiple losses can exert on their lives.

Clinicians shared that the most effective means of helping a client work with grief is to listen and validate the client's feelings. Participants would suggest rituals to facilitate this process if they believed that they would be appropriate for an individual client. A client's unresolved grief was agreed to be a potential risk for vulnerability to future crises.

Acknowledging and normalizing grief and loss was seen as perhaps the most important aspect of working with these issues. Clients often attempt to avoid strong feelings, clinicians may find loss issues uncomfortable to work with, and society gives messages that individuals should "get over" their losses quickly.

The participants in this study have been in clinical practice for a number of years. They recognized that working with clients in crisis has enhanced their clinical practice, sensitized them to probe for issues beneath the surface, and improved their ability to develop alliances with their clients. Clinicians stated that they feel more confident and engaged in working with intense issues such as grief and loss. They suggested that students work to recognize and understand their own feelings about loss and work with supervision to keep countertransference issues from getting in the way of the client process. The implications of these findings will be examined in the next chapter.

CHAPTER V

DISCUSSION

This exploratory study focused on clinicians who work with individuals who present in crisis. The research investigated whether these mental health professionals were adequately prepared by their graduate programs to identify and assess issues of underlying grief and loss in their clients. The study also explored whether clinicians found that an understanding of grief and loss is meaningful in the therapeutic process, and whether having an accumulated knowledge of grief and loss has enhanced their clinical work. This chapter reviews the findings from this study and the limitations of the research. It concludes with recommendations for further studies and a discussion of the implications of the research for the field of social work.

Major findings

Clinicians in this study spoke about grief and loss in broad terms and as a part of an individual's normal life process. Much of the research, as well as the literature that deals with grief and loss, focuses on loss in relation to death, bereavement and end-of-life (Berzoff & Silverman, 2004; Kubler-Ross, 1969; Lindemann, 1944; Nolen-Hoeksema, & Larson, 1999; Parkes, 1986). More recent works, such as Hooyman and Kramer (2006) note other significant life losses which may also be the focus of clinical intervention, but their writing also still centers on grief that results from bereavement.

The long-term and residual effect losses have on a person is noted in the literature (Davis, 2001; Hooyman & Kramer, 2006; Rando, 1993; Weenolsen, 1988). Clinicians in

this study noted that a person's losses early in life might have been significant, but people tend to minimize their losses. Past hurts tend to scar over if they are not part of a person's current life experience. Western society tends to encourage people to "get over" their losses quickly and to avoid speaking about them. With a loss through death especially, "there remains a taboo about speaking about death…as a consequence, the suffering of the bereaved is often ignored" (Klein & Alexander, p. 261, 2003).

The clinicians in this study recognized that most people, given sufficient supports, are able to move forward with their lives after experiencing even devastating losses. Participants warned against pathologizing grief and those who are grieving. They find the inherent resilience in clients that Mancini and Bonnano's (2006) work noted as occurring in "a significant percentage" of bereaved individuals (p.978).

Participants' accounts of grief and the grieving process had much in common with the descriptions provided in the literature. Raphael's (1983) bereavement assessment is echoed in the description participants provided about their work with grieving clients. A focus on investigating social supports and inquiring about whether there have been other times when a client has experienced similar feelings of overwhelm are found in several of the clinicians' responses. Bowlby and Parkes' (1970) observations that loss is at least part of many of the issues that bring clients into treatment is clearly stated in the clinicians accounts. Rando (1993) and Baum's (2003) observations that loss must be validated in order for grieving to take place is repeated many times in the words of the clinicians in this study.

What impact the group's extensive professional experience had on the findings of this study is hard to determine. Since the participants averaged nearly twenty-three years

of clinical practice, their collective level of comfort with grief and clients who are grieving is significantly higher than one would expect from less experienced clinicians. Participants reported having taken a number of workshops and trainings that dealt with aspects of grief and loss. Clinicians with less experience also may have chosen to participate in trainings, if they sought out workshops early in their practice to obtain skills and knowledge in this area. Furthermore, participants in this study were older than many beginning therapists (most age 51 and older). Their age may also contribute to their level of comfort in dealing with losses and life transitions. Participants reported that with age, they have encountered more losses, including deaths, in their own lives.

