

Running head: THERAPISTS' USE OF CONTINUING BONDS

THE DEAD IN THERAPY: THERAPISTS' APPROACH TO CONTINUING BONDS
IN TREATMENT

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ABSTRACT

As a universal and deeply painful experience, helping clients deal with the loss of a loved one is an issue most psychotherapists will encounter during their careers. As part of treatment, practitioners will have to make clinical decisions about whether and how to encourage or discourage clients' connection to the deceased as they move through the grief process. This decision-making process engages a debated topic in the literature, whether to follow an older model of decathexis of bonds or a newer one of continuing bonds. This study explored the experiences and approaches of psychotherapists who specialize in bereavement. Nine licensed psychotherapists with significant experience working with death and grief were interviewed about their work, with particular emphasis on how they incorporate clients' relationship with the deceased into treatment. Four areas of inquiry were addressed: 1) Participants' personal and professional education and training in the treatment of grief, 2) Participants' familiarity with and understanding of the theoretical literature on working with clients' ongoing relationship with the deceased, 3) Participants' ways of conceptualizing bereavement with respect to the relationship to the deceased, and 4) Participants' approach to treatment with respect to bereavement and the ongoing relationship. A qualitative study design was employed and data were analyzed using grounded theory methodology. Themes identified included: the lack of formal graduate training on bereavement and the relative importance of personal experiences, experiential learning, and post-graduate education; the convergence of participants' conceptual frameworks and intervention techniques with the literature on continuing bonds; the inhibitory and complicating effects of cultural attitudes on healthy grieving; and the importance of psychoeducation in treatment with the bereaved. The

findings of this study suggest important implications for practitioners and the field including: the need for more formal training on death and grief in graduate programs; the importance of adopting an open and accepting stance when working with the bereaved; the importance of attending to all aspects of bereaved clients' relationship to the deceased; the need to provide psychoeducation about the grief process; the need for the field to bridge the gap between the research and practice communities; and the potential for professional organizations to take a more active role in correcting misconceptions and in disseminating accurate information about death and grief to the public.

DEDICATION

To my mother, Judith Hope Glassman. Losing you was so painful, but finding you once again has brought me peace, strength, and joy. I was truly blessed to have you for the first eighteen years of my life, and I carry you with me and get to know you more and more as I continue to grow.

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Chapter I: Introduction and Background

Statement of Purpose

The death of a loved marks a universal experience that will impact every person at some point in their lives. The painful and often difficult experience of grieving and adapting to such a loss often motivates the bereaved to seek professional help from a mental health practitioner (Rubin, 1996). One aspect of the grief process that may surface in psychotherapy is the extent to which the bereaved holds on versus lets go of their connection to the deceased. The relative health of holding on versus letting go has been a major debate within the field of death and grief studies. For most of the 20th century, prominent theories of grief viewed severing the connection to the lost loved one as necessary to healthy adaptation. In fact, an ongoing internal relationship was viewed as exclusively pathological (Klass & Chow, 2011; Silverman & Klass, 1996). In the 1990s a shift took place in the field in which theories emphasizing relinquishing bonds were replaced by those that stressed continuing them (Field, 2006; Rubin, Malkinson, & Witztum, 2012; Shear, Boelen, & Neimeyer, 2011). New theories conceptualized a continued bond as not only normative, but potentially beneficial. Several current treatments for complicated grief incorporate some aspect of harnessing the continued bond in order to facilitate adaptation to the death (Shear, Boelen, & Neimeyer, 2011).

Despite the dramatic paradigm shift within the literature from severing to maintaining ties, it is largely unknown how this change has impacted practitioners. Historically there has been a large gap between the research and practice communities within the areas of death and grief (Klass & Marwit, 1996). As such, the conceptual frameworks and activities of grief therapists in the consulting room have remained

largely unknown (Klass & Walter, 2001; Neimeyer & Harris, 2011). Only a few studies have examined practitioners' understandings of grief and how they incorporate these understandings into their practice (Breen, 2011; Hatton, 2003; Payne, Jarrett, Wiles, & Field, 2002). However, none has looked specifically at how practitioners think about and work with continuing bonds in therapy with the bereaved.

The current study seeks to extend previous research on the practice of psychotherapists specializing in grief, and to illuminate how they incorporate continuing bonds into their work in particular. Using semi-structured interviews and a qualitative research design, the study explores the experiences and practice of nine grief psychotherapists with respect to working with the bereaved's ongoing relationship to the deceased. It is hoped that the findings derived from their collective experiences will begin to narrow the gap between what is written in the literature and what takes place in the consulting room, and will additionally help practitioners better serve the needs of the bereaved.

Review of the Literature

From breaking bonds to continuing bonds: a historical perspective.

The death of a loved one is one of the most painful and universal human experiences. Many people intuitively understand that the relationship with the deceased continues on beyond death. At the very least, the bereaved continue to recollect and imagine those whom they have lost, and some develop an even more interactive and layered relationship with their loved ones (Rubin, 1996, p. 225).

Despite the normativity of some type of continued engagement with the deceased, the mental health profession conceptualized this phenomenon as a symptom of

unresolved or even pathological grief for much of the 20th century (Klass & Chow, 2011; Silverman & Klass, 1996). In *Mourning and Melancholia*, Freud (1917) laid out what became known as the “decathexis” or “severing ties” model of bereavement. According to this theory, healthy adaptation to loss consisted of breaking bonds with the deceased in order to reinvest, or cathect, one’s energy in creating new ties to living objects. The initial period of grief was spent mourning and then releasing the bond to the deceased, freeing up the bereaved to reformulate their relational ties so that they were exclusively directed toward the living and no longer included the deceased.

