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A NATURALISTIC INQUIRY INTO THE TREATMENT DYNAMICS
OF GRIEF COUNSELING AND THERAPY: PSYCHOSOCIAL AND
THEOLOGICAL PERSPECTIVES

DISSERTATION

Presented in Partial Fulfillment of the Requirements for
The Degree Doctor of Philosophy in the Graduate School
of the Ohio State University

By

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ABSTRACT

This dissertation is a naturalistic inquiry into the treatment dynamics of grief counseling and therapy with adult bereaved persons. Social workers and chaplains who work in hospice settings were interviewed to discover what they do to assist the bereaved in clinical settings. The phenomena of the clinicians who do clinical work with clients who are in grief was discussed around the practical question of: "What do you do to help bereaved adults reconcile their grief"? Member checking was included throughout the project. Seven themes emerged: therapeutic presence, clinical intuition, empathetic listening, formative experiences, meeting the client where he or she is, confrontation and spirituality.
Dedicated to Gail, my companion for life
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I wish to thank my wife, the Rev. Gail Renee Ahern, for being enduringly gracious and for believing in me, even on difficult days, and for being a woman who is strong, loving and wise.
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PUBLICATIONS


FIELD OF STUDY

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CHAPTER I

RESEARCH QUESTION: CHARMS THAT CURE THE SOUL

And the cure, my dear youth, has to be effected by the use of certain charms, and these charms are fair words...implanted in the soul; there health is speedily planted, not only to the head, but to the whole body.

The Dialogues of Plato (375 B.C.)
The Charmides

Plato’s words introduce this dissertation which focuses on grief therapy and counseling: “The cure...is erected by certain charms...fair words ...that are implanted in the soul.” How the grieving soul is cured, even though I will not be using the language of “cure,” is the trajectory of this project. More precisely, the purpose of this naturalistic inquiry is to elucidate how social workers and chaplains who work in hospice settings understand the treatment dynamics of grief counseling and therapy with adult bereaved persons. Focusing on the phenomenology of the clinician's lived perspective, this study explores grounded theory as it is emergent in the therapeutic relationship with regard to reconciliation in the midst of grief and loss.

Such treatment dynamics in grief counseling and therapy are manifest in light of our contemporary psychotherapeutic zeitgeist with its bewildering array of psychotherapeutic alternatives with concomitant treatment dynamics (Turner, 1986). The conception that there are three basic schools of psychotherapy, psychoanalytic, cognitive-behavioral and humanistic, is giving way to different categories which deny easy categorization. A central
trajectory in all of these treatment theories concerns the treatment dynamics which bring about therapeutic change in a clinical setting. Each theoretical orientation of clinical practice as it relates to psychotherapy in general, or in particular to grief counseling and therapy, has its own epistemological, ontological and axiological assumptions about the nature of the psychotherapeutic change and growth, and Rychlak points out that psychotherapeutic orientations can be traced to either Kantian or Lockean intellectual constructs in that some theories presume an essentialist structuralism while others posit a tabula rosa model with an absence of any a priori realities (1973). Therefore, what brings about wholeness, healing or change, what is the genesis of human development or catharsis, what empowers clinical breakthroughs or symptom removal, and for the purposes of this study: what enables a bereaved person in counseling or therapy to be reconciled in the midst of grief, is hotly contested within the psychotherapeutic community. This contention is especially intense as health care changes related to managed care impact treatment pragmatics.

While the death and dying field is replete with over three decades of popular literature that is self-help in nature (Kubler-Ross, 1969, Westburg, 1971, Tatelbaum, 1980, Stauadacher, 1991, Moore, 1995), there is also a growing professional literature for those who do psychotherapeutic work with the bereaved. In the area of grief counseling and therapy, William Wordens's influential work (1982) has addressed four tasks of the bereaved in treatment and ten principles of grief counseling. Rando (1993) has addressed the issues of treatment with the bereaved who experience complicated grief. The treatment of grief within a family therapy or systems approach has been offered by Shapiro (1994). Doka (1989) has discussed the treatment issues related to disenfranchised grief and work has been done on
religion and grief (Nouwen, 1982, Chidwick, 1988). Theoretical issues based on
developmental theories have been discussed as related to grief counseling and therapy with
children and adolescents (Wolfelt, 1992a). Psychotherapy related to grief and AIDS has been
researched (Wicks, 1997) and Figley's (1997) studies have related thanatology to traumatology
by bridging grief counseling to Post Traumatic Stress Disorder issues. Work has been
published concerning grief counseling in group modalities (Hughes, 1995) and Klass,
Silverman and Nickman (1996) have discussed grief counseling as a function not of cutting
bonds with the deceased but in terms of creating meaningful connections with the deceased.
Grief counseling with teens has been researched (Perschy, 1997) and work has been done
which bridges North American cultural contexts with Europe (Jacobson, Kindlen, and
Shoemark, 1997). Jones has addressed grief counseling with the newly bereaved and power
issues in grief therapy have been studied by Bright (1996). While this impressive body of
professional literature continues to grow, a lacuna is extant with regard to treatment dynamics
from the emic perspective of social workers and chaplains who work in hospice settings.

In the psychotherapy literature treatment dynamics and therapeutic change factors have
been researched from many theoretical points of view. Cross cultural curative factors is a term
used to denote what factors can be applied across cultural boundaries which bring about
desired change in an existentialist psychotherapeutic context (Lantz & Pegram, 1989).

Psychodynamic treatment has been studied to determine what brings about catharsis in
Fenichel's classic work (1945). Yalom wrote about therapeutic factors that are the crucial
aspects of the change process and discovered eleven guided human experiences which help
patients in a group setting (1985). Change factors have been researched with regards to their
impact on short-term treatment (De Shazer, 1985), to women in therapy (Lerner, 1988), as well as with substance abuse treatment (Kritsberg, 1983). Family therapists have done research on the nature of therapeutic change (Minuchin & Fishman, 1981), while sex therapy (Offit, 1981) cognitive therapy (Burns, 1990) and Jungian analysis (Spiegelman, 1988) have attempted to understand the nature of therapeutic change and growth. Carl Rogers (1961) wrote about the necessary conditions for the psychotherapeutic relationship. There also have been calls for more empirical research on what constitutes treatment to create an accountable and research based practice (Bloom and Fisher, 1982, and Blythe and Tripodi, 1989).

The importance of such questions is grounded in the demand to produce results from psychotherapeutic interventions that can be demonstrated with empirical outcome evaluations.

Without knowledge about the nature of therapeutic change, direct practice social workers and chaplains can be unaware of the dangers of treatment to their client or to others: with regard to the client there can be a psychotic break or suicide, to the clinician there can be assault and malpractice litigation, to society there can be increased human harm and abuse. The psychoanalytic literature proposes that without an understanding of therapeutic change a client-therapist relationship can fail to move toward catharsis due to the unresolved oedipal conflicts that are left unconscious and the lack of insight into transference and resistance material (MacKinnon and Michels, 1971). It has also been noted that psychotherapeutic errors with an inadequate knowledge of therapeutic techniques and methods which bring about change and growth can result in erotic entanglements between client and therapist, sadomasochistic and narcissistic therapeutic relationships, the further development of characterological behaviors and the allaying of sensitive cross-cultural clinical work (Roberttiello and Schoenerwolf, 1987).
While the literature is replete with works dealing with grief and loss, there is a lacuna in the literature due to the paucity of studies dealing with the treatment dynamics of grief counseling and therapy. The clinician's pragmatic questions of what helped a person work through loss, how do clinicians aid people as they are bereaved, what does a clinician do to assist someone as they journey through grief, what happens in clinical practice when a bereaved person grows and develops, what brings about wholeness for a person who is bereaved, what enables the bereaved to be reconciled in the midst of grief, etc. have not been addressed from the clinician's standpoint with qualitative methods of research.

Research Question: How do social workers and chaplains who work in hospice settings understand treatment dynamics within the context of their clinical practice experience with adults who are bereaved?
"All true living is encounter."

Martin Buber

Paradigm Talk: Locating Myself Amidst the History of Ideas

I write this essay with an occasional eye and ear for qualitative or naturalistic positions within what has been called the "paradigm wars" (Gage, 1989), aware that I do not stand outside of the reference frame of research. Indeed, I stand within what I write about with my perspectives and values, for what I write in these pages emerges out of the quidity of the local cultures and parochialisms in which I have lived. It is important therefore, to consciously and intentionally "locate myself" in what I create to "authorize its point of view" (Riessman, 1993, p. v.).

I "occasionally" write from a naturalistic perspective because even as I align myself with much of the critique of positivism, I am not able to obdurately dismiss all forms of binary structuralism. What I find most compelling are the creative tensions between naturalistic inquiry and positivism, and in this sense I am indebted to the nineteenth century work of philosopher Friedrich Schelling (1988) and the twentieth century work of philosopher and
theologian Paul Tillich (1952) in that I reject dualistic thought and accept a synthetic view of polarities. In such a view, polarities are understood as being dynamically interdependent and organically integrative, as an ultimate unity. In light of this rejection of binary logic I am drawn to a place within the paradigm wars which is emergent and unfixed in any one ideological locus.

While I may not be "fixed" in an epistemological school, I value scientific inquiry which does take into account Kant's moral imperative, which holds that human beings are not to be objectified because we are in and of ourselves subjects, thus human beings are ends and not mere means to another end. Therefore, I stand against any study in the human sciences which separates data from the relationship that is established between the co-participants engaged in research. Even the language of researcher and subject contributes to such a separation of knowledge from personhood. Therefore, humans are subjects to be encountered as "thou's" rather than objects to be dissected as "it's".

Such themes are central to the intellectual current referred to as existentialism. From Dostoyevsky and Kafka to Kierkegaard and Camus, this non-monolithic movement understands the human being as a subject to be encountered, and in the face of the depersonalization of modernity guided by the positivism of the scientific method, I existentially reframe Luther's famous dictum: "Here I stand; I can not do otherwise".

The existentialist Soren Kierkegaard (1959) rejected the system of German idealism represented by Hegel, and with incisive logic argued that existence itself is so unique that any attempt to create a universal pattern or absolute structure is "a supreme example of humanity's arrogance" (A. Rogness, p. 1209, the Lutheran Encyclopedia). In Kierkegaard's thought,
arguments for objectivity brings about "Sickness Unto Death", which is the failure of the self to realize that the self is a self. While this attack on "objective truth" is a sagacious critique of positivism and the traditional scientific method, Kierkegaard's intent was to critique the Christendom of Denmark in the first half of the nineteenth century. However, his rejection of objective knowledge remains a significant place as I locate myself in the history of ideas, and a profound argument for naturalistic human inquiry.

So, I write with a deep appreciation for naturalistic inquiry, aware that the issues of the paradigm wars are far too complex and fascinating to merely dispense with positivism. In fact, during this period of modernity in which the Enlightenment has dominated our intellectual and cultural consciousness, positivism and the traditional scientific method has contributed much to our lives, from the computer on which this is being typed to the light bulbs which provide light for this room. In addition, I also cannot demonize or vilify positivism less I fall prey to what Jungians would call a “shadow projection,” which is to project onto the evil empire or enemy what is not owned in my psyche. I write therefore, not as a zealot to convert anyone to naturalistic positions. In fact, I hope that in whatever wisdom I may have acquired in the twists and turns of my life, that I have given up being a zealot for any causes beyond the invitation to unconditionally encounter other humans as subjects. Every person must be acknowledged as a person, and by saying that I move beyond the rampant relativism that makes up so much of our zeitgeist and especially post-modern studies which decenters all grand narratives and contextually understands all knowledge as a social construction, to what Perry calls commitment in relativism (Perry, 1970). Paul Tillich noted that the twentieth century is plagued by both the unmitigated relativism of autonomy and the mass psychology of
heteronomy, and he proffered a third stance which takes each of these poles into its own identity; theonomy is where the individual in community is grounded in ultimate concern. Thus, from Perry's commitment in relativism to Tillich's thenomous nature of human identity, I do "lean into" an emergent gestalt which is grounded in naturalistic assumptions and categories.

I occasionally write from within a naturalistic world-view well aware of what some post-modern scholars have called the multi-voiced character of the sociology of knowledge, and I am also aware that this dissertation has various self-conscious and potentially self-contradictory assertions. This dissertation is written amidst such a post-modern context while at the same time holding in tension philosophical thought from the last two centuries. A brief foray into intellectual history or the history of ideas provides background for further discussion of qualitative research methods.

In the late 1700's, the German idealist Johann Fichte argued that there is a distinction between ego and nature which is metaphysically absolute. Not only were the ego and nature independent of each other, a metaphysical hierarchy existed which posited the absolute ego or pure will as ultimate reality while nature or the world is penultimate as it is a product only of the ego, thus the material serves only to fulfill the nature of the ego as moral ego. In such a configuration there is a concomitant separation of the objective from the subjective.

Rene Descartes' separation of the soma and sarx, the body and soul, is consistent with this Enlightenment pattern articulated by Fichte, as is the Newtonian philosophy of nature which holds that nature is essentially inert and mechanistic and not unified and fluid. They both were Enlightenment thinkers in their separation of the subject from the object and that they
assumed a metaphysical dualism. Kant's critique made the distinction between pure and practical reason, which continued in the same dualistic mode as Fichte and Newton. Kant argued that practical reason is the realm of individualistic subjectivity and experience while pure reason is the objective and is based in the absolute ideal. The modern spirit, which gave birth to the traditional scientific method and positivism, is part of this intellectual and cultural zeitgeist, and traditional science seeks understanding by dissecting reality, but making separations rather than synthesizing reality into an organic whole.

A critique of Kant's critique leading to naturalistic categories is found in Schelling's response to Fichte. The early Schelling (whose later work is based upon irrationality or what one may call the "existential absurd," and is intentionally less systematic) argued that dualisms such as Fichte's distinction between the ego and nature are false, because what appear as polarities are in actuality dynamically interdependent in that reality is an equilibrium of active forces in dynamic opposition to each other within an absolute unity. Schelling wrote in 1803: "If, of the two unities in the absolute, the one in which the universal becomes a particular is that of nature, and the latter accordingly the universal realm of being-for-itself, then the world-structure is the total embodiment of the infinite into the finite, and thus itself again the unity which comprehends all others, so far as they recur in nature," (Schelling, 1988, p. 136). In light of Schelling, a naturalistic approach transcends dualistic configurations and seeks to apperceive a subject as a dynamic whole in context as the researcher "goes native" in the field of the lived experience of the co-participant. A naturalistic approach seeks the unities as what appears to be binomial logic is reframed as being dynamically interdependent, organically whole, synthetic and integrative.
Paul Tillich's (1936) philosophical theology was based upon Schelling's view of dynamic and organic wholism, and Tillich could be on "the boundary" between theory and practice, heteronomy and autonomy, philosophy and theology, Marxism and Lutheranism, etc. Likewise, this dissertation is self-consciously "on the boundary" between positivism and naturalistic inquiry, the researcher and the researched, the arts and the sciences and life and death.

Tillich's ontological system enabled him to be "on the boundary" between being and non-being as well (Tillich, 1952), with the courage to be manifest as being is affirmed in the face of non-being. This dissertation faces into non-being, into death and grief and loss, asking clinicians how they work in the midst of both being and non-being. In a sense, this dissertation wrestles with how to have the "courage to be" in the face of death, grief and loss.

This is the intellectual center of locating myself in the midst of paradigm talk, and leads to the specifics of the research methodology that is operative in this project. The "quiet methodological revolution" (Denzin and Lincoln, 1994, p. ix) of naturalistic inquiry is then put into a particular context and lived out in a concrete way.

INTRODUCTION TO METHODOLOGY

A paucity of research has explored the treatment dynamics from the perspectives of social workers and chaplains who work in hospice settings with bereaved adults. Few studies have had as their foci the subjective experience and lived phenomenon of treatment dynamics from the perspective of the clinicians themselves and from within the context of clinical practice. Thus, the purpose of this study is to explore how social workers and chaplains who work in
hospice settings understand treatment dynamics within the context of their clinical practice experience with bereaved adults. Naturalistic approach and qualitative methods were selected as the most effective means by which the subjective meanings of the lived experience of therapeutic change can be explored and understood. It is argued that the voices of individuals can be heard without adding the interpretive layer of deductive theory (Greenlee & Lantz, 1993), and this study attempted to understand such voices, in this case the voices of the therapists themselves.

This exploratory project is based on the self-reporting of social workers and chaplains with the understanding that relationships in a research context create data (Lather, 1986). This data is then systematically analyzed. The interpretive paradigm of inquiry with its phenomenological orientation contributes to respecting the uniqueness of the social construction of each co-participant so that the multiple meanings and contextualized understandings can emerge throughout the research process.