Only two clinicians interviewed for this study indicated that they had taken courses while in graduate school that dealt specifically with grief and loss. While most of the clinicians interviewed completed their training more than twenty years ago, the current educational standards for professional mental health training programs still do not require specific training in working with grief and loss or death and dying. Wass (2004) found that less than one-fifth of students in the health professions have access to a course about death. This persists despite recognition that "grief… is often central to the work conducted by social work practitioners" and an understanding that the "lack of attention to training in grief and loss may leave many students unprepared to work effectively with grief-related client issues" (Kramer, p.212, 1998). Participants interviewed for this study stated that to some extent, working with clients processing grief and loss, along with supervision in this area, helped to augment their formal coursework. These clinicians nonetheless sought out more formalized training to obtain additional knowledge regarding this clinical area.

The Council on Social Work Education (CSWE) sets educational policy and accreditation standards for graduate programs of professional social work education. CSWE works "to ensure the preparation of competent social work professionals" and "maintain the high quality of social work education" (http://www.cswe.org/). The accreditation standards listed on the CSWE website detail areas in which foundation content must be offered in social work programs. There is no mention of grief or loss contained in this document.

The Council for Accreditation of Counseling and Related Educational Programs (CACREP) is the accrediting body for licensed mental health counselor (LMHC) and related programs. CACREP defines the minimum criteria of clinical and course work that a student must complete in a professional counselor education program. CACREP defines eight core areas of curriculum in which knowledge must be gained, along with specific standards for mental health counseling programs. No mention of grief and loss is contained in the program standards or core areas (http://www.cacrep.org/).

The American Psychological Association (APA), the accrediting body for doctoral-level programs in professional psychology, functions as a quality assurance guide assuring that accredited programs have a consistent plan, principles and training model (http://www.apa.org/). APA accreditation standards also contain no specific requirement for training to be offered in the areas of grief and loss. Doctoral level programs in psychology tend to maintain a research focus on areas of clinical importance. Of the three hundred accredited clinical and counseling psychology doctoral programs in the United States and Canada in 2006, only nine schools offered research opportunities in the areas of death, dying and bereavement (Mayne, Norcoss & Sayette, 2006).

This dearth of program content and the limited interest in research studies focused on bereavement and loss seems to indicate that the mental health field and mental health professionals do not attach a significant level of importance to clinical work around grief and loss. Perhaps this is a reflection of the Western tendency to avoid dealing with death and to see losses as a kind of failure. Among the peers of my own graduate program, mention of this research topic tends to elicit a polite but rather disinterested response.

Since loss occurs throughout the life cycle and is a part of normal life transitions, there seems to be an expectation that mental health providers will be able to work with losses, including death, based on their generalized clinical training. These rich and complex issues are guaranteed to appear in clinical work and to challenge clinicians to provide a respectful and empathic response. Perhaps the expectation that academic programs hold is that issues of loss will arise and be addressed in field placement settings, where they will be addressed in some depth in supervision and through other outside resources. There may also be an expectation from academic programs that clinicians have the inherent resilience to deal with losses, their own and others', and that that, in combination with the theoretical base obtained through academic training, will be sufficient for them to assist clients dealing with these issues.

In contrast to what the academic accrediting bodies for the mental health fields offer, the participants in this study believed that more coverage should be afforded to grief and loss in the academic setting. Given the number of years that these clinicians have been engaged in mental health practice, that finding suggests that a greater understanding and appreciation of both the positive and negative roles that grief and loss can play in people's lives evolves based on clinical experience. Clinicians in this study

had some difference of opinion as to whether a course exclusively focused on grief and loss would be the best way to expand coverage of this material in clinical training. Participants stated that doing the work or having access to other clinicians involved with disaster response, hospice or other programs whose focus is on dealing with losses would be more valuable than reading chapters or articles. While graduate training currently focuses much time on attachment and creating bonds, there is little or no time in the current curriculum devoted to working with loss.

Clinicians in this study indicated that their enrollment in post-graduate workshops and trainings related to grief and loss were largely prompted by issues arising from client caseloads with which they felt ill-equipped to deal. Recent literature on grief and loss concurs and notes the "inadequate preparation of social and health care providers to address the needs of the bereaved" (Kramer, p. xv, 2006; see also Berzoff & Silverman, 2004; Wass, 2004). Given the lack of graduate school coursework in this area, an important implication for social work practice is the critical role for continuing education and training that the profession could provide its practitioners.

Much of what the study participants shared about working with grief, loss and crisis holds true for psychotherapy more generally. Respect for the client's struggle, being in the here and now, bearing witness to the client's story, understanding that as the therapist you can't alleviate what someone is going through – are all parts of any clinical encounter. What distinguishes grief, loss and crisis may be the immediacy and the intensity of the emotions or distress that the client displays. As Parkes (2006) stated:

> Therapy is concerned with helping people to feel safe enough to change their mind, to review their current assumptive world and to discover new perspectives. Following bereavement this is termed "grief work" but it is not essentially

different from other situations which, for whatever reason, people need to take stock, to give up some basic assumptions and to develop others (pp. 257-258).