This model of grief dominated the mental health profession for nearly one hundred years (Klass & Chow, 2011; Silverman & Klass, 1996). Theorists and practitioners viewed any deviation from the decathexis model as a sign of pathological grief. They did not distinguish between types of bonds that served to deny the reality of the death and those that did not, or those that prevented the bereaved from investing in new relationships and those that did not; in their view, a continued tie to the deceased could serve no adaptive function whatsoever (Silverman & Klass, 1996). Connection to the lost loved one provided no psychological benefit to the bereaved in this perspective, and so any investment in the tie was wasted and misplaced. The prevailing method of distinguishing healthy grief from pathological grief was the presence of a continuing bond to the deceased, with the continuing bond representing the bereaved’s failure to “move on” and invest in new relationships (Klass & Chow, 2011; Silverman & Klass, 1996).

The literature on bereavement counseling and therapy stemming from this school of thought emphasized helping the bereaved patient to sever ties with the deceased

(Stroebe et al., 1996; Zech & Arnold, 2011). Grief was seen as something that needed to be “worked through,” and once this was accomplished, the bereaved could return to normal functioning with no remaining relationship to the deceased. There was little or no consideration given to helping the bereaved integrate the loss or the deceased into their lives over the long-term. Specific interventions employed by practitioners, which Silverman and Klass describe as sometimes “brutal” (1996, p. 5) were geared towards confronting the patient with the finality of the death and forcing them to let go of any ongoing connection to the deceased, such as throwing away the deceased’s possessions (Zech & Arnold, 2011).

Over the course of the 20th century, the gap between prevailing notions of healthy grief and the lived experiences of the bereaved meant that those seeking treatment for difficult bereavement were left no space to hold on to the essence of the deceased (Worden & Winokuer, 2011). However, a shift began to take place towards the end of the century, although it would take another decade or so before it would gather steam. One of the earliest and most prominent figures to put forth the notion that continuing bonds could be adaptive was John Bowlby (1980), who proposed that a continued attachment to the deceased could provide a sense of continuity in the life of the bereaved, and could even help facilitate healthy adaptation to loss. Some early research was beginning to appear showing that continuing bonds were actually quite common and were not necessarily manifestations of a failure to adapt to loss.

It was not until the 1996 publication of the edited volume *Continuing Bonds* (Klass, Silverman, & Nickman) that continuing bonds as a normative and potentially healthy adaptation to bereavement became a major position among grief theorists. Klass,

Silverman, and Nickman were all trained in the traditional decathexis model, but found that its tenets contrasted with what they observed in their research and clinical experience (Wortman & Silver, 2001). They brought together numerous studies showing that across many populations of bereaved people, continued connection to the deceased was not only the norm but could also be adaptive. The subjects of in these studies expressed their ongoing ties to the deceased in various ways and these relationships held different meanings for them.

In their longitudinal study of children who had lost a parent, Silverman and Nickman (1996) found that the majority of the children they studied maintained relationships with their deceased parents, and that these relationships evolved over time. The children used a variety of strategies in order to maintain a bond, including keeping special objects of their parents, experiencing a sense of presence, and conversing with the deceased. Using the same data set, Nordmand, Silverman, and Nickman (1996) identified four different types of connections: seeing the parent as a visiting ghost, holding on to memories from the past, maintaining an interactive relationship, and becoming a living legacy. The children in the study tended to develop more elaborate and adaptive connections with their deceased parents as they grew older and their grief lessened, moving from more concrete types of connections to internalized representational ones. Notably, this shift tended to correspond with greater adaptation and resolution of the loss.

In children who lost a sibling, the bereaved child might engage in a number of activities that served to maintain their relationship to the deceased. Some children kept “spiritually in touch” with their lost loved one by giving them updates on their lives and

on how other family members were faring. Others sought guidance on difficult matters related to daily life and to growing up, while yet others tried to carry on their deceased siblings' legacies by continuing working towards dreams that they never got to achieve while alive. The authors observed that the children who maintained ongoing attachments to their siblings experienced increased resiliency and were able to grow from the loss, including gaining a greater sense of self and responsibility to others. The continued bond also helped facilitate adaptation to the loss, because as the bereaved children began to reconstitute their relationships to their siblings in spiritual terms, it made it easier to accept the finality of the loss (Hogan & DeSantis, 1996).

Separately studying the experiences of widows, Moss and Moss (1996) and Conant (1996) both found further evidence of the normativity of continuing bonds. Moss and Moss observed that while certain concrete aspects of the relationship to the deceased husband might be relinquished, such as a shared last name or family home, many widows continue to maintain an emotional tie to the deceased even after remarriage. Conant's (1996) results were similar to Nordmand, Silverman, and Nickman's (1996) findings regarding children. Specifically, Conant found that among a group of widows participating in a self-help group, the majority maintained a connection to their husbands, and that this connection changed over time and facilitated adaptation to the loss. The widows employed various strategies, including experiencing the presence of their husbands, conversing with them, and incorporating their values and qualities into their sense of self. This served to provide both comfort and company as the women in the group dealt with the death and the new life demands placed on them as widows and single parents. It also increased their experience of felt security and helped them regain a

sense of control over their lives that had been threatened by the untimely deaths of their husbands.