CONGRUENCE OF PROJECT WITH THE DISCIPLINE OF SOCIAL WORK

Social Work's historical emphasis on environmental transactions of the individual within the social environment is well suited to naturalistic inquiry that attempts to understand persons holistically within their lived context. Reductionistic science, with its deductive approach and philosophical assumptions of positivism, seeks to apperceive individuals with analytical methods, control groups and prediction, but I argue here that social work's historical mission to enhance the social functioning of marginalized individuals in the social environment is undertaken as persons are understood within the context of their whole lives. Heineman
(1981) has proposed that social work has adopted the overly restrictive logical empiricist tradition and that as a result research questions and subject matter have been neglected; she therefore, argues for the use of naturalistic methods within social work research. Naturalistic research, like social work, integrates the meanings that people have of their interactions with their social environments and the underlying values of qualitative methodology are consistent with the value axioms of social work (Shillito, 1993). While it has been argued that qualitative research and clinical social work practice have some competing demands (Padgett, 1998), it has also been written: "Naturalistic clinical research is ideally suited to advance knowledge in social work, because it encourages practitioners simultaneously to engage in the best practice of what they are capable and to generate rigorous and valuable research," (Heineman, Piper & Tyson, 1999, p. 279).

VALUE OF NATURALISTIC INQUIRY TO THIS PROJECT

This project seeks phenomenological information that is dense data from a small number of co-participants or subjects. The research question focuses on the treatment dynamics of grief therapy and counseling, and seeks to understand the internal experience of therapy and counseling from the perspective of the clinician, as well as what manifests externally in the therapeutic relationship. Issues such as the identity or personhood of the clinician are central to what is trying to be understood, therefore, face to face interviews with individuals who can then provide in depth details of their experiences is necessary. Thus, a small sample frame of clinicians provides dense data as a qualitative method best serving the trajectories of this project.
DESIGN

The research design of this naturalistic inquiry into the treatment dynamics of grief counseling and therapy is based upon research methods as discussed by those who write in the area of qualitative studies (Bogdan and Bilken, 1992; Patton, 1990; Lincoln and Guba, 1985; Lather, 1991; and Glesne and Peshkin, 1992).

EMERGENT DESIGN

The philosophical assumptions of naturalistic methods of inquiry are predicated on the ontological understanding that reality (not meta-reality) is socially constructed (Kuhn, 1962) and with a concomitant epistemological axiom that multiple realities emerge as the researcher and co-participant mutually impact each other within their phenomenological fields of meaning. Thus, the research design and specific procedures emerge and unfold within the context of relationships with the co-participants and cannot be completely elucidated a priori in an obdurate or formulaic manner. Meaning is determined in many ways by the context in that the interactions between individuals give rise to unique realities, and an emergent design allows for the taking into account every new observation, all which impact the design itself (Lincoln and Guba, 1985).

THE HUMAN INSTRUMENT

Rather than using statistically standardized instruments this project makes use of the researcher as the essential data-gathering instrument. The researcher is the human instrument
in the interviews which will be undertaken in this study, as well as in the grounded survey and member checking steps. In the context of ideographic or unique description and emic or particularizing "from within" approaches, this study will gather thick descriptions (Denzin, 1978) with the relationship between the researcher and co-participant being the instrument which gathers data.

**GROUNDED THEORY**

This study does not operate out of a fixed ideological orientation or with an a priori theoretical stance. The goal here is to inductively analyze data from within the co-participant's experience as new data gives new form to the design itself, which is grounded hermeneutic research in that meaning is not fixed but created within certain structures and interpretable (Crabtree & Miller, 1992). This grounded theory is phenomenologically based in that the phenomena of the co-participant is the data which is to be center of the project rather than a deductive theoretical posture which the researcher brings into the research to prove or disprove. Grounded theory ultimately follows from data rather than vice versa (Lincoln and Guba, 1985), and Glaser and Strauss (1967) point out that grounded theory is based upon participant observation as a method for constructing theory inductively.

**SITE OF THE STUDY**

Individual interviews were conducted in locations dependent upon where the participants live and where they felt that communication would be most facilitated. Time and place was determined by agreement between the researcher and the co-participants, for example, the offices of clinicians or meetings rooms in hospice settings were frequently used.
In another situation we conversed in a room in an inpatient hospice facility where a hospice patient had just died.

SAMPLE OF CO-PARTICIPANTS

A sample frame of social workers and chaplains is available from the National Hospice Organization. This author's knowledge of the individuals in the field led to purposive sampling.

The sample included senior clinicians in all of the non-profit hospices in Franklin County as well as two rural settings that are geographically close to Franklin County. The only for-profit hospice in Franklin County was originally considered, but due to the fact that it went out of business, only not for-profit hospices were included. The sample included co-participants who were both male and female, of different ages and different races. The social workers and chaplains had master's degrees or its equivalent and the ten co-participants each had at least three years of clinical experience in hospice settings. This purposive sampling is discussed by Bogden and Biklen (1992), Lincoln and Guba (1985) and Patton (1990) as a way to find information rich co-participants from whom much can be learned about the topic of study.

An explanatory letter of introduction which requests participation in the study and which provides information concerning the nature of the project including format and time frames was mailed to each potential co-participant. Follow-up telephone calls were made. Issues of confidentiality were made explicit in both the letter and telephone contact. Consent forms stating the specified purposes and stipulations of the study are included in the mailing and it was noted that competent mental health professional are available for referral if the need arises during the time of the research. No clinician turned down the request in this study.
DATE COLLECTION AND ANALYSIS

Interviews

Each interview took approx. sixty minutes, and with consent of the co-participants each session was audio taped. During the interviews, written notes were taken and after each interview a reflexive journal and field notes were completed. The interviews had a minimum of structure based upon the central research question: how do you as a social worker or chaplain understand treatment dynamics within the context of your clinical practice experience with bereaved adults? As data was collected, more specific questions emerged.

There were two interviews with each co-participant, with approximately, two months between sessions. The most loosely structured interview was the first set of interviews so that questions for the second set could be grounded in the sense that the questions arose from the relationship between the researcher and co-participant within the context itself. Some open ended questions remained in reserve: What made you become a social worker or chaplain who works with hospice? Did you have a vision early in your hospice career of the ideal therapeutic change experience? What have been the transformations or changes with regard to how you work with clients? How has your personal change and growth impacted your view of how client's grow and change in therapy? How have you changed with regard to the nature of the relationship between you and clients? Have any specific people or experiences brought about this change? What are the ingredients present in therapeutic encounters in which you experience yourself as most alive? Has any session or series of sessions with clients been critically illuminating with regard to the deepest meaning of what therapeutic treatment
dynamics are? How have you evolved with regard to understanding what brings about change in grief counseling and therapy?

The second interview provided deeper focus and exploration of topics raised in prior interviews. The specific nature of these questions was emergent with time as a relationship was built and as the researcher “went native” within the contexts and phenomena of the co-participants.

Member Checking

Member checking, which verifies the data by the co-participants themselves, was on-going in that each interview concluded with a summary of the session provided by the researcher. However, member checking is also a distinct phase of the research plan as data was formally shared with co-participants for their verification. In addition, as the researcher took notes and listened to audio tapes, thematic interpretation took place. Some of the final interview focused on feedback about the co-participants' comments regarding the researcher's thematic interpretation of the prior session. The direction of this member checking is provided by this question: "Do you feel that your understanding of treatment dynamics is adequately represented in this analysis?"

Member checking was also done after all the interviews took place and the cross study sectional analysis was complete. The participants were mailed a brief report representing the results of the interviews. I then made a follow up telephone call asking questions such as: do you feel that your experience is adequately represented? How would you change it? What did you gain from participating in this study? A cover letter was included which explained this final stage of data collection.
Miles and Huberman (1994) have shown that using more than one instrument of measurement (or data collection) enhances validity. These authors explain that by triangulating the ways data is collected, more dependable information is gathered. Thus, this dissertation used two instruments, both interviews and a written report that summarized the data.

DATA ANALYSIS

The data that was analyzed was text. The unit of analysis is the words and patterns of words that are used to explain treatment dynamics grief counseling and therapy. Both individual case analyses with particularities and idiosyncrasies, as well as cross case analysis focusing on common themes or patterns were used. These two types of analysis were done simultaneously.

While in the field data analysis was done as the researcher listened with a special interest to the co-participants as they responded to the general research question: in your clinical experience, what are the treatment dynamics in grief counseling and therapy? As Strauss proposes (1987), text was analyzed for patterns which when compiled creates a concept. I kept a running list of themes or patterns that were common in the conversations, as well as another list that included points of view which were unique to the individuals. I was able to visually get the "whole picture" by recording detailed outlines (but not word for word verbatim) of the conversations on seven large pieces of poster board and then used color coding and connecting lines to picture the patterns in the data. I also included my commentary about the data on the right margin of each poster board.
This data that was grounded in the individual experiences of the co-participants in each session was then analyzed for commonalities (for example, empathetic listening) across the interviews and across the co-participants to create a cross sectional analysis. These themes indicated commonalities while the prior mentioned concepts represented diversity of opinion.

CODING

Coding was initially done to determine the unique voice and idiomatic text of each co-participant. As Bogdan and Biklen suggest (1992), coding is grounded in what the co-participants discuss and includes events, activities, relationships and/or definitions. Coding began with general, open categories and moved to provisional concepts that created categories (Glaser and Strauss, 1967). For example, as I reread the written verbatims and listened to the tapes (I listened to the tapes five times and reread the written verbatim material many times) empathy and listening were linked together by the co-participants into empathetic listening. As Glaser and Strauss (1967) note, these categories are groups of concepts linked together by thematic relationships. Glasser and Strauss' constant comparative method (1967) was utilized to move the thematic development toward core categories which account for the broadest definitions and themes within a moiety that is inter-connected with thematic relationships. Quotations within these themes were edited in that germane quotations from different co-participants were collated manually to remain closer to the data (rather than with computer assistance).
TRUSTWORTHINESS

Trustworthiness is the general way that a researcher argues that his or her findings have good quality and are "true." As Glesne and Peshkin (1992, p. 146) wrote: "...Everything in there's true." Miles and Huberman (1994) note that the quality of the results of a qualitative study includes: 1) confirmability/objectivity, 2) dependability/reliability, 3) credibility/internal validity/authenticity and 4) transferability/external validity/fittingness. Confirmability/objectivity refers to the potential biases of the researcher that may impact a study. Dependability/reliability refers to whether a study is consistent over time and across methods of data collection. Credibility/internal validity/authenticity raises the question of truth: does this study make sense and give an accurate portrayal of what the research question is? Transferability/external validity/fittingness refers to whether the study has an application to other contexts. These standards for establishing the quality of conclusions will now be applied to this study.

CONFIRMABILITY/OBJECTIVITY

Confirmability/objectivity was established in this study so that there is "...Relative freedom from unacknowledged researcher biases- at the minimum, explicitness about the inevitable biases that exist" (Miles and Huberman, 1994, p. 278). This was established as follows. The study's basic procedures have been detailed so that background information is provided. The sequence of the study is clearly stated. A record of the study's procedures is available in an audit trail, which recorded all aspects of the study. As a researcher, I have been intentionally aware of my biases, and such has been processed with my doctoral advisor and
I gave special attention to two psychotherapeutic orientations which could impact my bias, Jungian therapy (my area of specialization in this doctoral program) and Gestalt therapy (I am a graduate of the three year post-graduate certificate program at the Gestalt Institute of Cleveland, with a focus on gestalt marriage and family therapy). I also was alert to a theological bias in that I theologically work out of the tradition of the existentialist Paul Tillich. As I listened to the taped interviews with each co-participant at least six times, one listening with each tape was with an ear only for the concerns of bias. My reflective journal also reflected upon my biases in a self-critical way. In addition, the study data (audio tapes, written transcripts of the interviews, a reflexive journal and field notes) have been kept for a secondary analysis, if necessary. Also, two independent readers reviewed the written transcripts to confirm that the themes, which I discovered, were accurate. One of the readers was a social worker while the other represented ministry. Their findings confirmed my conclusions.

DEPENDABILITY/RELIABILITY/ADAPTABILITY

The concern here is whether this study was stable and consistent over time and whether various methods of data collection found similar results (Miles and Huberman, 1994). Erlandson, Harris, Skipper and Allen, (1993) state that dependability has to do with the ability to replicate the study and consistency. This form of quality control was established as follows. The basic research question was clear and expressed in the same way with each co-participant. The findings show parallel results; seven themes clearly emerged from all the co-participants. Data was collected over a number of settings (rural and urban) and with a variety of co-
participants (different races, ages and genders). As noted prior, two independent readers analyzed the data to concur that emergent themes, which I discovered, were accurate. Data quality was checked after each interview as I studied each written transcript to assure that the same procedure was used throughout the process.

CREDIBILITY/INTERNAL VALIDITY AUTHENTICITY

The question here is whether the study makes sense. Does this study have credibility to readers and does it communicate truth? This was established in this study in that it is plausible and "rings true." Thick data that has meaningful depth with detail is demonstrated throughout the findings. In the member checking stages, the co-participants said that my conclusions were accurate. I was told that the written summary, which I presented to the co-participants for feedback, represented their opinions well. The conclusions of this study, therefore, were considered to be accurate by the co-participants. The findings were internally coherent in that the concepts are related (for example, the themes of clinical intuition and empathetic listening were frequently discussed in close relationship). The local context of work in hospice settings was clearly reflected in each of the conversations with the co-participants. This study did offer an accurate portrayal of what I was trying to discover the treatment dynamics of grief counseling and therapy. This is most clearly demonstrated by the agreement from the co-participants as they contributed to member checking and as the independent readers came to similar conclusions that were consistent with my findings.
TRANSFERABILITY/EXPERIMENTAL VALIDITY/FITTINGNESS

The conclusions of this study have meaning beyond the context in which they emerged. Lincoln and Guba (1985) understand transferability to be the applicability of one study to another context. Thick description, with its emphasis on copious descriptive data, establishes transferability and provides the reader with enough detail to apply this study to other contexts. Triangulation also establishes transferability as the co-participants reflected different age groups, races and genders. Also of note is that the chaplains who I interviewed reflected a variety of different religious traditions. The sample also included both male and female chaplains (clergy tend to be male) and male and female social workers (who tend to be female). Thus, the characteristics of this diverse sample are described with enough detail to provide comparisons to other contexts. The procedures of this study are also generic enough so that they can be applied to other contexts.

METHODOLOGY: CONCLUSION

The treatment dynamics of social workers and chaplains who work with the bereaved was studied with the use of qualitative methods. As their clinical experiences are seen with organic unity in which the dualism of subject and object are not possible, the dynamic interdependencies of their clinical encounters and insight was brought into a dialogue and meaningful encounter. We begin where we began with Buber: "All true living is encounter".
CHAPTER 3

LITERATURE REVIEW: GIVING GRIEF A NAME AND SHAPE

If you can give something a name and a shape, you can have power over it. If it remains nameless and shapeless, it will continue to have power over you.

Native American Proverb

INTRODUCTION

This literature review gives grief "a name and a shape" contextualizing the research question within the work of other authors. Rather than review all of the literature in the death and dying field, this theoretical and empirical review will place the research question in the context of previous work so as to explain the decisions that were made with regard to the trajectories of the research problem as it was formulated in chapter one of this dissertation.

This theoretical and empirical literature review focuses on the treatment dynamics of grief counseling and therapy under the headings of psychoanalytic foundations, recent non stage theories and diversified pragmatic work. These themes focus and narrow much of what has been written and point to the gap in the literature that impacts the formulation of the research question. The death and dying literature is immense, and over a thousand volumes have been published for a popular audience and well as for professional readers. An extensive body of work is also extant in journal literature. This
PSYCHOANALYTIC FOUNDATIONS

The first theme in the literature related to the research question is the groundwork material that impacted later researchers. This body of literature is influenced by the psychoanalytic and ego psychology movements.

Sigmund Freud wrote the essay, “Mourning and Melancholia” in 1917. His concern was depression or melancholia, as it relates to loss rather than focusing on mourning as a normal reaction to predictable losses. He saw the treatment of mourning as non-medical, and noted that “any interference with it as useless or even harmful,” (Freud, 1917, p. 244). While both mourning and melancholia are based on object loss, Freud understood depression as relating to the loss of self-esteem. This distinction remains today in the Diagnostic and Statistical Manual of Mental Disorders III when it is noted that uncomplicated bereavement can be marked with a “morbid preoccupation with worthlessness” (1980, p. 333). The Diagnostic and Statistical Manual of Mental Disorders IV (1994), does not make such a distinction. Freud held that mourning that is normal does not include ambivalent feelings about the lost object, and thus, the ego does not suffer from a loss of self-esteem and develop obsessive reproaches of self-masochism.