Limitations

This study was conducted using a very small sample of fourteen individuals who are clinicians practicing in Western Massachusetts. The generalizability of the study is limited; it is not representative of clinicians in general. The group of participants was not culturally and ethnically diverse. The sample did not include any clinicians younger than 39 years old. Those clinicians who chose to participate had an interest in the research topic. My own age, race and ethnic background are similar to those of the study participants.

As a social work intern who worked with a crisis team during my first field placement, this writer realized that unrecognized grief issues and losses were a significant part of why some clients presented in crisis. In order to support clients through their crises, it was sometimes necessary to help them identify the links between their past losses and their present difficulties. My field experience is therefore a potential source of bias in this study, as my experience predisposed me to believing that more education in this area is necessary for beginning practitioners. I was acquainted with some of the clinicians who participated in this study through prior personal and professional contacts. Having a prior connection may have impacted the quality of the interaction we shared in discussing this material. I attempted to remain as neutral as possible to the content of their responses during the process of conducting the interviews and analyzing the data.

The phrasing of the questions in my interview guide may have led participants to respond in ways that, to some extent, reflect my own views about the significance of grief and loss. In an attempt to minimize this possibility, I had two experienced clinicians review the questions prior to beginning the interview process. For a future study, I would ask fewer direct questions and allow participants a broader way in which to express their thoughts regarding this topic. I would ask participants to share an example of an occasion in which grief and loss was a factor that arose while working with a client in crisis. From their narratives, the clinicians' stand on the relevance and the impact of loss in the case example would be made clear. That description would provide the basis for further clarifying questions.

Research implications

This research was undertaken with a hope that it would prompt an interest in potential future studies to determine the clinical significance of this content in current mental health practice. Additionally, this research sought to raise the question of whether this subject area is being given ample coverage in current mental health curricula. Future research might benefit from a larger, more diverse sample which includes more recent graduates of clinical training programs. Including participants from a wider geographical area would increase the likelihood of including alumni of a broader base of clinical training programs. Questions that were not explored through this study, but were suggested by the literature, would include exploring the difference in the presentation of male versus female grief and loss in crisis situations, the impact of cultural differences for those who present in crisis and whether ambiguous losses or disenfranchised grief create more stressors and crises for clients.

Social work implications

One of the ethical principles stated in the National Association of Social Workers (NASW) Code of Ethics is competence. Clinicians in this study clearly stated that they did not feel competent to work with individuals experiencing grief and loss when they completed their training programs. The majority of the participants (n=9) had been trained in the field of social work. This finding would seem to indicate that schools of social work education need to enhance the coverage of this critical content in training future social workers. Since clinicians should only provide services in areas in which they have received training or supervision, many beginning social workers may find a need to seek out appropriate training or supervision to develop skills and competency in a vital area to which they had little exposure.

Supervisors who are experienced and comfortable working with grief and loss may not be readily available to all beginning clinicians. The supervisory role is expected to be one through which knowledge is shared, clinical issues are discussed and clinical skills are expanded. Supervisors who have not themselves received training in the theories of grief might find it difficult to impart this knowledge to their students. A supervisor uncomfortable with loss would be unable to discuss or model the process of working with grief and loss effectively. A supervisor who has not experienced many life losses would not know the potential toxicity or growth potential of loss from a personal perspective. Knowing about loss helps to create and open up a dialogue in which loss and grief are normalized, for both clinician and client.

The impact of culture and its role in how individuals respond to both grief and loss is another area of which social workers should be aware. As the literature notes,

mourning rituals and responses vary greatly between cultures. An understanding of the expectations of a client's ethnic, cultural and religious traditions is important to have in order to assist the client in grieving effectively. Much strength and support can be drawn from cultural roots, values and beliefs. Researching and understanding the differences in culturally prescribed grieving will help minimize the dangers of potentially pathologizing a client's normal grief reactions.

Conclusion

This study showed the importance of understanding and working with issues of grief and loss with clients across varying clinical settings. Since loss has the potential to create both great pain and/or enormous growth, people who experience loss can be overwhelmed by their feelings and find themselves in crisis. Losses of varying degrees occur throughout life; death is the most extreme example. Bereavement and loss potentially impact not only a person's way of interacting with the world but also their mental and physical health.