Evidence of the presence of continuing bonds was found for bereaved parents as well. Rubin (1996) found that parents who had lost their adult children frequently maintained a connection to the deceased, and also that this relationship influenced the parents' self-systems and interpersonal lives, as well as their ability to adapt to their current lives. In many cases, there was a feedback loop where the relationship to the deceased influenced their relationship to their current lives, which then influenced their relationship to the deceased.

Whereas the research previously described focused on a single population and type of bereavement, Marwit & Klass (1996) opened their study to college students who had lost any significant loved one. When asked to write about the role the deceased continued to play in their lives, the participants were all able to elaborate on this subject. If the deathtaxis model were representative of people's experiences of bereavement, one would have to conclude that all of these students were experiencing pathological grief. To the contrary, the authors did not find any relationship between the intensity of the attachment to the deceased and the resolution of grief. Rather, they found that the only variables that meaningfully predicted degree of resolution of grief were those that had already been established, namely closeness of the relationship to the deceased and suddenness of the death.

Taken together, the collection of findings in *Continuing Bonds* (Klass, Silverman, & Nickman, 1996) provide strong evidence for the thesis of that volume, namely that a large enough proportion of bereaved people maintain an ongoing connection to the

deceased, whether through sense of presence, conversations, or internalization of values, and that the presence of continuing bonds should not be considered pathological.

Continuing Bonds was a seminal and groundbreaking work. Over the next decade and a half, the continuing bonds perspective gained wide acceptance in the field, and is now considered an important aspect of working with the bereaved (Rubin, Malkinson, & Witztum, 2012; Shear, Boelen, & Neimeyer, p. 158-9; Field, 2006).

The rapid paradigm shift from breaking bonds to continuing bonds was possible in part due to a broader shift from modernist to a postmodernist ways of thinking. At the core of this shift was the growing recognition of how what is considered normal and appropriate is relative and is greatly influenced by culture. Grief is one of the many aspects of human social and emotional life which is regulated by culture (Klass & Chow, 2011). Historical and cross-cultural analyses show that what is considered healthy with regard to adaptation to bereavement and relationship to the deceased has varied greatly over the course of human history, and that the severing bonds paradigm that was dominant in 20th century western culture is in the minority (Klass & Walter, 2001). Studies of contemporary Eastern cultures, including the Japanese, Egyptian Muslims, Balinese Muslims, and Hopi Native Americans have found that in these societies, a continued bond to the deceased is considered normal (Stroebe & Schut, 1996). Even within Western history, the continuing bonds paradigm previously dominated. During the 19th century, romanticism was the predominant school of thought, and the romantic notion of grief was one of continued sentimental attachment and holding on to the deceased. In this paradigm, the length and intensity of grief signaled the importance of the relationship, and to sever that bond would indicate a superficial relationship. For

many years after the death of a loved one, individuals during the romantic era engaged in elaborate rituals that served to maintain the bond to the deceased (Klass & Chow, 2011; Stroebe et al., 1996). Death was viewed as a life-changing event after which the bereaved would go on living with a “broken heart,” perhaps for the remainder of their lives. (Stroebe et al., 1996).

As the romanticism gave way to modernism, the decathexis model came into favor. The notion of breaking bonds was more compatible with modernism sensibilities in psychology, which employed the machine metaphor of the human mind. Grief disturbed the homeostasis of the machine, and the goal of treatment was to restore functioning to homeostatic levels. In order to do this, bonds had to be broken (Stroebe et al., 1996). Despite the dominance of the modernist breaking bonds model of bereavement within the field of psychology during the 20th century, a significant portion of bereaved people during that period continued to engage in romantic grief behaviors and held fast to their connection to the deceased (Stroebe et al., 1996). Klass & Marwit (1996) attribute this mismatch between the field and the public to the tendency to define healthy versus unhealthy grief based on theoretical models without incorporating research on the experiences of the bereaved.

A continuing Bonds theory of grief.

Now that the pendulum has swung back towards continuing rather than breaking bonds, writing and research on this phenomenon have flourished. The term “continuing bonds” has been developed and elaborated upon such that it has now come to serve as an umbrella term for a rich set of psychological, interpersonal, and behavioral processes that serve to retain the bond to the deceased. Broadly considered, continuing bonds can be

defined as the way in which the bereaved “remembers, internalizes and maintains psychological involvement” with the deceased (Rubin, Malkinson, & Witztum, 2012, p. 10). The psychological involvement is both conscious and unconscious, and tends to evolve over the life course (Rubin, 1996). The processes of representation, accompaniment, and separation that everybody experiences with representations of living people also govern the relationship with the deceased, such that a bereaved person needs to undergo separation-differentiation from the deceased and experience the deceased as a whole object in the same way as they would the living in order to have an adaptive relationship (Rubin, Malkinson, & Witztum, 2012).