A historical note here is that this 1917 essay by Freud was written in the ferment time when he was reworking his earlier theory of personality (unconscious, preconscious and conscious) which was initially published in his influential 1910 work, Interpretations.
In 1923, six years after the 1917 piece, he would publish the *Ego and the Id* (Freud, 1961) with its tripartite structural theory (ego, id and superego) which would lead to later developments in ego psychology. Freud's 1917 work on mourning and melancholia, therefore, was written between his earlier period which emphasized sexual and aggressive instincts and his later work which was the beginning of ego psychology, with its emphasis on the autonomous ego. Freud's distinction between mourning and melancholia, with the later being a loss of the self-esteem of the ego as it copes with object loss, adumbrates his evolving view of the ego which is summarized in his concept that the ego comes to supplant the role of the id (Freud, 1964).

Freud wrote in his 1917 work: “All libido should be withdrawn from its attachments to this object... when the work of mourning is completed the ego becomes free and uninhibited again,” (Freud, 1917, p. 244). Grief work is done psychoanalytically not as a medical procedure but as assisting the bereaved in the severing of attachments with the lost object so that the ego is freed for new attachments. The libido that was directed at one object is withdrawn and refocused toward a new object in an incremental process; and in Freud's understanding this process can take considerable incremental time. To summarize at this point, cathexis, the energy once fixed on an object relation is decathected onto a new object relation.

A final word from Freud comes from a letter to Ludwig Binswanger after the death of Freud's daughter and beloved granddaughter. “…We shall remain inconsolable and will never find a substitute,” (Freud, 1929, p. 386). While he did not reconstruct his
prior stated theories, his personal experiences do point toward the inability to reconcile some losses for some people. Freud's 1917 work was in part a response to a prior paper by Karl Abraham. Abraham advances the argument that depressive psychosis is a pathological variation of grief and mourning. (Fine, 1979). He also noted that melancholia, or depression, is present in mourning, dependent upon the hostility that is present between the deceased and the bereaved. In Abraham's view, the clinician assists the bereaved person to introject the deceased person. Of note here is that Abraham does not recommend that the bereaved cut ties with the deceased but develop a relationship in a new way.

Continuing in the psychoanalytic tradition, Melanie Klein's view is that grief therapy in adults with complicated grief must focus on early childhood, when the newly weaned child mourned the loss of the breast which was both nurturing and threatening. If an adult is unable to work through both of these realities, grief will be pathological rather than normal, which calls for object relations work (Klein, 1940).

Otto Fenichel (1945) wrote from an ego psychology perspective, expanding upon Freud. Fenichel holds that introjection and guilt are significant to the process of grief therapy. An introject is the receiving of the deceased person into the self of the bereaved. This continued relationship with the deceased takes place prior to the process of letting go, or release, which is a final necessary step. He also states that the treatment of bereavement includes working through any ambivalent introjection. If a survivor has ambivalent feelings about the deceased, Fenichel wrote that guilt would be a significant
issue to work through in the therapeutic relationship. To do this the bereaved person must replace pejorative feelings about the deceased with positive feelings.

Harry Stack Sullivan went beyond his psychoanalytic training to develop a theory of personality that was based on interpersonal relationships (Sullivan, 1956). The psychoanalytic assumption of oedipal relationships that are recapitulated in later relationships is repudiated by Sullivan’s theory. He argues that the treatment of grief is socially based upon attachments as the bereaved begins to abate the interpersonal relationship that existed with the person who died. This relationship is not a recapitulation of oedipal conflicts from earlier developmental periods, for Sullivan holds that personality is impacted by human relationships in the present rather than being fixed at earlier stages. Sullivan’s view of the treatment of grief focuses, therefore, on the relationship between the deceased and the bereaved.

The ego psychologist George Pollack (1961) argued that the treatment of grief must understand bereavement as an adaptive function in that the deceased is struggling to create an intra-psychic balance. In Pollack’s view, the bereaved who are in treatment pass through an acute and chronic stage. Acute grief includes panic and shock, which leads to profound sorrow. Separation then is experienced but treatment is no longer needed if the relationship had been stable. The chronic stage then follows as long term adaptation and significant life changes take place, which include new roles and social connections.

While John Bowlby (1980) does not write out of a classical psychoanalytic model, he is mentioned here because of his emphasis on attachment theory with such being based in early developmental periods. In 1980, Bowlby discussed the treatment of bereavement
as a function of attachment theory, which are the emotional bonds created between an infant or toddler and one’s parents. Security and safety is developed here, and the processing of information about the loss of a loved one creates issues that relate to the attachment issues of security and safety. Bowlby noted that there are four phases of bereavement: numbing, yearning, disorganization/despair and reorganization. Working through these issues in counseling is how attachment issues are treated in a clinical setting.

Bowlby’s (1980) work also made use of human information processing theory in that sensory input is controlled so that some information is kept outside of one’s conscious awareness. Information that is a threat to a system is excluded in a defensive manner that presents itself as denial or repression. Clinically, this blocking of information must be opened so that the bereaved individual does not lose touch with reality and becomes unable to relate to others. Bowlby does not detail how this is done, the timing of such interventions or the value of such defenses for specific individuals; he only raises the issue of sensory awareness that is outside of the bereaved person’s conscious awareness.

Bowlby’s studies (1980) demonstrate the universality of grief as an experience, and he also confirmed such in humans as well as other animals. His research noted that there is a physiological basis of bereavement that transcends both species and culture. The distinctively human aspect of grief that asks “why” is a function of the recreation of the self in the midst of grief and loss. He notes that clinical treatment includes assisting the bereaved in developing new skills that are necessary in light of changing roles and life expectations.
Bowlby also dealt with the treatment of grief and loss in other work (Bowlby, 1979) and he expanded on the universal aspects of humans (and other species) to form human attachments and experience grief when such is abated. He noted that grief is needed in that it is a necessary experience for the bereaved if they are to go on with life after the death of an attachment figure. Seven tasks were included here: 1) Acknowledge the reality of loss, 2) Identify and express emotions, 3) Commemorate the loss, 4) Admit ambivalence, 5) Resolve ambivalence, 6) Let go, 7) Move on. For Bowlby, these seven tasks are the primary goals of clinical work with the bereaved.

RECENT NON-STAGE THEORIES

A second theme in the empirical literature review on the treatment dynamics of grief counseling and therapy concerns a number of works which have been published in the two decades and which do not make use stage theories of bereavement. In the qualitative interviews completed for this dissertation, these works came up time and time again as the primary sources that undergird most contemporary grief counseling and therapy. The co-participants in my research referred to these works as the most influential sources and basic texts for clinical work with the bereaved. Prior to this review, two benchmark volumes in the field of thanatology which are the basis for this newer work will be perused as prolegomenon to this section. Some contemporary non-stage theorists react to these groundbreaking volumes.
The death and dying field would not exist as it does today if it were not for the renowned book by Elizabeth Kubler-Ross, *On Death And Dying* (1969). Her book was based on empirical interviews that she and her associates did with dying people, but it focuses on experiences of the dying rather than the bereaved. But the final chapter, which is on therapy with the dying, is informative for the post-death process of grief counseling with the bereaved. She encourages the sharing and understanding of the mixed feelings that a dying person may have, and calls therapists, chaplains and physicians to deeply consider their attitudes about death which may cause them to run away from their client’s fears and anxieties. A “silence that goes beyond words” (Kubler-Ross, 1969, p. 276) is her final encouragement to clinicians, and she calls for the strength and love to sit in a person’s silence as they die. Such can also be profoundly important for those who work after death with the bereaved.

Another benchmark work serves as background to this section, Ernest Becker’s Pulitzer Prize winning book, *The Denial of Death* (1973). While not a clinical volume explicitly concerned with therapy, it is along with Kubler-Ross’ book, a frequently cited work by contemporary scholars. Becker argues with an interdisciplinary approach that the terror of death is one of the primary concerns of humanity. This concern is not morbid and has come to be repressed in our culture. According to Becker, the terror of death is addressed by the creation of the heroic individual who is essentially a theological being. Becker integrates Kierkegaard’s concept of despair and leap of faith with Rank’s concept of the soul and will, and in this theological and psychological nexus an individual can
grapple with the meaning of death. Again, while not a volume about grief counseling and therapy, it is an immensely formative book in thanatology, and its radical arguments go to the root of what death, grief and life entail. Becker calls social work, pastoral care and any professionals who work with the bereaved to be self-critical of how they deal with death, and by extension, with grief. Becker’s explicit integration of existential theology and depth psychology questions whether contemporary grief counseling and therapy deny what is necessary to truly be reconciled in grief. Within the context of contemporary psychotherapy, Becker raises the possibility that grief counseling and therapy are solely a function of the zeitgeist of the Enlightenment, with its positivist assumptions about epistemology. Clinical work with the bereaved may be a part of the problem rather than the solution due to the denial of death that is manifested when existential theology and depth psychology are not integrated.

With such self-consciously critical words and the works of Kubler-Ross and Becker as prolegomenon, we now proceed to the primary texts that are informing the current practice of grief counseling and therapy. These works have been published in the past two decades and do not use structuralist stage theories. Kubler-Ross (1969) established a five stage theory related to the experiences of the dying (1. Denial and isolation, 2. Anger, 3. Bargaining, 4. Depression, and 5. Acceptance). Parks (1972) provided empirical studies to substantiate four stages: 1. Numbness and denial, 2. Yearning, 3. Disorganization, 4. Reorganization. Already mentioned were Bowlby’s (1980) four phases.
Such stage theories are seen by many contemporary authors as being overly reductionistic. Kastenbaum (1974) argues that different diseases will impact grief patterns in different ways, and that personality and social environment make it difficult to prescribe a universal sequence to grief. In the same work, Kastenbaum also critiques most stage theories due to the general lack of scientific studies which establish their findings. Kalish (1978) has written that all bereaved persons do not pass through all stages of grief, and that the quality of the health care system itself has an impact on which stages an individual may or may not experience. The difference between the grief of a sudden loss as compared to death after a prolonged illness also impacts the experience of grief (Holland, 1989). Doka (1989) has pointed out how ethnicity, gender and religious differences impact the uniqueness of each individual as he/she grieves, which makes a structuralist approach to grief inadequate. With such strong critiques of stage theories as background, a number of contemporary authors have elucidated grief counseling and therapy from non-structuralist viewpoints.

William Worden’s classic work, *Grief Counseling and Grief Therapy* (1982), makes a distinction between grief counseling and therapy, with the prior being the facilitation of mourning so that the bereavement process is concluded while the later resolves separation conflicts that must be done prior to the completion of the tasks of mourning. He writes that mourning is complicated (note that he does not use the nomenclature of pathology or abnormality) when people fail to grieve due to relational, circumstantial, historical, personality or social factors. Such complicated grief can have
delayed, exaggerated, chronic or masked features. Grief therapy is required to deal with such reactions that are based upon separation conflicts. The dynamics of grief therapy are as follows. 1. Rule out physical disease. 2) Set up the contract and establish the therapeutic alliance. 3) Revive memories of the deceased. 4) Assess the bereaved to determine whether the person understands the reality of the loss that includes both latent and expressed affect and the impediments to readjusting and saying goodbye as energy is reinvested elsewhere. 5) Deal with affect or its lack stimulated by memories. 6) Explore and defuse symbolic linking objects. 7) Acknowledge the finality of the loss. 8) Deal with the fantasy of ending grief. 9) Say a final goodbye. These treatment dynamics are not necessarily accomplished in a linear fashion, and each individual will deal with these issues in unique ways.

While the above has to do with grief therapy, Worden (1982) also discusses the dynamics of grief counseling. He articulates four goals for grief counseling, which again, are not necessarily accomplished in a linear fashion: 1) Increase the reality of the loss. 2) Help the client deal with expressed and latent affect. 3) Help the client overcome various impediments to readjustment after the loss. 4) Encourage the client to say an appropriate goodbye and feel comfortable in reinvesting back into life.

Worden (1982) then offers ten guidelines or principles for grief counseling. First, the counselor helps the survivor actualize the loss by talking about the death so that it becomes real. Patient listening and encouraging the client to talk about the loss assists here. Second, the counselor helps the bereaved identify and express feelings. Worden (1982) encourages an intentional and focused working through of anger, guilt, anxiety,
sadness and helplessness. Third, the counselor assists in living without the deceased. This can refer to pragmatic problem solving and learning new and accustomed roles. Fourth, the counselor facilitates emotional relocation of the deceased. Emotional energy is divested so that the new tasks or relationships can become central to the bereaved person.

Fifth, the counselor provides time to grieve. Grief can take an extended time and critical times (anniversaries, holidays, birthdays) need special attention. Sixth, the counselor interprets "normal" behavior. To normalize behavior is to reassure the survivor that he/she is not "going crazy." Seventh, the counselor allows for individual differences. There are wide ranges of response to loss, and permission is given to deviate from how others may grieve. Eighth, the counselor provides the possibility of on-going work for a year or more since the process of grieving can take extended periods of time. Ninth, the counselor examines defenses and coping styles. Once trust is established with the client, direct feedback can be given on issues such as alcohol abuse or social withdrawal. Tenth, the counselor identifies pathology and refers. This gate keeper role accesses other professionals whose acumen may be needed.

Worden (1982) also suggests specific techniques for grief counseling. The use of writing, drawing or role-playing has proved to be useful in his experience. He also recommends the intentional use of emotionally charged language to provoke feelings and the discussion of concrete symbols that elicit telling of the deceased. Worden (1982) also affirms the use of the gestalt "empty chair" technique and the use of journaling and memory books. Cognitive reconstructing is also noted to deal with irrational thoughts.
related to the deceased person or death and dying. Directed imagery and meditative work is also a helpful technique to help the bereaved work through dysphoric feelings.

All of the above relates to the treatment dynamics of individual counseling and therapy, but Worden (1982) also makes reference to the use of group modalities. He states the necessity of clearly defined expectations and group rules, and expresses the value of group settings for grief counseling.

Another extremely significant work that deals with grief Counseling and therapy is Therese Rando's, Treatment of Complicated Mourning (1993). Complicated mourning is a distortion, compromise or failure within the mourning process, and requires a specific set of clinical protocols. She does not proffer a universalized theory of grief, but a series of non-linear processes. The first phase in avoidance, and in treatment this is the time when death is recognized, acknowledged and understood. The second phase is confrontation phase. The themes which emerge during this time include: a reaction to the separation (pain is felt and given expression), a recollection and re-experiencing of the new relationship with the deceased (realistic review and re-experiencing of the relationship and feelings) and relinquishing of old attachments and the prior assumptive world. The third phase is the accommodation phase. This time includes readjusting to the new world and reinvesting energy in new directions.

Rando (1993) suggests that an important treatment dynamic in grief counseling is a clinical assessment. Such an assessment includes an emphasis on grief history, any secondary losses and perception of death, the circumstances around death, the circumstances prior to death, the nature and meaning of what was lost, the mourner's
reaction to death and coping abilities, the degree of support that is available and the relationship of the mourner to the deceased.

Rando (1993) offers the following guidelines for the treatment of complicated mourning. Permission to grieve is given and support in coping is offered. Social supports and family systems are utilized after a medical evaluation is complete. Surface issues in counseling are probed for underlying issues and work is done to assist the client in accepting the death and in normalizing affect, wishes, cognition, behavior, experiences, fears and symptoms. Working through grief is done by identifying, labeling, differentiating, and tracing emotions in a repetitious way; these feelings are then given expression. The symbolic meanings of persons and resistance to mourning are examined. Any unfinished business with the deceased is discussed as are secondary losses. Security issues are dealt with and absent emotion is addressed. Finally, treatment is tailor made as based on the specific issues that each mourner brings to treatment.

Rando (1984) also offers seven broad phases of treatment for uncomplicated grief.

1. Make contact with the person and assess. 2. Maintain a therapeutic and realistic perspective. 3. Encourage verbalization of feelings and recollection of the deceased. 4. Help the griever identify and resolve secondary losses and unfinished business. 5. Support the griever in coping with the grief process. 6. Help the griever accommodate to the loss. 7. Work with the griever to reinvest in a new life.