The participants of this study believed that this clinical area is not covered sufficiently in mental health training programs. As a group, participants stated that, as new clinicians, they had felt unprepared to effectively work with these clinical issues. Since the field of social work takes a person in environment perspective, perhaps it is time that those who establish the curriculum standards for academic training programs respond to the current needs of both clients and clinicians. In a world that operates at breakneck speed, the potential to accumulate losses has also increased. Perhaps it is time that the mental health field learns from clinicians and clients that grief and loss are issues which cry out for more empathy and clinical attention.

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January 18, 2007

Frances Cwiertniewicz
xxxxxxxxxx
xxxxxxxxxxxxxx

Dear Frances,

Your amended materials have been reviewed and you have done a good job in attending to all of the needed alterations with one exception. Although you've said it's for your thesis in the Consent, you still haven't said that in the Application. Please change that and send page one of your Application with that to Laurie. She will inform me when she receives it.

Assuming that that detail is taken care of, and a typo *fell instead of feel* in paragraph four of your Consent is corrected, we are glad to give final approval to your study.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain signed consent documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

Cc: Marsha Pruett, Research Advisor

Appendix B

Recruitment Email

February 2, 2007

Dear Clinician:

My name is Frances Cwiertniewicz, and I am a graduate student at the Smith College School for Social Work. I am conducting research for my Master's thesis and am contacting you to ask if you would be interested in participating in the study.

I am conducting a study of mental health professionals to learn how having an awareness of grief, loss and clients in crisis has enhanced their work as a clinician. I am also interested in discovering what training about grief and loss clinicians received in their clinical programs, and how additional learning has transpired.

To be eligible for participation you must be 1) licensed to practice in your discipline and 2) have three or more years of clinical experience, which includes work with clients in crisis. If you choose to participate, I will interview you about your work with clients in crisis and the role that issues of grief and loss play in the development and presentation of an individual's crises. In addition, I will ask you to provide some demographic information about yourself. Interviews would last approximately one hour.

Please contact me at fcwiertn@email.smith.edu if you are interested in participating, or wish to learn more about this study.

Thank you.

Appendix C

Informed Consent Form

February 9, 2007

Dear Clinician:

    My name is Frances Cwiertniewicz, and I am a graduate student at the Smith College School for Social Work. I am conducting a study of mental health professionals to learn how having an awareness of grief, loss and clients in crisis has enhanced their work as a clinician. I am also interested in discovering what training about grief and loss clinicians received in their clinical programs, and how additional learning has transpired. The study is being conducted in partial fulfillment of the requirements for the Master of Social Work degree at Smith College School for Social Work. The findings of the study will be written up in my Master's thesis, disseminated to colleagues and included in any other presentations and publications written up as a final product of the research.

    I am asking you to participate in this study because you are a clinician who assesses and treats clients in crisis. To be eligible for participation you must be 1) licensed to practice in your discipline and 2) have three or more years of clinical experience, which includes work with clients in crisis. If you choose to participate, I will interview you about your work with clients in crisis and the role that issues of grief and loss play in the development and presentation of an individual's crises. In addition, I will ask you to provide some demographic information about yourself. The interview will be conducted in person or by phone. It will be audio tape recorded, and will last for approximately one hour.

    The potential risks of participating in this study are minimal. It is possible that some interview questions might trigger uncomfortable thoughts, feelings, memories, or grief reactions of your own. However, this risk is minimal since all questions will be focused on your clients' grief, and not your own. A list of reference material dealing with grief and loss issues will be made available to you, should you desire further reading on this topic.

    Benefits of participating in this study include the opportunity to contribute to research that may enlighten other clinicians in their own work with clients around issues of grief and loss. Also, participants will have the opportunity to reflect upon this important area of treatment and to assess for themselves whether they feel sufficiently trained to deal with the challenges involved. Finally, clinicians will have the chance to share knowledge

they have gained through their clinical practice with clients in crisis. I am unable to offer financial remuneration for your participation.

Strict confidentiality will be maintained as per Federal guidelines and the NASW Code of Ethics. Only I will know your name and demographic information. As required, consent forms, interview notes, tapes and interview transcripts will be numerically coded and stored in a locked file during the thesis process and for three years thereafter. At the end of this time, the files will be destroyed. If an additional data handler, transcriber or analyst is used in this study, I will require him/her to sign a confidentiality agreement. Participant names will never be linked to the information provided for the study. In the written thesis, demographic data will be combined to describe the aggregate subject pool. Individual participants will therefore not be identifiable in the final report, nor in any presentation or article written up as a final product of the research. When illustrative quotes are used, they will be disguised.