Within the continuing bonds paradigm of grief and mourning, part of healthy adaptation to grief involves accessing and developing the relationship to the deceased. This can be quite difficult for the bereaved, especially in the presence of intense yearning to physically rejoin the deceased: “It is a paradox that our desperate struggle to get them back ‘out there’ can blind us to the fact that we never lost them ‘in here’; those we love literally do ‘live on’ in our memory” (Neimeyer et al., 2011, p. 4). The task of grieving involves arriving at the realization that “we never lost them ‘in here’” and reworking that relationship to account for the loss of the physical presence of the deceased so that it is integrated into the bereaved’s past, present, and future life narrative. This process can proceed non-linearly, and will fluctuate over time. The bereaved will likely have to reengage in this process during major life milestones and at different developmental stages (Rubin, Malkinson, & Witztum, 2012). According to Rubin (1996), this is a lifelong process and thus adaptation, which implies an endpoint, is not an appropriate term. He chooses instead the word resolution (see also Silverman & Klass, 1996). The

relationship to the deceased continues to evolve throughout the lifespan in a fashion that parallels those with the living: "While the death is permanent and unchanging, the process is not" (Silverman & Klass, 1996, p. 18-9). However, there is one key difference in the relationship to the deceased: the absence of any present or future interactions with the loved one leaves the entire burden of the relationship on internal psychological processes. In order for the relationship to reach a state of resolution, the bereaved must resolve any conflicts, disruptions, or disturbances in his or her internal relationship to the representation of the lost object. Rubin believes that "The greater the comfort and fluidity with which the bereaved recollects and remembers the deceased, the more appropriate it is to use the term 'resolution' in the context of loss." Unresolved grief, by contrast, persists when there is "intensity, conflict, depression, or anxiety engendered by thinking of the deceased" (Rubin, 1996, 220-1).

In cases of unresolved grief, the bereaved is unable to construct a meaningful and adaptive relationship to the deceased. For those who are able to reach a stage of resolution, the relationship to the deceased acts positively to allow them to continue on in their lives without the physical presence of their loved one. One essential function of continuing bonds is to reflect and affirm our sense of self. When they are alive, loved ones transmit messages to us about who we are, and these messages are integrated into our sense of self. The same can be true after a loved one has been lost. Those who have achieved an adaptive bond can continue to draw on the internal representation of the deceased in order to maintain self-esteem, and affirm a whole and cohesive self. Those who cannot access the relationship or who experience negative thoughts and feelings about themselves when recollecting the deceased, or for whom the thoughts and feelings

associated with the deceased clash with the experience of the self, are more likely to experience difficulties in reaching resolution (Rubin, 1996; Rubin, Malkinson, & Witztum, 2012).

In addition to self functions, the continuing bond can also serve a secure base function. The ongoing relationship to the deceased can provide a sense of grounding and of felt security. In relating to the deceased, the bereaved is able to induce a sense of felt security and comfort (Rubin, 1996). The secure base function played by the continuing bond is crucial in facilitating adaptation to loss, because the internalized self-compassion, self-soothing, and caregiving functions allow the bereaved to face the challenge of living without the bereaved. The internal representation of the deceased serves as a secure base from which the bereaved is able to venture away as he or she explores this new life, all the while continuing to feel “held” by their loved one (Field & Wogrin, 2011).

Finally, the internal representation of the deceased can also serve as an object of identification in the presence of a healthy ongoing relationship. This may consist of internalizing values and ideals which give the bereaved a sense of inspiration or guidance as they continue on in their lives (Field & Wogrin, 2011). However, not all forms of identification are positive or adaptive. In the same way that identification with the living can be either healthy or pathological, so too can those with the deceased. Overly rigid, frozen, or introjected forms of identification can be problematic and potentially hinder the adaptation to a loss (Silverman & Klass, 1996).

As can be seen from the above discussion, although continuing bonds are normative, they are not necessarily adaptive (Field & Wogrin, 2011). Like any relationship, they can range from largely healthy to highly problematic. A review of the

effects of continuing bonds on adaptation to loss was inconclusive, with the authors charging future researchers to empirically disentangle different types of construction of the continuing relationship in order to determine which characteristics of the bond are adaptive and which are not (Stroebe & Schut, 2005). There is growing theoretical consensus that unhealthy continuing bonds are characterized by rigidity, denial, and avoidance (Field & Wogrin, 2011; Field et al. 2005; Normand, Silverman, & Nickman, 1996; Rubin, 1996). In maladaptive continuing bonds, the deceased might be rigidly idealized rather than experienced as a whole object. The representation might also remain frozen despite changing input and demands from the bereaved's outer world. In addition, the relationship may serve as a substitute for relationships with the living, allowing the bereaved to avoid investing energy in current relationships. Perhaps most importantly, any type of continuing bond which serves to deny the finality of the death or which indicates a failure to relinquish the goal of gaining physical proximity is likely unhealthy and will increase distress. These types of relationships allow the bereaved to dissociate the mental representation of the deceased, in which he or she is living, and the intellectual knowledge that he or she is dead. While somewhat normative in the early stages of grief, in later stages these types of bonds signal a failure to adapt, accept reality, and to move forward. Expressions of such a relationship might include hallucinations or delusions, which demonstrate disbelief in the death, or holding onto the possessions of the deceased, which indicates being stuck in a fantasy that the deceased will return. They can also include defensive constellations that allow the bereaved to deny the finality of the death, such as excessive guilt, identification with the pain of the deceased, or obsessive use of linking objects in an attempt to undo the death (Field & Wogrin, 2011).

By contrast, in adaptive continuing bonds, the relationship with the internal representation of the deceased coexists alongside the knowledge that he or she is no longer physically present. Rather than futilely seeking physical proximity, the bereaved who is engaged in an adaptive ongoing relationship is able to gain psychological proximity through such processes as identification, recollecting, and drawing on experiences of feeling cared for and loved in order to induce a state of felt security (Field et al., 2005). In order to construct a healthy bond to the deceased, the bereaved must not only relinquish the goal of physical proximity, but also accept the loss of any future expected or hoped for changes in the relationship (Field & Wogrin, 2011). This is especially true of bereaved parents who will never have the chance to see their children grow into adults, and in cases where a conflicted relationship can never be resolved with the deceased in the real world.