Ester Shapiro (1994) discusses the treatment dynamics of grief counseling and therapy from a family systems perspective. She understands bereavement as a family development stressor that challenges the rate of discontinuity and change within a family
system. She argues that the first priority is to enhance a stable family reorganization so as to bring about emotional equilibrium. A restrictive emotional equilibrium may be adaptive during the early time of family grief. Thus, emotional avoidance can be a reality that brings about family stability. As a family's organization is disrupted by death, the family may triangulate onto a third party to bring about balance. "Triangulation of the dead" (Shapiro, 1994, p. 164) can be an issue in treatment if there was a family disturbance with the deceased, or if the deceased was the emotional center of the family. An extreme focus of the bereaved family on the deceased can be an issue in treatment, and some families cope with overwhelming loss by keeping the dead person as an idealized family ghost. In such situations much support from the clinician is necessary. Shapiro (1994) argues that an emphasis on "letting go" of the deceased is not necessarily helpful, and she recommends a memorializing of the deceased to establish a meaningful and realistic connection with the deceased person. This encourages family development. Shapiro (1994) also alerts clinicians to the treatment dynamics of dealing with families who place new burdens on children in the family system. Families may turn to children for emotional support or a child can take on a parent or adult role, and such a factor necessitates attention in treatment.

Shapiro (1994) also states that grief counseling in a family context makes use of the concepts of enmeshment or differentiation. As a deceased person physically leaves a family, or is differentiated, a grief counselor assists the family to tolerate the emotional experiences of the family members. The clinician also works with the circumstances of stress and anxiety, for such can move a family to differentiate or enmesh in ways which
may be either healing or harmful. From her work it is clear that autonomy and independence are key factors in the lives of families who grieve.

Shapiro’s (1994) primary theme is that grief counseling and therapy should “construct a new family narrative” (Shapiro, 1994, p. 180). A rewriting of a shared family story, which includes prior family history which may be excluded in present family history, can help a family rework the balance of its system after the stress of death of a family member. Families can review the past and reorganize reactions to death with a new level of safety and stability.

David Crenshaw (1990) presents the treatment dynamics of grief counseling and therapy within the context of developmental psychology. In different places within the life span an individual in grief has different needs, and clinical work must include such an awareness in its scope of understanding. Crenshaw (1990) also discusses the treatment dynamics of clinical work with the bereaved in terms of their own context, which includes respect for the specific ethnic, cultural and religious background of a person. He encourages empathy with the pain of the deceased as a primary clinical intervention, and notes that the clinician has the role of companion who listens and understands. Of note is Crenshaw’s word about over-identifying with the deceased client. In Crenshaw’s (1990) discussion of treating the bereaved in counseling and therapy he makes mention of story telling as a way to give permission to grieve and as a means to reminisce and come to terms with the past. He also includes practical issues of adjustment as key to grief counseling and therapy, stating that such concrete tasks help the deceased forge out a new identity. Crenshaw also wrote, “Helpers must come to terms with their own death
anxiety,” (Crenshaw, 1990, p. 30), and included such as a key treatment dynamic in
dealing with the loss and grief.

Marilou Hughes (1995) wrote a significant book that focuses on the treatment of

grief from a group therapy perspective. She holds that group modalities are especially

significant for grief counseling and she documents the differences between structured and

unstructured groups. This work also gives information about special populations, and

explains how group work must be specific to the uniqueness that each individual brings.

Kenneth Doka has expanded the discussion of clinical work with the bereaved to

those individuals who are not publicly sanctioned in their grief in his book *Disenfranchised

Grief* (1989). He argues for the sensitivity of a therapist to explore grief with those who

may be restricted by society, and must then mourn and grieve in private. For example, he

calls for therapists to be aware of the special needs of the griever when he/she is dealing

with the death of a lover from an extramarital affair, an ex spouse, a cohabited significant

other or a gay or lesbian individual. He also highlights the clinical issues that are

concomitant with those who have lost a loved one to AIDS, pointing out that homophobia

is a distinct issue that is a significant variable in how people in the gay and lesbian

community may grieve. Doka (1989) discusses the value of public rituals of
dead, and how to work with those individuals who choose to keep their mourning private.

Rabbi Earl Grollman is one of the most significant writers in the field of

is the only work in the area of treatment dynamics of grief counseling and therapy which

uses qualitative interviews to collect data. While his methods are not systematic this
volume is quite useful as the deceased respond to what helped them in the midst of grief. Of note here is that he did not interview clinicians as this dissertation has done, rather he focused on interviews with the deceased. In his 1981 work mentioned above he included such points as the value of silence in dealing with grief, turning to faith, retelling of times shared and writing down feelings in a journal. Grollman (1981) also takes care to include various types of grief, including the loss of a child, parent or spouse.

Alan Wolfelt (1992b), another extremely influential writer and researcher in thanatology, has written helpful material for clinicians in that common myths about grief and mourning are articulated. In the treatment of grief it is significant to be aware of myths such as: it is a myth to expect that grief and mourning are the same realities and it is a myth to expect grief and mourning to be experienced in predictable and orderly stages. Most significantly, he argues that our society draws us to move away from (or around) grief when healing comes by moving toward (or through) grief. He forcefully argues that each person is unique in their grief and that no blueprint of healthy grieving is extant for the deceased. Wolfelt (1992b) claims that one does not “get over or get beyond” grief with these words: “A number of psychological models describing grief refer to resolution, recovery, re-establishment, or reorganization as being the final dimension of your experience. These words suggest a total return to your normal life or the life you experience before the death...I suggest you use the term reconciliation” (Wolfelt, 1992b, p. 97). Wolfelt calls for a language that focuses on healing from grief in terms of reconciliation, and he established a criteria for such reconciliation that is concluded with these words: “The capacity to acknowledge that the pain of loss is an inherent part of life
resulting from the ability to give and receive love” (Wolfelt, 1992b, p. 100). Wolfelt (1992b) also details what to possibly expect from grief in terms of affect (sadness, relief, anxiety, panic, fear, guilt, regret, numbness), cognition (confusion, disbelief, inability to concentrate, magical thinking) and physiology (fatigue, sleeping and eating changes). He also states that the uniqueness of each individual’s grief is impacted by support systems, personality, cultural, ethnic, gender and other realities. Such knowledge and insight is profoundly important for clinicians as they work with individuals in grief.

Wolfelt (1988) also suggests seven tasks for grief counseling which make up the central treatment dynamics in his system. 1. Listen to the bereaved (empathy is the essential helping principle). 2. Understand the bereaved (be familiar with their thoughts behaviors, and feelings, and communicate your understanding). 3. Educate the bereaved (normalize experience). 4. Support the bereaved (with the structure and validation of counseling, be with the bereaved). 5. Advocate for the bereaved (concrete and practical intervention may be necessary). 6. Encourage the bereaved (offer hope so that the self of the bereaved can be restored). 7. Refer the bereaved (Be aware of the specialized needs of the bereaved that may be beyond one’s level of professional competence or discipline of training).

These seven treatment dynamics stated by Wolfelt (1988) enable the following to take place. Wolfelt (1988) notes six overlapping needs for grief reconciliation. 1. The reality of death is acknowledged. 2. The pain of loss is embraced. 3. The person is remembered. 4. A new self-identity of the bereaved is created. 5. Meaning is searched for. 6. Support is ongoing. Wolfelt notes that these six needs are not orderly and
experienced in a predictable fashion. Wolfelt's (1988) elucidation of the treatment
dynamics of grief counseling and therapy with those in grief include these qualities for the
clinician: empathy, respect, warmth and caring, self-awareness, congruence and
knowledge.

**DIVERSIFIED PRAGMATIC WORK**

A third theme within this empirical literature review summarizes pragmatic works that
include a wide variety of clinical issues. This section is diverse in its practical concerns and does
not have an integrated theoretical orientation.

Denny and Lee (1984) researched grief therapy with substance abusers. They used
qualitative and quantitative methods, with a focus on interviews of three hours in length.
Bright (1996) argues that a significant treatment dynamic for grief counseling is assessing
and treating chemical dependency, for some individuals who grieve medicate themselves
with chemicals to go around rather than through grief.

Krigger and Lippman (1997) discuss grief counseling by relating bereavement to
mood disorders. They argue that the key distinction between these two is that one's self
esteem is more of a factor with mood disorders than with bereavement. Of note is that the
Diagnostic and Statistical Manual of Mental Disorders IV (1994) makes use of a
differential diagnosis model so that other diagnostic possibilities can be ruled out.

Flatt (1988) researched group therapy in a study with a sample size of 500
widows. Considerable gains were made in treatment, as measured by perception of grief
level, number of social relationships, nature of actions, level of depression, ability to live
with memories, feelings about the future and the extent of perceived happiness. Schwartz-Borden (1986) also wrote about grief therapy in group modalities. Treatment of bereavement was also detailed by Hughes (1995), with an emphasis on group goal setting.

Grief therapy with pathological symptoms is discussed by Volkan (1985) and Leicki, Davidsen-Nielsen and Stoner (1991). Vogelsang (1983) shows how theological/spiritual themes can be used to help prevent pathological reactions to grief, with a focus on recognizing that grief is a natural process that requires feelings to be worked through as one accepts death so as to reorganize one’s life. James (1995) has dealt with treatment issues related to grief counseling with adults with learning disabilities. Grief counseling for persons living with agoraphobia has been researched by Sahakian and Charlesworth (1994). Luchterhand and Murphy (1998) make use of Worden’s (1982) schema to discuss how to help adults with mental retardation grieve a loss with the treatment dynamics including the encouragement of the griever to share his/her feelings while providing assurance that he/she is not alone. This is followed by being aware of the time involved to grieve and the necessity of leaning from the survivor what their grief is like.

Olders (1989) argues that grief and mourning are significant issues for healing in psychotherapy in general, for the failure to mourn brings about both psychopathology and psychosomatic illnesses over time. With the use of case studies, this article argues for the identification of loss as an integral factor in all psychotherapy. In a similar vein, Lloyd (1992) argues that grief counseling should be a core skill of doctors, nurses, social workers and clergy due to the wide range of behaviors which emerge if grief is not
adequately resolved. Basic helping skills that are core to all these helping disciplines are key to the treatment dynamics of grief counseling.

Cross-cultural issues related to grief counseling and therapy are discussed by Wilby (1995). Eisenbruch (1984) deals with the practice of grief counseling from the Western Hemisphere and whether such is acceptable to non-Western clients. Hanson (1978) discusses grief counseling with the Native American population, with attention to ceremonies in this community. Jacobsen, Kindlen and Shoemark (1997) have discussed the treatment dynamics of grief counseling and therapy from the United Kingdom, by stressing the importance of clinicians working through their own fears of mortality. Bhaduri (1992) has written from an Indian perspective, that the law of karma can be a factor in bereavement counseling. This article argues that karma is not a fatalistic concept, but one that assists the grieving person in containing grief rather than being controlled by grief. Corwin (1995) examines cross cultural issues and argues for culturally sensitive interventions in grief counseling and therapy. While treatment dynamics are not discussed, grief counseling with individuals from the gay and lesbian community has been written about by Dworkin and Kaufer (1995). They discuss how grief is impacted by homophobia and stigma and they dealt with HIV issues and grief counseling as well. Socioeconomic factors in grief counseling and therapy are dealt with by Cook and Dworkin (1992).

Casdagli (1995) articulates a vision of grief counseling and therapy that makes use of the arts. She notes that drama and story are useful interventions for all age groups, and such provides information, support and practical life skill assistance. Directed imagery work is suggested by Cerney (1989), and she finds that imagery can assist in the
processing of death related loss. Schut, de Wiser, van den Bout and Stroebe (1996) did a study with a sample size of 52 persons in an inpatient setting which used art therapy in conjunction with behavioral therapy, with stable improvement being demonstrated. Grief counseling and the musical genre of the blues are connected as a way in which emotions are expressed and ventilation happens in a way that can be cathartic (Ellis and Dick, 1991). Irwin (1991) offers case studies to demonstrate the place of drawing as a diagnostic tool as well as a healing intervention in grief therapy.

The role of ritual in loss was discussed by Bolton and Camp (1989). With a sample size of 50 widows, it was found that there is a relationship between post-death adjustment and the use of rituals. Nouwen (1982) has also highlighted the importance of ritual in dealing with loss. Haig (1990) also discusses the place of ritual in therapeutic interventions with the bereaved, as does Manning (1992), who values rituals because they assist in talking about the loss.

Grief therapy with adults who have lost a child to death was discussed by Doka (1989). He suggests such interventions as personal quests, editing a video about one’s child and affirming one’s role as a parent. Panzer (1989) has researched the dynamics related to parents who are dealing with the loss of a child due to Sudden Infant Death Syndrome, and argues that conventional grief counseling is less effective than a social networking approach. She uses both qualitative and quantitative methods to collect and analyze data.

Flatt (1989) discusses the most significant factors in grief counseling and therapy. He includes attending, caring, sharing and referring. It is noted that the grief counselor
must offer balance to his/her emotions in that one must be emotionally present and sensitive while staying in control of one’s emotions. Flatt (1989) also states that the helper must accept the griever’s process and not hurry the process, while reinforcing healthy behavior. He also suggests that the counselor can, in a planned and intentional way, share his/her experiences with grief with the client, making the point that interpersonal transparency on the part of the clinician can, if done correctly, be significant for the bereaved person.

A number of articles cluster around existentialism and phenomenology as a foci for the treatment dynamics of grief counseling and therapy. Lantz and Ahern (1998) have written about reminiscence as a way for families to make meaning of loss. Maniaci (1982) writes from the Franklian school and suggests five stages of grief counseling: contracting (create climate of trust with listening, sharing, empathy and paraphrasing), assessment (understanding meaning of loss, defense mechanisms and coping devices), intervention (confront what is most feared), reconstruction (interpretation and directives to fill empty spaces) and reevaluation/termination (present day conflicts resolved, as well as optimism about the future and internalization of new attitudes). Phenomenology has been demonstrated to be an effective method of grief counseling, with the assumption that by re-experiencing the loss or trauma there is a reduction in subjective stress (Frank, Prigerson, Shear, Reynolds, 1997). Thompson (1996) has also raised the issue of meaning as an important issue in grief clinical work.

Cognitive therapy has served as an orientation that has been of assistance to grief counselors. Reda (1984) has published on cognitive therapy as a means for the treatment
of grief, and O'Donohue and Krasner (1995) have done the same with cognitive behavioral therapy. Malkinson (1996) has written how rational-emotional therapy can be useful with clients who are dealing with grief-related beliefs that are problematic.

Scholars working out of the schools of contemporary psychoanalysis have contributed to understandings of grief counseling. Salka (1997) makes use of metaphors, guided imagery and affirmations to use the unconscious to deal with loss and grief. Scott (1997) also uses a psychoanalytic model, with an emphasis on a transformation of consciousness as the nexus of change for the grieving soul.

Much work has been done by Charles Figley (1996, 1997) on trauma as a factor in grief counseling and therapy. Post traumatic stress disorder is presented as a diagnosis that calls for specialized treatment in bereavement clinical care. He includes eye movement desensitization, thought field therapy, visual/kinesthetic disassociation and traumatic incident reduction as helpful models of treatment. Cable (1996) has also done research on the experience of trauma and grief counseling.

The treatment dynamics of grief counseling and therapy are explicitly elucidated by Leick and Davidsen-Nielsen (1991). They state that the methods and principles of grief counseling are based in a directive, active approach by the therapist. A client is encouraged to tell his/her story of grief by reviewing the circumstances around the death and memories of the deceased person. These authors suggest that many clients need assistance in contacting the deeper pain that accompanies loss, and they encourage the therapist to help clients get in touch with their own pain and loss in profound ways. They discuss body contact between the counselor and client, with an encouragement to touch if
verbal permission is given. The treatment of loss in this work is centered on intense work with anger (directed at the deceased and God), bitterness, guilt and shame; the therapeutic assumption here is that the pain of grief and loss is, in the final analysis, healing. It is also stated in pragmatic terms how different risk groups and factors impact grief counseling and therapy.

Lendeur and Syme (1992) also detail the treatment dynamics of grief counseling. They note that such work requires in the very least active listening and attention to distractions, reflecting experience and feelings back to the client and reflections based in deep empathy. More advanced grief counseling calls for dealing with the meaning of limits and boundaries (including pacing in a session with attention to the initial and concluding times frames and the termination of treatment) and clarification (of dreams, hallucinations, behavior and repetitious thoughts and images).

Writing from a psychiatric perspective, Raphael (1980) outlined four major tasks for the caregiver who works with grief therapeutically. 1. Offer basic human comfort and support. 2. Encourage the expression of grief. 3. Promote the mourning process. 4. Supplement the personal support system that already exists in order to facilitate the grief process. Corazzini (1980) also offers a similar list of tasks that make up the treatment dynamics for grief counseling and therapy. 1. Help the griever remain open to the loss and resist blocking or discounting the process. 2. Develop empathy with the griever that allows the counselor to experience the complex multifaceted feelings of the bereaved and to communicate such an understanding to the griever. 3. Encourage reminiscing.
4. Remind the griever that death has really occurred, especially in the first few days after the death.