Your participation in this study is completely voluntary. You may refuse to answer any interview questions and may withdraw from the study at any time without penalty by indicating in writing that you are no longer interested in participating. You have until March 15, 2007 to withdraw from the study. After this date, I will begin writing the Results and Discussion sections of my thesis.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS, AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

_____   _____

SIGNATURE OF PARTICIPANT   SIGNATURE OF RESEARCHER

_____   _____

DATE   DATE

Please return this consent form to me by February 23, 2007, to indicate your intention of participating in the study. I suggest that you keep the duplicate copy provided for your records.

If I do not hear from you by then, I will follow up with a telephone call.

Thank you for your time. I look forward to having you participate in my study.

If you have any questions, please contact:

Frances Cwiertniewicz
MA College of Liberal Arts
Counseling Services
375 Church Street
North Adams, MA 01247-4100
(413)-662-5331

fcwiertn@email.smith.edu

Appendix D

Interview Guide

Demographics

1. Please provide the following information. What is your:

    a. mental health discipline (social work, psychology, nursing, etc)

    b. licensure information (LICSW, LMHC, Psy D, etc)

    c. number of years in clinical practice

    d. estimated percent of time spent working with clients in crisis (per week)

    e. setting you normally practice in (ER, clinic, college counseling, etc)

    f. age

    g. gender

    h. race

Interview Questions

Training

Did you receive any specific training in your graduate program on how to work with clients experiencing grief and loss?

If yes, was this through an elective course, or required? How extensive was the content?

Have you taken any post graduate courses on grief and loss, or any in-service trainings?

If you've taken course work or trainings, what prompted you to do so?

Please describe the training (length of seminar, specific content, etc.)

If you haven't, is there a reason (no interest, financial, none offered, etc)?

Have you ever received any on-the-job training or supervision that prepared you to work with clients experiencing grief and loss?

Crisis

How do you personally define crisis?

How would you describe your process of assessing a client in crisis?

What do you look for that's not on the assessment form used by your setting?

How do you engage with clients in crisis?

When working with someone in crisis, do you explore relationship patterns? Do you explore social supports?

As a part of your crisis assessment, do you ask about whether the client has had major life losses?

Loss

How do you define loss?

What symptoms or behaviors might lead you to consider grief or loss as an underlying issue for individual in crisis?

How often do you discover that there is an underlying loss or grief issue fueling a client's crisis?

What kinds of losses do clients speak about most often? (death, divorce, job, etc)

What kinds of significant losses have clients experienced that they initially don't speak about?

Grief

Are you comfortable talking about grief with clients?

How did you get to that level of comfort?

How do you help a client resolve begin to resolve their grief?

What strategies, if any, do you suggest to clients who are dealing with grief/loss? (rituals, journaling, etc?)

Do grief/loss situations create any additional challenges to resolving crisis?

Do your own religious/spiritual beliefs guide your practice with a grieving client? How? Are those beliefs from organized religion? Where did they come from?

How often does overt grief cause a client to present in crisis?

Clinical Implications

What is important about grief in the clinical setting?

What is important about loss in the clinical setting?

Can you do crisis work without an accumulated knowledge of grief and loss?

Given what you've learned working with clients in crisis, how has it enhanced your clinical practice?

What has changed about the way you sit with grief and loss with clients now from when you first began this work?

Suggestions for students and training programs

What suggestions would you offer to students in graduate programs to better prepare to themselves for work with clients experiencing grief and loss?

Would you have benefited from a course dealing with grief and loss in your training program?

Is content on grief, loss and crisis important enough to supplant other material? Is it at that level of importance, or is there already too much to do?

Is there else about crisis, grief and loss that you'd like to share?

Appendix E

Resource Information

Association for Death Education and Counseling Website http://www.adec.org/

Dunne, K. (2004) Grief and its manifestations. *Nursing Standard*. 18 (45) 45-51.
Retrieved June 19, 2006 from EBSCOhost database.

Hooyman, N. & Kramer, B. (2006). *Living through loss: Interventions across the life
span*. New York: Columbia University Press.

Grief and Loss Resource Center Website http://www.rockies.net/~spirit/grief/grief.html

Project on Death in America Website http://www.soros.org/initiatives/pdia/links

Rando, T. (1984). *Grief, dying and death: Clinical interventions for caregivers*.
Champaign IL: Research Press.

Servaty-Seib, H. (2004). Connections between counseling theories and current theories of
grief and mourning. *Journal of Mental Health Counseling*, 26 (2) 125-145. Retrieved
July 25, 2006 from EBSCOhost database.

Worden, J. (2002). *Grief counseling and grief therapy: A handbook for the mental
health practitioner.(3rd ed.)* New York: Springer Publishing.