In addition, a healthy relationship is fluid and changes over time. The deceased is experienced as a whole object, and his or her memory is associated with positive thoughts and feelings, which are aligned with the bereaved's sense of self. Finally, the adaptive continuing bond coexists alongside rather than replaces relationships with the living (Rubin, 1996). Summing up the struggle of the bereaved to create a healthy continuing bond, Rubin, Malkinson, and Witztum (2012) write: "Because [the lost loved one's] existence was important to [the bereaved's] psychological well-being (in the present as well as in the past), there is a need to strike a balance between letting go of what can no longer occur, for example, the physical interaction involved in spouses' sexual intimacy, and the maintenance of the sense of significance and value that [the deceased communicated to the bereaved], which is not dependent on live interaction" (p. 9).

Clinical intervention from a Continuing Bonds framework.

Given the continuing bond's potential to facilitate either adaptation or distress, it has become an important area of focus in clinical approaches to treating patients who have been unable to achieve resolution following a loss. Certain types of continuing bonds hold the power to lessen the bereaved's pain and reorient them towards the future. As such, the relationship to the deceased becomes an important point of intervention for clinicians: "Reworking relationships...can function as an important key to allowing people to live on. This [work] assists them in taking up authorship of their life narratives, living fully in the world with themselves and others, and retaining the connection to the deceased" (Rubin, Malkinson, & Witztum, 2012, p. 84). In some cases, the focus of treatment might be on regaining access to a relationship to a loved one that has become disrupted or blocked after the death, while in others it might be on relinquishing unhealthy forms of the bond in favor of more adaptive forms. When patients are able to reorganize the bond to the deceased such that they can experience a positive internal connection with full acknowledgment of the death, they are better able to relinquish maladaptive behaviors and defenses which were being used to deny this reality and keep the deceased "alive" (Field & Wogrin, 2011).

Whatever the particular goal, it is clear that assessing and, when necessary, transforming the bereaved's continued connection to the deceased should be a feature of grief therapy (Rubin, Malkinson, & Witztum, 2012). This aspect of adaptation to grief was long neglected or even pathologized by mental health professionals, who tended to focus on symptomatology and neglect more nuanced indicators of distress as they related to the continuing bond (Rubin, 1996). Any approach which does not incorporate

continuing bonds, according to Rubin, Malkinson, and Witztum (2012), “is to risk missing one of the most fundamental features of interpersonal loss.” Beyond monitoring how the bereaved functions in the world, the task of the grief clinician is to recognize how the patient “reorganize[s] the relationship to someone important to [them] who is no longer living” (p. 9).

Several approaches to bereavement counseling now incorporate some type of continuing bonds interventions. In a 2011 review, Shear, Boelen, and Neimeyer identified five common elements among prominent bereavement treatments, including attachment, coping, cognitive behavioral, and constructivist therapies. In addition to increasing affect regulation and problem-solving skills, revising life goals without the physical presence of the deceased, confronting traumatic details of the death, and confronting avoidance behaviors, all of these therapies also included some element of “encouraging engagement with the image, voice, or memory of the deceased to facilitate a sense of ongoing attachment while allowing for the development of other relationships” (p. 158-9). The authors conclude that there is growing convergence within the field of grief therapy about the essential elements necessary for the successful treatment of unresolved grief, and work with continuing bonds is one of them.

Three well-known approaches to grief which incorporate continuing bonds are the task model of bereavement, cognitive behavioral therapy (CBT), and constructivist grief therapy (CGT). In the task model of bereavement, the bereaved continually revisits and reworks four interrelated tasks that are necessary to achieve grief resolution. These tasks include acknowledging the reality of the death, processing the associated pain, adjusting to a life without the physical presence of the deceased, and creating an enduring

connection to the deceased which allows the bereaved to also move forward. The latter task is clearly aimed at cultivating an adaptive continuing bond to the deceased.

Therapists working from this model aim to help the patient memorialize and continue to involve the deceased in their lives in a way that still allows them to embark on a life without their physical presence. With the help of the therapist, the patient finds “an appropriate place for the dead in their emotional lives—a place that will enable them to go on living effectively in the world” (Worden & Winokuer, 2011, p. 65).

In CBT, grief is conceptualized as the cognitive, behavioral, and emotional process of continually adapting to life without the deceased, and adaptation to grief means achieving “a balanced reorganization of life in which there is neither denial nor avoidance of the memories nor emotional flooding of the bereaved” (Rubin, Malkinson, & Witztum, 2012, p. 124). In cases where resolution has not been reached, the bereaved may experience flooding, avoidance, a sense of lack of control in their lives, or continued shock at the loss. CBT seeks to intervene in these cases by modifying problematic thoughts, feelings, and behaviors related to the loss, including those related to the relationship with the deceased. For instance, some of the common problematic cognitions present in unresolved grief include “I am a worthless person without [the deceased]” and “Life has no meaning anymore [without the deceased].” Both of these cognitions assume that access to the deceased is permanently lost. A CBT therapist would use cognitive restructuring interventions to replace these thoughts with more balanced ones, and in doing so, would help the patient rework their conceptualization of the relationship to the deceased to include continued meaning and involvement while also accounting for their physical absence (Shear, Boelen, & Neimeyer, 2011).