A major theme in contemporary grief counseling challenges the premise that loss is a reality that one gets over by saying goodbye and letting go of the deceased person. Wolfelt (1992b) and Shapiro (1994) have discussed such. Klass, Silverman and Nickman (1996) have forcefully argued that grief counseling and therapy should not work toward cutting bonds with the deceased, but assist in grief resolution by enabling the bereaved to maintain an appropriate bond with the person who has died. This concept of continuing bonds is applied to work with widows, widowers, bereaved parents and siblings, adoptees and their parents by these authors.

While the studies on grief counseling may be many, there is nothing in the research that addresses from the clinician’s perspective what helps in the treatment of grief. Many of the mentioned articles and books in this review are opinion pieces, and as much as they offer considerable insight, there is a lacuna in the literature in that empirical studies are uncommon. Furthermore, qualitative studies that focus on in depth data about the treatment dynamics of grief counseling and therapy are not extant. Thus, the trajectories of the research design for this dissertation are informed by a paucity of studies in the area of the research question.
Data analysis. It is more than that. As I painstakingly reviewed the tapes and transcripts, I encountered not just the treatment dynamics of grief counseling and therapy but more: illustrations of what it means to be a human who, on occasion, relates to another human as a thou, as a subject. These encounters emerged around the research question: how do social workers and chaplains who work in hospice settings understand treatment dynamics within the context of their clinical practice experience with adults who are bereaved? Themes and patterns clearly emerged from these discussions, and the following brings together a summary of the results of humans relating as subjects around the following seven themes: therapeutic presence, clinical intuition, empathetic listening, formative experiences, meeting the client where he or she is, client confrontation and spirituality. While making distinctions between these themes and patterns, I am aware that they overlap and flow together like morning and the dawn. I am also aware that these stories are about death, grief and life, and are filled with pain and hope. A client who I worked with years ago wrote these words: "To feel love one must open oneself to the chance of pain. Together, my late husband and I, experienced great love and excruciating
pain.” The themes in this chapter tell of great love and excruciating pain, the love for one who has died, the love for a client, the love for one’s wounded self in the midst of the helping process. As the Portuguese saying holds that, “God writes straight with crooked lines.” The sometimes straight-crooked human encounters of clinical work with the bereaved rings true in the pages that follow.

These stories of the treatment dynamics of grief counseling and therapy give voice to such future joy and wretched, muddled fate. They tell about life and death; they tell the truth.

THERAPEUTIC PRESENCE

Kirk Schneider and Rollo May (1995) write about presence as a primary moiety of the therapeutic process. Schneider and May tell of a young man who came to Martin Buber for counsel, but due to Buber’s spiritual preoccupation he was unable to be attentive. The situation ended in the young man’s death, and after that Buber was deeply recommitted to being present with people. One of the most pronounced themes that emerged from my dialogues with clinicians was therapeutic presence. In a sense, this theme was the central nexus which ran through the discussions, and presence had to do with what it means to sit with a grieving client in a way that was meaningful and healing in the moment. None of the clinicians overtly discussed a theoretical orientation with regard to presence, but much of gestalt therapy’s emphasis on the here and now within the cycle of experience (Zinker, 1977) is consistent with what the clinicians said.
A repeated metaphorical phrase that brought together much of how presence was understood by the clinicians was “being with.” “Being with” had to do with entering into the pain and loss with the client in a way in which the clinician is not imploded by the grief itself. The following quotation by one of my co-participants connects the concept of “being with” with human trust.

The metaphor here is being with. It is a presence and they know that they are not alone. Just a presence, not saying anything. Trust, it is a trusting presence. I want to know what people are really saying.

One of the clinicians made the distinction between four therapeutic orientations that represent differing ways of being present with the bereaved. 1) Abandonment orientation (clinician protects him or her self and keeps distant); 2) Sympathetic orientation (clinician gets close to the pain, but does not quite encounter the depths of pain); 3) Identification orientation (clinician becomes absorbed in the client’s grief and introjects the process; the therapist comes too close to the grief and loss of the client and over-identifies) and 4) Empathetic orientation (clinician goes into the pain without becoming overwhelmed). He elaborated on this schema with the following words that use the metaphor of an open pit as the experience of loss.

In the empathetic orientation, the counselor sees the griever in the pit of his loss. The counselor ties a lifeline on a tree outside the pit and lowers himself into the pit to help the bereaved be pulled out of the pit. The identifier just jumps into the pit while the sympathizer looks into the pit from the edge and the abandoner just runs away from the pit all together.

This clinician provides clients with these concepts on a diagram. The different ways to be present are photocopied with a pictorial depiction of a pit with different helpers providing.
assistance in different ways. He sometimes hands this out to clients, when appropriate, so that they are aware of what he is doing and why. This clinician works very hard at being clear and direct about how he is present with clients. Another clinician stated the following that was similar to the prior comments about an empathetic orientation of being present. He refers to the image of the wounded healer, from the book by that title by Roman Catholic Priest, Henri Nouwen (1972).

I try to find something in a client that is damaged in me and to be with that. Something hooks my desire to heal because it has to do with them and me. I have to be able to recognize the pain, what is going on, pulling counter-transference to heal, support, hold. If I do it wrong I over-identify, seeing their stuff as yours. If I am doing it right it is not a confusing your pain with theirs. The wounded healer paradigm, the best and worst therapists are wounded healers. The best therapists have been hurt and learned to grow. The worse therapists have not grown.

Some of the clinicians noted that presence had both spiritual and psychosocial aspects. In fact, a compartmentalization of the spiritual and psychosocial which posits such in discreet ways was antithetical to the organic sense that spirituality and psychosocial realities are interconnected and part of a dynamic unity. As stated below, presence has both human and noetic character.

Theologically, spiritually, I really believe that human beings encounter God in a variety of ways. But one of the chief ways that I observe and believe for myself is that we encounter the Divine in other human beings, in an incarnational way with a small “i.” If that is what informs the whole idea presence, both making it kind of a sacred encounter and a moment suggesting that there is real depth there with me and the divine.

Another clinician spoke of “being present” in ways that integrate the helping skills of psychosocial care and spirituality, connecting such to acceptance and understanding. He used
the metaphor of “walking with the other” as the way of being present with the client, highlighting the unique and celebrative nature of such a rare experience.

I know what presence means for me in terms of focusing on the here and now with what is going on with the other person. Looking at the various passages of scripture how God promises to be present, like “I’ll be with you always to the very end of the age.” Now what did that mean to them and how did they take it? A sense of what happens to another person is to know someone else is present with them. It is not just words, but that individual is somehow concerned about me, to know that the person is personally connected to them and it is not just the idea that “I can talk to them.” It is more than that. They understand and accept me for who I am in my humanness. They are with me; they walk with me through the good times and the not so good. They hear the pain. They rejoice in reasons to celebrate. There is just a unique experience when truly I am present and people are present with each other in a way that doesn’t happen very often. To celebrate that and remove the barriers so that it can happen is unique and wonderful.

Another person spoke of presence as a “walking with” and a “companioning” of a bereaved person on their journey of grief. This clinician also discusses how she doesn’t try to be a “fixer” of person’s problems, but rather “stays with” them in suffering and pain.

Companioning people along the bereavement journey and through grief is a walking with, this is likened to a journey… I am called not to fix this person’s problems or to do some kind of intervention and suddenly they feel integrated. Very often it is less those things and walking with, being present with. Jesus in the Garden of Gethsamané… he asked his friends, to stay awake with him in his suffering, so that they would be present with him, he is not alone and they are companioning him. All those words speak of images to me about the work I do.

Water was an image used by another clinician. As the above uses a “being with” language, another of the co-participants spoke of “wading with” a bereaved client as a way to be present. Notice that the clinician is not ahead of the client in the water, but by there side, with them.

We wade into the water with them. I think when my kids were little and you were at the ocean. You took their hands and wade into the water with them. You are
present with them and it will be OK. There is some kind of image of being with people as they face their mortality.

While the above quotation refers to “walking with”, and “being with” has already been referenced, another clinician spoke of presence as a “staying with” the person in grief. Letting them wander and be distracted is encouraged and the chaos of loss is accepted here, as long as the clinician does not create the chaos itself.

Part of grief is that I am willing to stay there in the initial crisis and preparation, through the family coming in and the phone calls that need to be made and the police coming for the body. That takes not being distracted and not looking at your watch and sending signals that you need to be somewhere else. The other thing that staying with is willing to let them wander and be distracted, and laugh and cry and get back on the issue because people in grief are in chaos. And chaos is something I want to enter into but I don’t want to create more of. And sometimes the wandering is very fruitful, this morning the person who had tears.

It was acknowledged that as a clinician, one is not always present with clients. Presence is a therapeutic ideal that is manifest amidst the foibles and flaws of human encounters. To sit with someone and to enter into their suffering can be profoundly difficult, and it is noted below that this usually has more to do with the therapist than it does the client.

Very often I am non-present. If a third person observed me, there would be a test pattern on my face and you would know that I am not truly engaged with the person. With a gesture the whole countenance shows that there is not much energy there, not much happening. And so much can enter into that, boredom, fatigue, distraction, preoccupation with something else that prohibits a connection. I try to be aware. So much can be going on at any given time and you can operate at many different levels. But when I am aware of not being present, then I can look inward and figure out what is going on with me or the other person. Very often it has little to do with the other person but has to do completely with me.

Another clinician spoke of presence in light of trust in the therapeutic relationship which does not try to “fix” the concerns or problems. She noted that such a presence is a
calm presence, which is similar to the non-anxious presence spoken of by the family therapist Freedman (1985).

If they don't trust me they won't share what is going on. Trust is a key to their being open and being willing to invite me into the bereavement. First of all, I keep my word. Secondly, I also try to be present at the times that are critical. Like the diagnosis. Being present means being willing to sit in the midst of the problems without fixing them. Or not feeling like you have to. Sometimes I feel helpless because I would rather go in and fix it and make it better, but that is counterproductive. If what they need to do is cry until they can’t cry anymore, until they don’t cry anymore and if I can sit there and be a calm presence and a patient listener, I have done a lot more for them than if I quote Scripture at them or tell them that if they prayed they would be a better person, you know all the cliches that people use... Calm presence, I think that one of the things that happens in grief is that your life becomes chaotic and if you put on a diagram chaos on one side and calm on the other, calm can be lots of things. It can be the assurance that life goes on. It can be the assurance that your life may be chaotic but the whole world is not chaotic. It is ultimately a symbol of hope. If I went into the situation and became hysterical because the family is hysterical the hysteria would build in the room and not diminish. It is like adding fuel to the fire and I don’t want to add fuel to the fire.

Boss (1979) has noted how counter-transference material has a significant place in phenomenological psychotherapy, and concomitantly how the voice of the researcher is an important source of information that may mirror the viewpoint of the subjects, thus, the following is my voice from my reflexive journal. As I discussed presence and “being with” with ten individuals, I am, in a sense, the eleventh subject or co-participant in this project. Included in these direct quotations from my reflexive journal are my reflections about the theme (in this case therapeutic presence) and how such relates to the humanities. Thus, I will conclude each of the themes that emerged from my research with references that include discussions of art or poetry as they were included in my reflexive journal. I originally wrote these as reflections to myself, and they are included without editing for this dissertation.

To be present with someone is to “be with” as expressed by the poet in the 23rd Psalm: “I walk through the valley of the shadow of death. For thou art with
me.” To “be with” is to walk with another in their shadow of death that brings to mind my death as well. We may not all be dying, but we all walk in the valley of the shadow of death for who knows what the day may bring. I will die and so we all, and to do gestalt closure with this dissertation I must plan my funeral. To “be with” and have therapeutic presence invokes phenomenological compassion, enabling the other person to fill in their tabula rosa without my unresolved agendas, so that I can weep with another while they are weeping. Tillich’s concept of the courage to be gets at this as it is played out in a psychotherapeutic context: we are to have the courage to be in the face of non-being. For the Guatama compassion was the sign of wisdom, and if I can compassionately weep with another because of their loss and usually keep my unfinished business out of the way, then I am “being with another.” Certainly “being” and “doing” must be balanced in working with people, but being seems to be denied in our age of managed care, but “being with” seems to be where healing happens. Such an I-Thou is probably all that matters in therapy, in life in general, in death in particular. All this brings to mind a favorite work of art by Pablo Picasso. Picasso’s painting from the 1920’s, entitled, “The Lovers,” gives a vibrant picture of therapeutic presence. With a classical vein that is almost theatrical and not cubist, the individuals gently touch and gaze into each other’s eyes. They encounter each other as subjects rather than objects, as a thou, and the focal point of their overlapped bodies gives a vision of being present with each other. One’s eyes are drawn among the painting’s colors to the human connection that is slightly off center on the canvas. Is this how we are present with clients? Not completely, for the physical touching may raise ethical issues, but in the colors and shapes Picasso portrays two people who appear truly present with each other.

CLINICAL INTUITION

While Julian Jaynes (1990) has demonstrated that the bicameral brain is too complex to be broken down into a simplistic right brain and left brain distinction, the language of right brain and left brain, which distinguishes between the artistic and intuitive and the mathematical and logical, do symbolically serve as non-literal physiological metaphors for different ways of knowing. A pattern throughout my dialogues with social workers and clergy had to do with the non-linear intuitive functions which some termed
“right brained” activity. Included here was a discussion of the intuition, poetry, metaphors, dance and the visual arts. Compton and Galaway (1989) argue that the helping person includes creativity within their skill base (along with being a maturing person, having courage, being able to be self-observant, having sensitivity and desiring to help). The therapeutic process is presented as an intuitive or creative function by all the clinicians that I interviewed.

A clinician noted that the creativity, intuition and silence have importance. It is stated that mutually “gazing” into another’s face takes in the other, and intuition is discussed as a way of knowing.

Even if very few words are said when you know intuitively that something is said, something is created, very often in silence. I think of being with someone who is dying or in grief, it is a gazing into their face and you sense they are gazing at you, taking you in.

Metaphors were discussed by a clinician who noted that once rapport was established, risk could be taken with the client. It is also stated that the intuitive process (“There is some sense, gut, in your gut”) has theological realities as its nexus.

Metaphors come from being clergy and from being me, it is a part of who I am, how I see the world and how I see God in it... That is such a compliment to me, to have an active right brain, to use both parts, both hemispheres. The metaphor of dancing. Dancing with the family, let them take the lead and allow my toes to be stepped on now and then. An example was a man who died last Friday...I know nothing about sports, but he loved Michael Jordan. As an African American, he loved Michael Jordan and related to him. I remember my husband had a couple of Michael Jordan books because he also loved Michael Jordan so I would take them, and we would talk. We were making a connection. Michael Jordan and his thoughts about life and success, became a plan and my agenda was to try to connect with the client, to establish rapport. I also made an intervention by using something that was important to him and talking about some of Michael Jordan’s thoughts with the intent or goal of
mine, as we began to talk about Michael Jordan’s thoughts then slowly we would begin to talk about this client’s thoughts. We moved from, “What did Michael think about that…to what do you think about that?” Move it right on. Eventually, I prayed. I was praying about this client and I was praying about our encounter. So simultaneously we moved in the last two visits to him saying what he had never done before, “Can we pray? I’m having a hard time catching my breath, can we pray right now?” …It progressed; it was a combination of my assessment and intervention which was difficult for me. This was difficult for me, for as social workers we have interventions. And I thought, spiritually we have to let things flow…and then I learned that no, you have interventions too. And then things started coming together. Prayer is an intervention. Utilizing this particular book was an intervention. Establishing rapport via talking about whatever the client wanted to talk about was an intervention…for you meet the person where they are at and trust the process. I was able to then take a risk. The son and the grandson, the father’s son, this is interesting because I had never met the additional generation…we were all in the room and I said, Charles has really changed, and when you’re ready I would like to talk about how you are going to take care of Charles’ body…have you thought about funeral plans. And they said, “Do you mind if we step out of the room and talk?” And I told them that I had always been up front with Charles. And I went over to the patient and said, “Charles, we have had prayer,” and I said the 23rd Psalm and I got to the part where it says I walk through the valley of the shadow of death and I said, “Charles, this is the valley of the shadow of death.” And I said, “You and I have journeyed together”…so I took a risk. The son said, “I can’t believe how much he let you in.” And I said, “That was after walking together. Your father really does love you. He made mistakes. I don’t know what those were but he mustered up the courage and says he is sorry and asks for forgiveness. You see, when you wish your father was different, and maybe you look at your own life and be able to tell your son before you die. He was very receptive and it was very powerful because I was willing to take a risk. He could have told where I could go. But he didn’t.” There is some sense, gut, in your gut. And not just your gut, but where is God in the process. Where God is in the process of nudging and then we take this a little bit further. I’m doing some reconciliation in this family. Let’s take this a little bit further. Trust me. I stepped out, it is not just gut but where God was leading me. In addition, for me, where God leads us has to do with gut and intuition.