CGT also employs specific cognitive and behavioral interventions in order to strengthen or alter the bond to the deceased. The central focus of this therapy is on helping the bereaved reconstruct a sense of meaning in their lives after the death. The death of a loved one has the potential to shatter our understandings of the world, such as that the world is a safe place. Many bereaved individuals experience a loss of meaning in their lives following a death, and the aim of the CGT therapist is to help the patient construct meaning around the death and in their new life without the deceased. Because relationships are a crucial source of meaning in our lives, one of CGT's focal interventions serves to restore felt access to the relationship, to work through residual conflicts at the symbolic level, and to retain the deceased as a constructive presence through conversation with others and through ritual practices. Interventions allow the patient to access the continued bond in a vividly experiential fashion. They may include having an imaginal conversation with the deceased, exchanging correspondence, and tracing the life imprint of the deceased on the bereaved in aspects of the bereaved's life ranging from mannerisms to core values (Shear, Boelen, & Neimeyer, 2011). By facilitating an adaptive continuing bond to the deceased, the therapist reconnects the bereaved to an important source of meaning in their life. Restored meaning is then assumed to aid in reaching resolution of the grief.

One therapy which heavily relies on work with the continuing bond is the two-track model of bereavement. This treatment takes a life-cycle perspective which addresses the effects of loss beyond the acute phases of mourning. According to this perspective, the loss of a significant loved one will impact the entire life course of the bereaved and may need continual revisiting and reworking throughout the life course.

Areas of focus are divided into two tracks: on track I are indicators of biological, psychological, and physical functioning, and on track II are indicators of the nature of the relationship to the deceased. These two tracks are somewhat intertwined and mutually influence one another, but Track II seems to be more relevant to later-stage bereavement when functioning has been largely restored but there is an ongoing difficulty in the relationship (Rubin, Malkinson, & Witztum, 2012).

The nature of the psychological construction and relationship to the deceased is assessed along three dimensions. The first dimension assesses the intensity and nature of the relationship: to what degree is the relationship sought out and focused on? Is there painful yearning for the deceased, or perhaps a wish to rejoin them? On the other hand, is there avoidance of thinking about the deceased or the relationship? How much time is spent thinking and talking about the deceased? The second dimension assesses the bereaved's experience of the deceased: how does the bereaved experience the deceased? What are the bereaved's thoughts and feelings when remembering the deceased? How does remembering the deceased affect the bereaved's sense of self? Finally, the third dimension maps the cognitive and affective content and organization of how the deceased is remembered. What are the images and sensations associated with thinking about the deceased? How emotionally close or distant does the bereaved feel to their memories of the deceased? To what extent is the deceased perceived positively? Are there active or hidden conflicts with the deceased? How is the deceased memorialized? To what extent does the bereaved identify with aspects of the deceased? How much emotional involvement is there with memories of the death itself? How flexible, powerful, or rigid

is the relationship? Does it interfere with functioning or processing the loss? (Rubin, Malkinson, & Witztum, 2012, p. 42-5).

A treatment focused on Track II of the bereavement focuses on finding a way to continue living a satisfying life with the memories and feelings associated with the deceased. The goal is to create accessibility and connection to a rich set of mental representations of the deceased without becoming stuck there (Rubin, Malkinson, & Witztum, 2012). The treatment makes ample use of transitional space, which lies between reality and fantasy. In this space, there is still cognitive awareness of the death but also freedom to move outside the constraints of reality in order to engage with the deceased. When the bereaved is rigidly reality-oriented, they may be cut off from important sources of emotional support derived from the relationship to the deceased. In the transitional space, however, the patient has the opportunity for “playful and creative engagement with possibilities and wishes outside the limits and demands of harsh reality.” Such engagement can include believing in an afterlife or continuation of the soul, which the person might reject when in a completely reality-oriented logical space. The patient may also feel freer to detect the “presence” of the deceased through sensations and signs, or to “talk to” the deceased. All of these forms of engagement involve blurring the distinction between the living and the dead but without losing sight of the reality of the death in the external world (Rubin, Malkinson, & Witztum, 2012). Work within the transitional space allows the bereaved to access the relationship and to rework it in cases where the bond is problematic. Even highly skeptical individuals may be surprised to find that they are able to slip into a transitional space in which they can

access their unconscious thoughts, feelings, and wishes regarding to the deceased, allowing the therapist to help rework them so that they are optimally adaptive.

Despite the burgeoning writings on therapy making use of continuing bonds, the current approaches remain largely underspecified. There is little writing on what the therapist actually does or says in order to facilitate and strengthen adaptive relationships to the deceased, leading Neimeyer and Harris (2011) to write “A closer understanding of the strategies by which [construction of an adaptive continuing relationship] is accomplished—perhaps by close process analysis of successful realignment of the relationship in grief therapy—would make an important contribution to future practice” (p. 411).

Cultural considerations in working with continuing bonds.

While the arguments for the use of transitional space to facilitate increased access to the continued bond are compelling, certain aspects of modern Western culture might make it more difficult for the bereaved to be open to exploring their connection to the deceased, let alone share their experience with a therapist. As members of the mental health profession, therapists are part of the social institutions which “police” grief and determine what emotions and behaviors are normal and appropriate within the culture. The mental health field has the power to label some manifestations of grief as “normal” and others as “pathological.” Patients can be hesitant to share experiences that lie outside the norms of the culture, for fear of being branded as “pathological” or “crazy” by a mental health professional (Klass & Chow, 2011).