One of the individuals who I interviewed is an artist himself, and his work with watercolor as a medium informs his understanding of grief counseling. He spoke of
colors on a palate and correlated such to the counseling process. As he spoke the following words he moved his hands as if he was holding a brush and painting a watercolor in the air.

The ingredients that are present when I do my best work are when I am in touch with my intuitive side. So that I can be responsive to the spontaneous stuff that surfaces and within that encounter...I keep in touch with the intuitive by painting...watercolors are a very different medium than oils. The spontaneity of water and laying down color on a wet sheet of paper. It just flows...it is drawn into and out of the paper. Sometimes you have to learn to work with these happy accidents that happen on the paper and somehow incorporate them into the painting or you scrap them. To salvage it you have to work with the accidents that happen. The water can swirl the purple and the other colors and you got another color. Or it will go over a line a little bit, uh oh, now what do I do? You have to paint with a different color. You keep working with it...I guess, I am aware on one level, of being with people, and I flip into a metaphor in my head of I think of using a brush and picking up a different color. And I am aware of that metaphor as I am with someone so it is almost a different color. You know, we have too much blue here, so we need to warm it up a little bit so we get a little bit of orange...so I am aware of that metaphor and that activity informs the work...In a different way. This may be the second or third visit with a patient and I may have an idea of where it may appear where it might go based upon my last conversation at that point. So I am rehearsing in my mind some things about a way to help process that, some questions to ask and when I get there I find an entirely different patient than what I anticipated. And what I thought would be important is no longer, or maybe it is important but something else is higher on the agenda.

So I choose to discipline myself to put my thoughts aside and we are going to stick with what is here.

Back to the water color stuff. I may come in with a blue palate and they have a red palate, so we are going to use the red...I don't want to get stuck with one color, but if they keep going back to one color, that is OK. It may be monochromatic, if that is what they want. Paul Simon, Kodachrome, the song. I just ran into him in New York. He was walking down the street and I was there for the weekend, staying up by the Dakota, Central Park West and 73rd, whatever it was. And there he was.
Another individual told of the use of writing and painting as a therapeutic intervention with the bereaved. There was also mention of the intuitive feel of when clients need confrontation and it was simply but clearly stated that “it is an intuitive process.”

I think a lot of grief is right brain. It is not just what you can organize and feel in your head. It is what makes you sick to your stomach and you want to vomit. It is an intuitive process. It is when you look up at the stoplight and think that it is your Mom in the other car and she is gone. And she has been gone for ten years. One thing I have them do is to have them write. Write letters to the person who has died, to the remaining relatives, to themselves, to God. Or if they are more artistic draw a picture of maybe the favorite thing they did with that person. Sometimes it is just an intuitive feel. It is hard to put into words, but I have a sense that I know people well. I know that if they are moving into a self-destructive mode because I see them. If they drop off the face of the earth it will take more than a gentle nudge to get them back.

Words from my reflexive journal summarize this section from the point of view of the eleventh subject.

Hearing these tapes and reading and rereading the transcripts allays my right brain atrophy. This is the water that I swim in, and it gives life. I have been healed from grief time and time again by the arts, in particular, the loss of my mother was reconciled by the visual arts. Many a trip to a gallery has been my best therapy, and my love of gestalt therapy rings true because it is, in a profound sense, an art, a healing art. When I have been with clients with a balance between the linear and the non-linear, then I am at my best. If I can use both logic and creativity, then I am freed to be creative as a clinician. The more I lean with my intuition and trust my feelings, then I am more than a typical talking head of a therapist and pastor. Case management with a dose of the Socratic method, what a combination when there is both concrete problem solving and meaning that is made. Some of these interviews touched me with awe as I saw the colors and shapes of the conversations. In our positivist zeitgeist there is hope after all, in the rhythms and rhymes of a poet and the colors of Matisse and shapes of Picasso and the tones of John Coltraine. Ah, my first love is the arts and humanities; the social sciences come in a distant second. My final words about clinical intuition are based upon a painting by Paul Cezanne. This work was completed in 1906 and influenced by Pissarro, and the dimension of light is depicted on different surfaces. During the last decade of his life, he did considerable work with the human figure, and he expands our view of an incarnate aesthetic. The intuition that was spoken of so
eloquently in these tapes with clinicians was brought into full beauty in the work of Cezanne’s painting, “Large Bathers”. Without the use of live models and with only his imagination (rather than direct observation) he gave shape and color to the human figure. He was long freed from attempting to reproduce reality and he reduced his vision to essential elements from his imagination, intuition. His imagination was more accurate, more evocative of the human encounter, than empirical observation, at least in some ways. If only I can be grasped by Cezanne, and by the clinicians who I interviewed for this dissertation and come to transcend linear empirical observations so that I can be embraced by other ways of knowing and being.

LISTENING WITH EMPATHY

Compton and Galaway define empathy as “the capacity to enter into the feelings of another- knowing what the other feels and experiences- without losing oneself in the process” (Compton and Galaway, p. 291, 1989). This was distinguished from other themes, for example therapeutic presence, in two ways. First of all, the location in the texts made a distinction in that listening with empathy was a separate theme and occurred in a different location from other themes. Secondly, the language itself helped make a distinction, because presence and listening were discussed in different ways. Listening with empathy emerged again and again in my discussions with the clinicians. Every interview made mention of the value of listening, and it was noted that the very act of listening itself is a healing act in grief counseling and therapy.

Listening is mostly what I do. I am lucky to get an uh-huh in. They need to tell the story over and over again. Listening helps heal and it is important to feel heard.
It was also noted that the most important skill a counselor or therapist is listening. The following clinician spoke of listening “through” in a way that transcends the agenda of the counselor.

Listening is my most important skill. It is not appropriate to go in with my agenda only. I have to meet the person, theologically, meet the person where they are. So, a patient may not be very responsive. I need to listen to body language, not just the words. I may need to listen to the family, listen to stories the person shares. I’m listening to the person, for the person. There are different levels of listening. I’m listening to hear what might be issues, concerns, feelings. Sadness, frustration, fear, anger, hurt. I am listening, for instance, through anger to hear sadness. Listening not just on the surface but deeper than that. I sometimes listen through a conflict. I may be in a situation that is filled with conflict, and I see the pieces and I am listening to hear whose issue is this? In social work we talk about the presenting problem and the latent problem. The presenting problem, for instance, is that the siblings are in conflict, because the sibling who lives here and gives, or knows, that Mom no longer wants to be on life support. But the sibling who has not been there to give care, who lives in California, is angry and does want life support. The presenting problem is that there is a conflict between the children who are the next of kin. The latent problem may be that the son who lives in California feels guilty cause they weren’t around to give Mom care and now they want Mom to be around a little longer so that they can come and care.

It was also frequently noted that the listening also calls for feeding back reflections of what was heard so that the client is aware that he or she is being heard accurately. This was referred to as a reflective response in the first quote; also pointed out the importance of being aware of non-verbal communication. The second quote refers to the place of clarifying questions as part of reflective responses.

Listening is to not be tied up emotionally. Attention. Reflective response is feeding back what they say. Non-verbals are important. Eyes tell you more than anything. A flicker can be incongruent.

The act of listening, the interactive sharing, in that I understand what they are saying. I will ask them questions that will help them to see the light, see
a pathway, so they can walk. You see, maybe I could take large steps up
the mountain but these folks might need a gentle path around and up.

Empathetic listening was a term that was frequently used. The following two
quotations make reference to the role of empathy in listening.

Empathy is being able to breathe with and have sorrow for the loss...to
listen and recognize that for this mother, this may represent broken dreams,
unfilled promises. There is a sorrow and I too, theologically, think of Paul
when he talks about the body of Christ talking about when one hurts we all
hurt. It is not my loss, but there is a part of me that when she grieves a part
of me grieves and hurts for her. Or for this gentleman who is loosing a
limb. Because he hurts there is a part of me that is touched that I can be
sensitive to that. It is not just a sympathy, but a sympathy with a
compassion. But I am not bailing it out on the floor. I can maintain a
professional stance and but I can be compassionate, sensitive.

A lady was referred to me, interestingly enough, by her medical doctor and
a friend of hers. The lady had lost her estranged husband. He had died.
She had divorced this husband and remarried. The divorced husband was
the father of her children, and she grieved his death. She was having real
difficulties with her grief but didn’t realize that was what it was. She went
to the doctor for her nerves and so on. The doctor told her, “You know,
there’s not much I can do. Your problem is you’re stifling your grief and
you need some help from a grief counselor.” She came to me and sat. I
listened to her story. Listening is the number one thing when they come to
me; I really focus on what is happening inside of them. I want to hear the
story and if they have difficulty telling their story, then I try to select a
means of helping them go on with their story. It might be a question. It
might be an empathetic statement.

An issue in the discussion about listening has to do with the agenda of the counselor
vis a vis the agenda of the client. Both of the following deal with agendas for listening,
the first clinician included that she is “willing to not know the answer”. In addition, the
second quote concludes with another reference to listening that is empathetic.

Some of my best work is when I have no agenda but to listen. I think that
was an important growth for me. In the parish setting, you go to visit the
sick. You let them know, let sister know that we miss her at church, that
God is able to keep her and you give communion and you leave. With my patients it is not like that. You don't drop something off and leave. You go and meet the person, again it is a theological concept, to meet them where they are at and listening is to assess what you need to do. Which ironically, it what we need to be doing in the parish too. But this field forces you to do it differently. So I can't just go in with this as what I think they need to do. I need to listen and use my skills, and be willing to not know the answer.

This quotation also refers to listening that is empathetic. The practical aspects of paperwork are balanced with the necessity of listening in an empathetic way, in this case after the death of a child.

When I am on call in the hospital and I get called to what we call a fetal demise, a fetal death, I have never been pregnant. I have never lost a child. I have nothing in my life experience to equip me for that. Part of what I have to go with is, yeah, I have an agenda, one of my agendas is that I am responsible for the paperwork...so I can properly tell what needs to be done with this baby's body...however, another part of that is that I don't know what that mother is feeling. I don't know what frustrations that father has, I don't know who is going to do the funeral. There is a sense of just having to show up and to trust, trust God in the process. In the process some amount of relationship will get developed and some amount of trust will get established. However, I will be able to listen and empathize with this mother and father and whoever else is present and get the paperwork done.

Both social work and pastoral care operate with unconditional positive regard as a significant value, but if we are honest, there are days when we just do not do our work very well and our listening suffers. The following quotations reference such.

Social Work talks about positive regard. Positive regard puts you in situations that are non-judgmental. It is safe. But it is tough.

Sometime I don't hear everything. I try.

I can listen to loss without running and without having to deflect the person who is telling the story. I have been there, done that. Don't need to repress your story. I don't have to do that. And that is so different from most people who have experienced death imagery or thrown-ness. They
can't tolerate it or work with it so they need to be superficial. I don't need to be superficial.

My reflexive journal included the following words about listening.

After reviewing all that was said in these discussions about empathetic listening, I suppose that it begins and ends here. Listening is meaning making in a concrete sense, and nothing is harder work than listening. To listen to a woman tell the story of her infant son’s death is such hard work, and as I listen to her story I hear my story as well. I hear her voice and my heart beating, the ticking of the clock on the wall. And when she has left my office I sit there, listening to my life, listening to how the last hour of grief counseling brought tears to both of our eyes. I don't always know why I choose to do this work; maybe I am like an owl that can see in the darkness. As an owl interviewing people about listening and how I felt listened to in profound ways in these interviews. It does begin and end here. Empathetic listening brings to mind another of my favorite paintings, “The Conversation” by Henri Matisse. No one makes a foray into color better than Matisse; this painting a couple converses, as noted by the title. He stands curiously far above her, she seems almost imprisoned by her chair, and neither of their mouths are moving. They listen to the other amidst an almost voiceless conversation. There is so much passion is in these colors, yet Matisse is typically controlled in his vision, and somehow “The Conversation” calls us to listen all the more and to do as they do, keeping our voices quiet much of the time. As neither of their mouths move, so is silence cathartic. The silence during confession in a liturgical setting calls forth life in the midst of death and grief. How God must listen to us from our silence to hear the torrent of our lives.

FORMATIVE EXPERIENCES

“I am my history,” (Harbaugh, 1984, p. 22). Such words raise the issue of how the formative experiences of social workers and chaplains influence our vocational lives and therapeutic skills. This pattern emerged during my conversations: that earlier formative experiences impacted them as clinicians. These varied from early childhood to early adulthood, with most referring to experiences from adolescence or prior.
One of the people who I interviewed explained how the experience of grief after her grandfather’s death influenced her. Also of note is that her mother’s manner of offering comfort, with spiritual symbols, impacted how she works with the bereaved.

When I was in the seventh grade my grandfather died and I remember the night my mother tucked me in and told me that he had died. She was crying. And she told me that he had been very sick and just didn’t wake up that morning and she told me he was in heaven fishing with Jesus. That was somehow a real image to me that sustained whatever grief I had. And now, one of the things that I do: “What would Mary be doing in heaven”? Today, it was Uncle Fred. And she said, “Walking on the beach and playing with his trains.” There is a sense of comfort and a sense that life goes on. You are really sending two messages. One is that your loved one is still cared for in heaven and that life has to go on. If he is playing in heaven, what should I be doing?

The presence of death in the life of a child assisted one of the co-participants in a way that enables her to deal with death as a professional. She focused on why she does not fear death, an important reality for those working with the bereaved who are dealing with death.

I know that I don’t fear death. It seemed to be a natural part of life. My grandfather lived with us when we were growing up... he had a stroke when I was very young and I can remember my Dad walking with him and doing his rehabilitation at home. This modeled for me and my grandparents were an integral part of my life.

Another of the co-participants in this study noted that the death of a loved one was a formative experience that impacted him as a grief counselor. He notes he has experienced healing from loss and that as he works with others on their issues that his issues are worked on as well.

I think I’m more comfortable with people because my wife died twelve years ago, the 14th which was two weeks ago, well coming two weeks. You know, I felt the healing process and have observed that as I have helped others, working on their process, that mine was helped as well.
Another clinician told of how experiences from his childhood are “bridges” to working with the bereaved in empathetic ways. Having experienced multiple losses as a child created, in his understanding, a sensitivity and empathy for those who are dealing with loss.

I was in a children’s home from the time I was eight years old. My mother was in a TB hospital and father was physically handicapped. Mother died while I was in a children’s home, she was twenty-eight years old and I was eleven. I was in a foster home when my father died of cancer. He was only thirty-eight... As I was growing up in foster homes, the number of people who just told how sorry they were and what a rough time I was having and all along the way I can remember people saying, “Boy, you have had it rough, but you are making it”. It was the pity stuff; it wasn’t pity that helped me. It was the people who came to me and talked to me. They saw me steering off in a direction and they would come and say, I would like to talk with you a little bit. I would like to be a friend. I would like to the Uncle that is not around. They would tell me, that what you are doing will not get you anywhere... They had some feeling for me. Genuine. There was some compassion... who are experiencing some of the things that I experienced. But my response to them is coming more from those people who helped me than from those people who pity parties. Using my experience as a bridge to helping these people. And it is not being insensitive. It is being very sensitive, more sensitive. The empathetic person is the more, the most sensitive.

A clinician shared how a formative experience that impacts her work with the bereaved has to do with her cultural heritage. This person explained how the mystical elements of an Irish fog embody her work with the bereaved in a way that respect, peacefulness and mystery are a welcoming therapeutic presence. It is pointed out that this can assist the bereaved in establishing a meaningful connection with the deceased, which may include the experience of a supra-sensory encounter with the person who had died.

That experience of going to Ireland I guess just clarified for me so much of what my Irish heritage had given me that I presumed was a shared world-view. But I grew up with sense of my ancestors being part of my family... My grandfather died before I was born, but he was a part of the family... So, there has always been a very fine line between life and death and the phrase that I heard several times while I was in Ireland that rings just so true to me is that “the other side, death, isn’t that far away; it might just be a foot above your head or maybe in the backyard at
most... I realize that’s just the way I perceive life... one of my favorite weather is fog. I think it sort of captures my sense of life. Just because you don’t see it, doesn’t mean its not there. It’s a mystical way to be. Ireland has all kinds of fog... And again, it wasn’t like I grew up knowing, “Oh, its foggy in Ireland; I like fog.”

It was just sort of this natural sense of comfort in the fog. ...We have people who come here to die... The fog, if you will, welcomes in a very peaceful way. And, we’re really able to maintain, by in large, that respect, peacefulness and mystery. You know, welcoming whatever they bring. And, obviously the experiences of those who are dying reporting seeing people who have died before then, we know as a bridge is very consoling to the people who are dying and the bereaved. And the bereaved, very often, later will talk about just what an overwhelming experience it was... of a different kind of presence that they don’t have a lot of sensory experience for, but that is the absolute sense of connection.

My reflexive journal included the following entry regarding formative experiences.

Life and death are woven together in my words. It is clear that my journey continues.

The death of a sibling, whose name and gender has been lost to time, as well as my parents’ death in my early thirties, certainly formed me in that loss was is in the air of the life that I breathed. Being the “only child” of a father who was a social service administrator and a mother who was an artist who skidded on the edge of the avant-garde - formed me as well. Certainly my life in the church impacted me the most as that community formed my sense of identity. The earliest painting that I can remember was one of my mother’s oil paintings. She painted the face of a child on driftwood that she found on the beach near our home, and the face was one of peace and calm. I wish I felt such peace and calm with my past and I have work to do before I die. I have work to do regarding life and death, and William Stafford said it well when he wrote, “I am learning from both sides of the window, standing between, turning to glass.” (Stafford, 1992, p. 29). Standing between life and death, both formative experiences, I am turning to glass, hopefully glass with an intriguing hue and some texture.
Shankar Yelaja (1986) points out that respecting the self-determination of the client enhances human choice. When a clinician "meets the client where he or she is," such an emphasis on the client's choice is made concrete. A theme which emerged throughout my conversations with social workers and chaplains had to do with focusing on the agenda that the client brings to a session. Repeatedly the phrase was used by both social workers and the chaplains that it is important to "meet the client where he or she is." One person noted simply noted: "You go to where they are, it is not just your agenda." Another succinctly noted, "My best work is when I have no agenda."

One of the clinicians spoke of meeting the client where they are as it relates to denial. It is pointed out that the clinician does not feel it necessary to challenge the denial, and the clinician sometimes waits to be invited into the experiences of the client.

You may feel that the patient is not at peace, by his or her own volition. Maybe they are unable or unwilling to let other people journey with them, including me or their family or those who are at a distance. I have a patient who is in deep denial and I have no necessity to move them beyond denial. I meet the patient where they are. And in some ways denial can be healthy because it is a method of coping. So sometimes I have to wait to be invited in, until the guards are down, and then sometimes at that point they allow me in when before they wouldn't allow that.

The following quotation refers to how meaningful it can be when a client's agenda is addressed. When the client "addressed their agenda" something happens which has much depth, within the soul.
It has been meaningful when a person has addressed their agenda. When a person has taken a look at something that is deep within the soul. An example, a man who has experienced PTSD after getting back from Vietnam. And to be with him as he gets that out and talks about it, I know something meaningful has happened.

Trust is an issue that relates to meeting a client where he or she is. The following quote refers to how trust is developed. The keeping of promises is also noted here.

I develop trust by my willingness to set aside my agenda. You have to put in your time that proves down the road that you are there for them, not for your agenda. The very act of valuing what is valued to them and follow up practically. If you say I will call you next week, do that. If you will see them in two weeks, deliver on your promises. Being honest and truthful with people.

The following two quotations deal with the uniqueness of each client and the importance of meeting the client where he or she is. The first quotation notes that the relationship that the bereaved had with the lost person impacts the uniqueness of the experience. The second quotation has to do with empowering the client to make choices. These words call to attention the courage that it takes to let a client feel whatever it is that they want to feel. A “touchstone” of grief counseling is courage.

Every person’s grief is unique to that person and each person’s needs depend upon the person’s relationship with the one he has lost.

I am looking for some touchstones of what is going on in a particular moment and time. If it is a person who has committed suicide then it is a different kind of grief than the hospice patient who for a long time we knew that he would be dying one day. I am a lot more courageous in letting them feel whatever they want to feel. I think that a lot of therapists and pastor types think that they are there to make you better. My
philosophy of grief is that you get better because you choose to. And I can help you choose that, but I won't force you to.

Different clients have different needs. Whether it is for feedback, dialogue, silence, the following quotation refers to such differences. Of note is the comment that some individuals or families need closeness with their grief counselor while others need distance.

If they want feedback they can have feedback. If they want dialogue we can have dialogue. If they want silence we can have silence. I can go to their needs. I have the capacity to follow. It is a window of opportunity when I was there at the right time in the right circumstances and the patient opens up. It is not about you it is about where the patient is. We get to conversing and dialoguing and something is happening that we couldn't have planned any better. I show up, with a general sense of areas we might be working on. But I don't show up with an agenda that today we will go from A to B. I show up thinking what we might cover and that we might get to A or Z or might not do any of that. But where the patient is and where is the need today. And all we may have is today. I can be as close or as distant as a family would have me to be.

The following is a case offered by one of the clinicians to illustrate the importance of meeting the client where he or she is. It is noted that clients have different time frames in therapy; some clients take six weeks to get where others may move during the initial session.

I have a couple of patients in which the first or second visit I got further than some patients who have had five or six. The time I entered their lives they were able to express their fears and anxieties, they were able to confess things that they had done and which they had regrets about and wish they could change. And they really shared their struggles, their fears, the unknown. And this could happen in one or two visits versus the patient who on the third visit the most they could say is I am angry. But they are
not able to share the “why’s” of their anger or their frustration or make a
request or get to the point where they can spit and cuss me out. And I sit
there when they cuss me out and we then go from there. And they want
you but when we are together I am not going to talk.

My journal included the following words about “meeting the client where he or she
is”. Reflected here is my dual training in both ministry and social work, and what my
clinical experiences give me.

I forget the very basics. Sometimes I confuse my agenda with the agenda
of clients in therapy. To make contact with the client/consumer in a gestalt
sense requires that I be aware of the tension between what is going on
within me with what the client is experiencing. I cannot forget the
personhood of either the client or myself. However, my unfinished
business gets in the way so often, and I can be a lousy clinician on those
days when I am not alive and depressed and “heady”. When I visualize
Edvard Munch’s painting “The Scream”, the raw terror of the picture pulls
me out of my pain into another’s pain, into another person’s agenda of
pain. The deep colors in the background and the vertical figure is in the
foreground, emptied and in utter pain, drawing me into meeting the other
where he or she is. But I can confuse my pain with the pain of a client, and
then there is estrangement. A lacuna separates us and I become the patient.
Damn. Roethke was right, “The winds of hatred blow cold, cold across the
flesh and chill the anxious heart...each man stands apart,” (Roetheke,
1975, p. 29).

CONFRONTATION

Another theme that emerged in my conversations with clinicians had to do
with confrontation of the client as well as the therapist’s self-confrontation. Hepworth
and Larsen write: “Confrontation involves facing clients with some aspect of their
thoughts, feelings, or behaviors that is contributing to or maintaining their difficulties” (Hepworth and Larsen, 1990, p. 350). Compton and Galaway (1989) also deal with the therapist’s self-confrontation when they argue that self-observation is necessary to clinical practice. How this is done by the clinicians in quite different ways, but confrontation of both the client and the self did arise as a consistent theme. The following case elucidates client confrontation in a manner that shows both the risk involved and the possibility of intimacy that can be achieved in a therapeutic encounter when confrontation takes place. The “gentle confrontation” that follows demonstrates the importance of giving clear, direct feedback to clients.

I did a gentle confrontation with a patient, “I am aware that we have had about eight visits and I am not sure whether you want to keep on” and she said, “Yeah, yeah, I want to continue.” I said, “I’m not sure that the work we do together is different than what anyone else could do. I am not sure how I impact your life and whether our times together are meaningful”. She said, “Yeah, yeah, they are”. I went on, “But this is our eighth visit and it feels to me like you do this”. I put up one hand and then held the other hand far away. And there was a moment of silence, like a revelation, and she said, “I guess I do people like that all the time. I have been like that all of my life”. And boy was that intimate. It was a risk on my part that this is what you are doing to me, and if you want we can do it that way but I am offering you a different way. Because of that gentle confrontation she had that ah-hah moment, the light bulb went on, and our next visit was very intimate.

Another clinician also told of challenging or confronting clients. The focal point of this confrontation had to do with reminding the client that they are in control of their grief and victims to grief.

I am not afraid to challenge people. I think that sometimes people need to reminded that they are in control of their grief. By that, I mean that although you lost someone, you have no control over that, you have no
control over that fact that Sally died. What you do have control over is how you live in light of that. Sometimes people think that they are victims of grief. Well I feel bad as opposed to acknowledging that I couldn’t make him feel better and stop the death from happening. But I can stop my own frustration. I can move on with life and make some choices that are life enhancing. Often I do this by asking probing questions. I can be more assertive in my tone an sometimes it takes a gentle nudge. I use a gentle nudge if it was something that was a bleep on the chart. But it if was going to be more self-destructive because of grief I would be more assertive.

One of the clinicians told of how he experiences some patients as boring. Rather than openly confronting the client, the clinician tries to find something curious or attractive about the client. It is also noted that boredom may be due to what is going on with the clinician himself, which requires self-awareness. In a sense, this is the therapist engaging in self-confrontation. The therapist’s self-observation is the essential clinical skill here.

If I don’t like a person, I consciously try to find something to like about the person. If don’t like the person I sometimes stay away, I don’t get interested in a person...When we don’t make a connection it isn’t a high priority and this frequently says more about where I am than where they are, this is my stuff...for me there just isn’t a personal connection. Somebody once said to me years ago, that “you have to fall in love with the person.” They said it in sexual terms, “you have to attracted to the individual.” It could be a physical attraction, sexual, or it could be an attraction out of curiosity, or attraction out of “boy, I’d like to get to know the person.” Sometimes I have to work at a reason to be attracted to the person, and it I can’t find that, I get bored. Sometimes I’m there because I’m very curious. I try to put myself in their place. I see the person coming in and I try to ask, “what would benefit me?” Try to sense, the curiosity is the honor of being there.

The same issues were discussed by another clinician who spoke of the importance of self-reflection when the therapist is disengaged with the client. A
"mid-course correction" then can be made. Again, this is a form of the therapist's self-confrontation or self-observation.

This Monday I felt bored but the man wasn't boring. A man was telling me things that could have been interesting if I was in a different place. I was aware that I wasn't involved. I was almost pathologically fatigued. Usually, self-reflection will help me get on a different place. I take a second look inside myself. Focus. Attend. Often I can make a mid-course correction.

While the psychoanalytic concept of transference and counter-transference did not emerge as a pattern in my interviews, the following quotation made such a reference. The therapist's ability to check out his reactions with the clients themselves is noted. Likewise, the psychoanalytic concept of the unconscious was not a recurrent theme, but the second quotation does again deal with the therapist's ability to be self-confrontational or self-observant.

Counter-transference is a shift when I become aware of listening more. I caught myself and check out with patients. I will say, "If I am tired I don't feel good" or "I don't know what I am doing here."

When you come into hospice, you are unconscious of your abilities. Then I became unaware of my abilities. It feels depressing, scary, I almost resigned. It had to do with my reactions to clients, not vice versa.

It was stated by a one of the co-participants that "there are some clients who I just don't like," but a breakthrough came as he came to see the client in a new way. Of interest here is that a second staff member assisted the clinician in this breakthrough.

When I don't like someone, and it does happen, I develop a sense of curiosity about that, and what it is about the person I am finding a turn off, or disinteresting. I think of a man who is a classic. I won't forget him for a long time. He was a real racist. We have an African-American aid that has been wonderfully attentive to him. And he made racist comments to me, and it was such a turn off to me. It was such a turn off, but I was
aware of how disgusting this man was. As I got to know the man he was even more disgusting. There was not a lot of redeeming qualities about this guy. It was a challenge. I want to see the image of God in this man. I wanted to, but boy was God hidden in the recesses of this guy’s character. But there was a breakthrough, when there was a student with me, and she was able to engage him in different ways. And as I observed them there were some winning qualities to his personality that were bubbling out and becoming evident. She was exploring with him his relationship with his wife and he was more tender. And bingo, here were some things and that created the ability for me to make a connection with him. I wasn’t just disgusted with him, was more engaged and interested with what he had to say. I could feel less judgmental.

The following two quotations deal with how to engage a clients. Again, the issue of the therapist’s self-observation emerged. The second quotation mentions peer support as important.

I try to go fishing for something with people to get something we like about the person. I’ve often heard it said that you don’t have to like everybody you work with...but it is a challenge, we probably are more effective when we find something we like. If the liking resulted with me being preoccupied with them, overly worried, not able to let go, taking them home with me and in my mind, waking up at night. This suggests I am getting hooked in ways that I had better look at. What is reason for this? This doesn’t happen too much.

Some people you just don’t like. Use professional peer support and remove yourself...they might not want us back and it goes both ways. I have found some people challenging.

My reflexive journal included the following words. They reflect my struggling with client confrontation.

When I am at my best clinically, I can be confrontational with a soft voice but a firm eye. My anger becomes my enemy here, and if my father’s anger takes hold of my therapeutic behavior then I can be cold and arrogant. Such a confessional stance admits a strength and weakness, a blessing and a curse, in that I can be a magician as I confront clients and motivate much growth, but I have my other days as well. Clients confront me too, and have I learned from such encounters! Much of my clinical work hinges on being aware of my experience of both the client and myself while we are together in therapy.
That awareness is consistently healing. I recall a painting by Rothko in which the strong blue and orange colors confronted the white canvas. The canvas was changed as were the colors, and we all change as we are healed by confrontation in therapy as well, the client and therapist alike.

SPIRITUALITY

Spirituality was a topic that emerged from my conversations with the clinicians, but how this was operationalized in clinical settings was quite varied. A common issue was to demarcate between spirituality and religion, as shown by differing job titles in that some of the agencies referred to chaplains as spiritual caregivers while others are engaged in pastoral care. Apart from job titles, the self understanding of pastoral care vis a vis spiritual care was an issue for both social workers and chaplains, and religion tended to refer to the organized and dogmatic function of the institution of religion while spirituality reflected more of an individual’s journey into depth and transcendence. Certainly these realities can overlap, but it was pointed out that many people who are not active in a church, synagogue or mosque have considerable acumen in appropriating issues that relate to spirituality, even as such a spiritual journey is not part of a larger faith community. Such issues play out in the concrete lived experiences of the clinicians whom I interviewed, and the following quotations point to some of the distinctions between spirituality and religion.

There is a difference between religious and spirituality. Religion sometimes help access the spiritual and express our spirituality.

That is a spiritual process. And not religious, it may or may not be religious, but spiritual. You are creating a ritual. See, the pastor had referred those people to me and I knew too, I knew some relatives, so I knew that background a little bit even though I didn’t know those ladies. I
had known the father’s relatives so I knew what would be meaningful to them. Now to some people who don’t look so much to religion as a resource, I might use a letter, use a mirror, or a photograph and tell them to do essentially the same thing and you see that it is satisfying a spiritual need. I say spiritual rather than religious there; if they don’t think in terms of religion they can still be spiritual.

I don’t hesitate to use the word spiritual. I think that the relationship is spiritual. It gets expressed in a sensory way, bit it is a spiritual way.

The use of Scripture was discussed in the following words. It was noted that after sharing Scripture the client moved into much personal sharing and reflection. Visual imagery is also a technique that is used here, with scripture being the jumping off place for further exploration.

She asked me to share Scripture, which she had never been able to do before. And she had a particular Scripture which was meaningful to her. And then she disclosed that she wasn’t afraid and we were able to do some things in terms of visual imagery. I gave her a visual image about her struggle with shortness of breath. And I asked about the imagery of not being able to breathe and those moments when she couldn’t breath. So we went from surface, how is the weather, to the point of sharing when she couldn’t breath in her life, discovering that she had a history of domestic violence? And there was a lot of psychological leftover stuff and when he came into to the room she couldn’t breathe.

Another clinician discussed the use of Scripture in clinical work with the bereaved. Only after the client had considerable time to talk and ventilate was Scripture mentioned by the clinician. The clinician was asked a question to which he did not know the answer, and his willingness to admit such was as a prelude to the use of Scripture.