Patients might be especially reticent to talk about an ongoing connection to the deceased because this is in conflict with the dominant culture: “As the modern Western

world has moved toward a more and more autonomous and individualistic definition of the self, it has tended toward valuing reality-based' behavior that precludes acknowledging any ongoing relationship with the deceased" (Silverman & Klass, 1996, p. 19). Our current secular rationalist culture provides a limited framework for continued relationships to the deceased, which usually incorporate some elements of spirituality or religion. Within the context of secular positivism, the notion of sensing the dead or drawing on the dead for comfort can be easily seen as abnormal or even pathological. Furthermore, the continuing bonds paradigm is somewhat incongruous with our culture, because it tends to value youth and autonomy rather than tradition and the notion of being guided by elders, especially deceased ancestors (Klass & Walter, 2001).

Some researchers who have studied people's relationships to the deceased have noted subjects' difficulty reconciling their relationships to a dead loved one with the dominant cultural framework, and also their hesitancy to discuss experiences that fall outside of the cultural norm. For instance, Bennett and Bennett (2000) found that in interviewing a sample of British widows, their subjects had to switch between competing materialist and supernaturalist discourses. Interpreted through the supernaturalist discourse, a moment of felt presence was really an instance of connection with the deceased. On the other hand, seen through a materialist discourse, the same occurrence would be viewed as a hallucination or some other form of psychopathology, or at best a fantasy. The widows frequently switched between the two discourses, even from one sentence to the next. They also tended to be reluctant to draw openly on the supernaturalist discourse, which would allow them to believe that their connection to the deceased was real. Fear of being judged led many subjects to switch into the materialist

discourse or to use evasive language in order to avoid coming out strongly as believing in supernatural occurrences while in the presence of the researcher.

Valentine (2008) observed a similar pattern in a different sample of bereaved individuals. She found that like Bennett & Bennett's, her subjects also had to negotiate between two distinct discourses, and that subjects were similarly embarrassed to disclose the continuing role the deceased played in their lives. They perceived their continuing bonds with the dead as unusual and failing to conform to societal norms. The author found that many of her participants were initially hesitant to discuss their experiences of a continued relationship and to first test her for trustworthiness. Some used qualifiers about the "reality" of their experiences, which allowed the subjects to share their incredible stories while maintaining their credibility as sane and normal. However, it also tended to dilute the power and significance of their experiences. Some demonstrated a perceived need to justify their ongoing bond to the deceased in front of the researcher, or questioned whether they should have moved on already, which they believed psychological wisdom would dictate. In another study of widows, Conant (1996) also found that subjects experienced a cultural tension in talking publicly about their relationships to their deceased husbands. Ongoing contact or sense of presence was associated with insanity. The subjects expressed fear that the broader culture would interpret sensing their husband's presence as such.

Both Valentine (2008) and Bennett and Bennett (2000) suggest that people may be especially hesitant to discuss their ongoing relationships with the deceased in the presence of strangers, particularly medical professionals who are likely to be associated with rationality and skepticism. "What one can be pretty certain of is that interviews

conducted by strangers will encourage respondents to opt into the materialist discourse they know will be safest and most acceptable, if for no other reason than that scientific researchers often assume that respondents share this worldview” (Bennett & Bennett, 2000, p. 154-5). These findings have important implications for therapy with the bereaved. It is likely that some patients will be especially hesitant to speak about experiences that fall outside cultural norms with a mental health professional, who is endowed with the power to label them as pathological.

Even within their social networks, the bereaved frequently hesitate to talk openly about their grief and their continued connection to the lost loved one. Klass and Chow (2011) attribute this to contemporary cultural norms. Around the time that the deathecism model came to dominate, grief was also transformed from a social process with many public rituals to an interior, individual one. In our current culture, few public customs remain for the bereaved beyond the funeral. As such, “continuing bonds are restricted to the private sphere, and grief remains defined as an internal psychological process” (p. 347). Both Valentine (2008) and Conant (1996) found that their subjects were more likely to engage in private rather than public displays of grief. According to Valentine, continuing bonds are taking on highly personalized and idiosyncratic forms rather than sanctioned religious rituals. Many of the bereaved in her sample focused on ‘everyday’ and personal ways of remembering the deceased rather than public ritual. Conant observed that among the widows he studied, there was a perceived pressure to keep grief hidden, as well as a perception that others were uncomfortable with their grief when they did share it.

The perceived lack of social support or space for their continuing bonds risks leaving the bereaved feeling isolated at one of the most painful junctures in their lives. Because of the limited space for integrating the dead into the lives of the living in our culture, bereaved people may find themselves unable to talk to others with whom they regularly interact about the deceased or their relationship to the deceased (Klass & Walter, 2001). This may not only leave the bereaved feeling isolated, but may also cut them off from important social sources of healing. Research has identified the potential for social processes to facilitate and strengthen a continued relationship to the deceased. Valentine (2008) observed that subjects felt that their relationships to the deceased were legitimized and affirmed by sharing them with others. Klass and Walter (2001) believe that there has been an increase in self-help groups among the bereaved, because these groups afford the bereaved an opportunity to discuss their relationships to the deceased openly and to have it affirmed by others.

In fact, in his research on the therapeutic factors of groups for bereaved parents, Klass (1997) found that it was the combination of the internal continuing bond and the external social affirmation of that bond that led to healing. Part of the parents' distress was due to the mismatch between their internal reality, in which they were trying to hold onto their child, and their external reality, in which it was socially unacceptable to discuss the bond to the deceased child. Once in the group with other bereaved parents, the participants received affirmation of that bond and a space to strengthen it. "As grief becomes resolved, the phenomena that indicate active interaction with the inner representation of the dead child...are no longer occasions for the parents' concern about their own sanity. The phenomena are accepted as a positive part of everyday living" (p.