I let her talk and all this came up...she asked me a question. She said “you don’t have to answer” and I said, “I don’t know the answer, will you ask the question again”. She put it in terms of, “what do you think, what do you believe?” I said, “I don’t know, well, lets see just what scripture says in regard to this”. So I opened the Bible and read a few verses to her and she found those very helpful to her and its something that she shared with
her husband. I always have a Bible available, I don't carry it into the home when I make a visit but it is in the car.

Prayer is another theme that emerged in my discussions. The following quotations discuss prayer in a way which is specific to a Christian context. It is also included here that religious realities can block or assist the progress of grief work as well as the issue of being sensitive to the needs of others when prayer is offered.

One thing that was very helpful that I do share with Christian people is praying through...many say it is helpful because one of the things is to acknowledge your loss before God and everything that is, you know, your anger. Be honest God, don't hesitate to tell him how terrible it is. I take cues from the client to enter into religious aspects. Anything that in a person's religious background may block progress or move the progress.

I may ask them, would you like for me to pray, or would you like to for us to close in prayer? And I asked her yesterday, would it be all right if I prayed for you right now? And sometimes, Bob, it is not a matter of praying for you. I may ask them, how can I pray with you? What is there that you feel the need for. And recently, one of our patients told the admitting nurse: "I'm not a religious man, I don't want any preachers coming out here". And she told him "Well, he is not a Bible thumper" and he said it would be all right. I was the second preacher in their life that he ever said he liked. His wife said, "He likes you, you pray with him the way that he wants to be prayed for...You see, this is a change. This is one of the changes I have made in the last few years. Being sensitive in prayer...not preaching at them, telling them what they need. I ask them, "What can I pray with you for?"

Rituals have an importance place in grief and bereavement. The following quotation refers to creating of rituals while at the same time being intention not to contribute too much to the therapeutic process. The metaphor offered here is the clinician as a guide who doesn't get in the way of the client's trajectory.

It is a metaphysical and physical happening. I feel like I can contribute in that situation, maybe a ritual, or a holding of a family member that makes me feel good in being able to give...to stay quiet, to stay away, to stay
close, to say a few words. I purposefully don’t say a lot. I flow with the
flow, giving people permission to cry, to laugh, to tell their stories, to
touch or if they don’t want to touch. It is being a guide without getting in
the way in the way that I wouldn’t want anyone getting in the way for
me...I do become an authority to some people, a religious authority or a
hospice authority.

A clinician offered hope that as theology and psychology are integrated in grief
counseling and therapy the fragmentation between these two disciplines may be healed, or
as it is stated, possibly we can “turn the tide” of such fragmented disciplines.

It is worth noting that working with the dying and grieving is the place
where psychology and theology meet. Just being on that threshold
between life and death brings things into simplicity that we usually keep
pretty fragmented. I am hoping that that working with people who are
dying or grieving can turn the tide so that we can get a nice backsplash into
the rest of life, so that our practice can be more integrated, not just dealing
with death issues but life issues.

For people within the Christian tradition eternal life is an issue that was discussed
by a clinician in the following way.

Another theme is scripture and where they find hope in scripture. Passages
that are important to them for a variety of reasons. The issue of eternal life
is important for people who are of the church, and we talk about eternal
life and we talk about how the person who died might wish for those who
have been left behind would want you to live from this day forward. For
instance, would they want you to be stuck in grief, not caring for your
children, not working, or would they want you to resume a normal life in
memory of them...consistently I let them know that they are in my prayers.
I always give resources to people who are bereaved. One of things that
people are feeling when they have lost someone is abandonment. And I say
to a person that I will visit you in a week and I don’t call and don’t go not
only have I broken trust, I have done the same thing that the person who
died, I have abandoned them.
My reflexive journal included the following words about spirituality. These words brought together my ponderings about spirituality, and they tell of my own struggles and doubts.

As a Lutheran Pastor I have much intellectual solidarity with skeptics, agnostics and doubters. I concomitantly remain committed to life within the Christian community and due to my ordination sense a responsibility to the two thousand year tradition of the faith. I am fascinated by the spirit of secularity and am keenly aware as a therapist that spirituality and religion can be either a significant healing or wounding experience. In the tradition of Tillich (1952), I am curious about the windows that have been opened to the modern spirit and how the historic world religions can integrate with such and forge some creative reality, some healing nexus. I use spirituality and religion meaningfully with a few clients, rarely with most, and understand that much current psychotherapy is therapy without the psyche. Existential issues are certainly not in touch with managed care realities, and we all lose something as meaning is undervalued. I recall the starry night skies of Vincent Van Gogh, his depiction of common laborers, the abject expression on his self-portrait. His canvases are imbued with “God questions”, and the same is true of grief counseling and therapy as well.

Summary of Data Analysis

Seven themes emerged from the richness of the data that I collected in interviews with social workers and chaplains. As they work with adult bereaved persons, the quidity of the narratives forged these themes: therapeutic presence, clinical intuition, empathetic listening, formative experiences, meeting the client where he or she is, client confrontation and spirituality. The themes overlapped and were part of an organic whole that centered on how these clinicians help clients who are in grief. The moving language that they used, as well as the tones of voice and facial expressions, frequently spiced with illustrative gestures as well as subtle posture changes, sought to open up the profoundly important issue of
grief. The importance of these pages has to do with the topic itself, how do people reconcile themselves with grief? Death is a topic that challenges life itself, and I am close of a brief anonymous poem that a client gave me which I had framed and which hangs on my office wall:

In attending to death,
We learn much of value that enriches life.
And in preparing to die,
As we grieve fully, we learn
To live fully and well.

The fifth chapter, which follows, concludes this dissertation. In addition to a summary of this study as a whole, I will offer some trajectories for the future about grief as it relates to social work clinical practice and pastoral care. I will also briefly reflect upon some broader social realities and some deeper philosophical concern.
CHAPTER 5

CONCLUSION: EXTREME GRACE

I watched the psychic surgeon,
Stern, skilled, adroit,
Cut deep into the heart
And yet not hurt.
I watched it happen-
An act of extreme grace
And sovereign love.
From hell I entered Heaven
And bowed my head,
Where nothing had been suffered,
But all given.

May Sarton, from the Action of Therapy
(Sarton, 1978 p. 198)

This dissertation has been an inquiry into the treatment dynamics of grief counseling and therapy, as understood by social workers and chaplains who work in hospice settings with bereaved adults. Qualitative research methods have been used to enter into the phenomenological experience of clinicians who work on the edge of life and death as they assist clients in reconciling grief. Seeking what the clinicians do to help clients in this reconciliation, seven themes emerged from the naturalistic interviews: therapeutic presence, clinical intuition, empathetic listening, formative experiences, meeting the client where he or she is, confrontation and spirituality. My encounters with these ten clinicians was an encounter of subjects encountering other subjects, “thou’s” who expressed the acts of “extreme grace”
which Sarton writes about above. Indeed, my interviews were experiences of “extreme grace” and my response was to frequently “bow my head.” As these pages come to a close I want to “bow my head” one more time and offer some implications, questions and challenges for the future of social work clinical practice and pastoral care which have emerged from these many months of immersion in this project.

First of all, death and dying must be on the forefront of social work clinical practice and pastoral care. All of the clinicians that I interviewed for this study emphasized the importance of dealing with death, grief and loss. Social workers and chaplains work in many contexts, but the issue of death and dying is universal and impacts so much of life that attention to loss and grief is profoundly important no matter what the context is. While the ten co-participants had the sagacity to tell of the importance of dealing with death and grief in their personal and professional lives, another implication of this project is for social workers and chaplains to begin to come to terms with how they are dealing with death in their own lives. How we as helpers grapple with our own mortality is of profound importance as we work with clients in therapeutic settings.

In spite of what the presenting problem of a client may be, an individual’s history of loss may have impact on what they bring to a social worker. When a routine psychosocial assessment is done by a social worker in any context, I argue that part of that assessment should include a brief history of loss and grief. Loss can impact human beings in an emotionally profound manner and may be experienced in many ways, whether it is death, divorce, a geographical move or loss of a job. We all encounter loss in one way or another. As we grow through the life cycle, the movement from one era to another requires letting go
some realities, and this can be a loss issue for some individuals as well. In a sense, loss is universal, and therefore demands attention by all social workers. It is true: how a social worker copes with loss and has reconciled who or what is lost, how one integrates death into life, can have a profound impact all social work clinical practice.

As social workers can take loss into account in psychosocial assessment interviews, likewise, pastoral care specialists that are engaged in spiritual assessment (Fitchett, 1993) or pastoral diagnosis (Preuser, 1976) need to do the same. As one journeys into spiritual issues of depth and meaning, one's experiences with loss are of primary importance. Many rituals within religious traditions deal implicitly or explicitly with loss, and clergy should be intentional about including loss as a reality in various form of ministry.

The seven themes which emerged in this study raise implications for the future of social work clinical practice and pastoral care. The first theme, therapeutic presence, was discussed in my interviews as being both an art and a science, and social work education and seminary training could focus on how therapeutic presence is manifested. In our world of managed care with its emphasis on short-term solution focused psychotherapy, therapeutic presence remains as a necessary ingredient in the helping process whether treatment is short term or not.

The second theme, clinical intuition, also has implications for the future. In a therapeutic zeitgeist with its emphasis on empirical outcome measures, do intuitive realities have a place? Is there a way to operationalize the intuitive functions that are so important in therapy so that their value can be demonstrated? This is a complex issue that deserves attention beyond the limits of this project, but I argue that there are ways to demonstrate the effectiveness of the so-called "intuitive" issues in social work clinical practice and pastoral care.
While quantitative measures may be foreign to intuitive issues, certainly qualitative evaluation can focus on such. Also, how can we express to clinicians who do make use of the intuitive aspects of their personalities in counseling and therapy that what they do is valued and deemed of high importance? "Thinking outside the box" is a buzzword in contemporary parlance, but certainly intuitive right brain thinkers have something to offer our "high tech" cyber world.

A final implication here is to challenge clinical practice, both for social workers and clergy, to integrate the arts into their modes of treatment. Poetry and visual art, dance and music, bring much potential depth if they are integrated into how we work with clients.

The third theme that emerged, empathetic listening, raises issues which relate to both social work and seminary education. Learning to be a good listener, learning to be empathetic, can be hard work, and how can clinical settings be created for both social workers and clergy which help students deal with their own issues which can get in the way of being a skilled empathetic listener? This is not necessarily a traditional class room issue in graduate school and more of a clinical supervisory issue in the field, but I do not have confidence that such is always dealt with in helpful ways. Experiential learning may be the best possibility here, but that sometimes flies in the face of traditional models of pedagogy.

The fourth theme, formative experiences, has profound implications for social work clinical practice and pastoral care. How can we become "wounded healers", individuals who may be hurt but have gone through the process of healing? For example, how can a social worker in the midst of mid-life wrestling make use of one's past in ways that are both clinically helpful and personally fruitful? The professions of social work and ministry, in professional development contexts, can strive to at help clinicians come to terms with their own stories,
their personal mythologies, so that there is a link with one's past and present. In a sense, one's formative experiences are not just from one's early childhood, for as a growth oriented professional and personal formation takes place throughout the life span. How can the professions of social work and ministry foster such a growth orientation?

The fifth theme, meeting the client where he or she is, continues to be all the more important in our times. The question is, since some solution focused short-term therapy is sometimes directive in nature, how do we truly meet the client where he or she is? How does meeting the client become more than just a cliché? This was a very important theme that emerged as I dialogued with my ten co-participants, and it remains as a cardinal rule in clinical work, both for social workers and clergy.

The sixth theme, confrontation, raises questions about how clinicians confront clients in skilled ways. My conversations for this dissertation showed that client confrontation is done in many ways by different clinicians, but all agreed that it has a significant place. As a clinician, how do I find my style of client confrontation? How do I keep my anger issues from negatively impacting how I confront clients? Also, the issue of the therapist's self-confrontation emerged and I wonder how therapists can best learn to be self-observers? To be aware of the dyadic process in which confrontation takes place between a client and a therapist moves from an intrapsychic focus to an interpersonal focus, and this movement to another level of system is integral to clinical practice. Also, confrontation of both the self and the client raises supervision issues for both social work and pastoral care.

The final theme, spirituality, has many implications for the future of social work. If social work is to be truly wholistic in its approach, spirituality must be included within the
realm of social work concerns. Spirituality must be included as a treatment issue when the client raises such, and even though the Diagnostica and Statistical Manual of Mental Disorders IV does not include a diagnosis that allows spiritual issues to be reimbursed by insurance companies, spirituality remains a significant clinical issue for some persons.

The chaplains whom I interviewed understood how spirituality and religion may or may not refer to the same realities for some individuals, and the challenge for the future of pastoral care is to broaden what spirituality means in ministry settings. I argue that existential issues of meaning and depth can be a helpful way to integrate spirituality in the lives of many modern people. Individuals who may be alienated from traditional church, synagogue or mosque settings may find much spiritual depth if they are engaged by a chaplain who works out of an existential framework.

Another implication of this study has to do with death anxiety. Philosophical theologian Paul Tillich (1952) has pointed out that there are three types of existential anxiety: 1) anxiety about fate and death, 2) anxiety about emptiness and meaninglessness and 3) anxiety about guilt and condemnation. An implication for clinical practice is how to include existential anxiety as an issue in treatment with clients who suffer from concerns related to fate and death, emptiness and meaninglessness, and anxiety and guilt. Of note here is that social work clinical practice and pastoral care that accepts existential anxiety as a significant clinical issue transcends symptom removal as a focal point in therapy. This is treatment that is growth oriented and reflected in nature. To wrestle with the human condition is to come to terms with meaning issues, and both social work practice and pastoral care are invited to such issues. An understanding that both death and dying as well as grief and loss are important clinical issues
concomitantly encourages clinicians to be open to existential issues in treatment settings. This is not to say that a social worker or chaplain directs the clinical interview toward existential issues, rather, if the client brings issues to treatment which relate to spirituality, existentialism can be an appropriate method for entering into such themes. Such a counter-cultural perspective that values meaning issues is certainly out of step with much of our current therapeutic zeitgeist, but the results of this dissertation call us to take spirituality and existentialism seriously as issues for clinical practice.

As I heard clinicians tell their therapeutic stories of grief and loss, another implication emerged. Lantz (2000) has pointed out the differences between primary and secondary existential reflection. Primary existential reflection has to do with concrete problem solving while secondary existential reflection has to do with meaning and purpose. Lantz (2000) argues that both have a place in social work practice, and I argue the same for pastoral care. This study, with its inquiry into the dynamics of the treatment of grief and loss, points to the necessity of both primary and secondary existential reflection. Some people dealing with loss need assistance with basic life issues, how to balance the checkbook or to shovel the snow now that they are alone. Other clients bring such practical needs to treatment and then choose to move into issues (secondary existential reflection) like “Who am I now that she is gone? Do I have a purpose in life now that I am no longer a caregiver for a terminally ill person?” An implication for the future of social work clinical practice and pastoral care is to make use of both primary and secondary existential reflection. It seems that with the current demands on clinicians, the concerns of secondary existential reflection can be abated, and it is my hope that the existential is not neglected in treatment by either social workers or chaplains.
To take existential issues seriously in clinical social work practice is to challenge the human service system. In a radical sense, which gets to the root of an issue, human service systems that ignore questions of meaning are dehumanizing. It becomes an occupational hazard of social workers to develop an “agency mindset,” and this study raises implications that go beyond the limits and day-to-day routines of bureaucratic organizations.

This dissertation concludes with words about what I have experienced as I worked on this project. In the literature review I read what the “masters” had to say about grief counseling and therapy, and that stimulated me to think in new ways. In the interviews with ten vibrantly alive clinicians I experienced what May Sarton (1978) called “extreme grace” that caused me to have a “bowed head.” They stimulated me to feel and think in different ways. Some of my grief that relates to my mother and father’s death is bled into these pages, and I feel a tad more comforted in my loss by what I have learned. In another sense, I also miss them all the more. I know that my life may be over before I finish this sentence, and with an occasional moment of courage I continue typing nevertheless. With a sly smile and a touch of melancholy, I close with the words of a long lost friend from my boyhood years in the Panhandle of Florida. He died while collecting driftwood, but prior to that he penned these words of “extreme grace”.

As the sizzling sun sets over the blue-green hues of the Gulf
I hear a quiet and distant song.
Beneath the rolling swells of the warm water,
In the coming darkness of the night
The song surf will never cease.
The holy is incarnate in that song
About the inevitable loss of day
And the birth of the night.
In that surf, shadows and song,
The loss of day is mourned
And darkness is embraced,

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From the darkened song of the surf
There I will find life.
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