169). Once the bond to the deceased child was sufficiently strong and secure, the parents were able to leave the group, believing that they had resolved their grief as much as possible.

Despite the potential and importance of the social processes of strengthening bonds and resolving grief, it has been relatively overlooked in the literature. Much of the research that flourished following the publication of *Continuing Bonds* defined the continuing bond as an exclusively individual and intrapsychic concept. This was not, however, consistent with the way Klass originally conceptualized this phenomenon. In responding to a special issue of the journal *Death Studies* devoted to continuing bonds, Klass (2006) wrote “As I read the articles in this special issue, the most obvious element missing is the social and cultural component of continuing bonds” (p. 848) and suggests that “we would learn a great deal more if much of the data presented in this issue were reinterpreted in a more social and cultural context” (p. 851).

As the concept of continuing bonds has begun to influence treatment approaches, little attention has been given to how the social aspect of therapy will impact changes in the relationship to the deceased. It is not known “how the communal creation of a place for the dead [as seen in groups] functions in...bereavement counseling...Whether counseling practice overall reflects the textbooks’ silence about interacting with the dead is not known because there has been no systematic research into what actually happens in one-to-one bereavement counseling” (Klass & Walter, 2001, p. 443). One potential barrier to successful continuing bonds work is cultural prohibition against speaking about a connection to the deceased, especially with a mental health professional, might inhibit potentially therapeutic processes.

Implications for the present study.

Despite the growing understanding of the nature and normativity of continuing bonds, there is minimal empirical research on therapists' use of a continuing bonds framework in clinical work with the bereaved. The sizeable body of literature exists on non-clinical samples suggests that continuing bonds are a common response to bereavement, and researchers focused on continuing bonds have written a number of case studies on how continuing bonds can be utilized as a point of intervention in clinical work. However, as of yet no studies have examined the broad array of experiences, applications, and approaches to continuing bonds work among practicing clinicians who work with the bereaved.

The purpose of the current study is to begin to fill this gap in the literature by exploring and clarifying common themes in the experience and process of doing continuing bonds work with the bereaved. This study is unique in the bereavement field and will provide valuable insights into how continuing bonds theory is currently integrated into practice and how it might further be integrated in the future. As Klass and Walter (2001) wrote over a decade ago, it is unknown whether practice reflects the lack of discussion in the literature about interacting with the deceased due to the lack of research in this area. Although the literature is no longer silent on this topic, there continues to be a lack of clarity about what takes place in the consultation room with respect to continuing bonds and bereavement therapy. It is hoped that the findings of the present study will illuminate current approaches to working with continuing bonds as practiced by therapists working in the bereavement specialty, which will allow for the further development of theory and technique.

Chapter II: Methods

Qualitative Research

The current study employed qualitative research methods in order to shed light on the experiences and techniques used by practitioners who specialize in treating grief.

Qualitative methodology was selected specifically because it allows for a richer and more detailed description of how therapists conceptualize and work with bereaved clients, and how they incorporate clients' continued relationship with the deceased into the therapy. Currently there is minimal empirical research on therapists' use of a continuing bonds framework in clinical work with the bereaved. The sizeable body of literature on non-clinical samples suggests that continuing bonds are a common response to bereavement, and researchers focused on continuing bonds have written a number of case studies on how continuing bonds can be utilized as a point of intervention in clinical work.

However, as of yet no studies have examined the broad array of experiences, applications, and approaches to continuing bonds work among practicing clinicians who work with the bereaved.

A qualitative research design was deemed especially suitable to provide a deeper understanding of practitioners' experiences in this area because these methods enable a more thorough exploration of a specific practice. Qualitative approaches seek to see experiences from the participants' point of view and to uncover how they ascribe meaning to those experiences. As such, qualitative methods enrich our understanding of a particular practice or phenomenon by staying near to its subjects' experiences. The themes and general understandings that come to light through the aggregation and analysis of the subjects' experiences can then be used to generate hypotheses for further study. In the current study, these methods were employed to paint a more detailed picture

of how practitioners specializing in grief incorporate work with continuing bonds into treatment.

Grounded Theory

The current study used grounded theory, a specific form of qualitative research. Grounded theory allows for the analysis of process and the construction of theory based on qualitative data. Unlike other methods of analysis that test ready-made theories and hypotheses, grounded theory methods aim to build new theories from the bottom up that are “grounded” in the data. In this approach, the theory emerges from the data through analysis. The end goal of grounded theory analysis is not to confirm or disconfirm a theory, but rather to develop a theory that is a sensitive and adequate representation of the data (Morse & Richards, 2002). Grounded theory also provides a highly rich description of a phenomenon and has the power to generate hypotheses for future research (Corbin and Strauss, 2008). The current study employed a modified version of grounded theory in order to reflect participants’ experiences and to develop theory from the data.

Participants

Participants were recruited through a networked sample of therapists who were known to specialize in and have significant experience providing services to bereaved clients. Participants consisted of nine licensed psychotherapists who fell into two categories: those in private practice who maintained a current caseload of at least half bereavement cases, or those who currently or previously worked for at least five years in a setting that provided services exclusively related to death and bereavement (e.g. hospice). A small sample size was used due to the study’s qualitative design and no control group was identified.

Three of the participants (33.3%) were psychologists and held doctoral degrees. One participant (11.1%) held a Master's degree and was a Licensed Professional Counselor, and the remaining five (55.6%) were licensed clinical social workers. The average number of years in clinical practice was 30.4 with a range from twenty-one to thirty-nine years. Two of the participants (22.2%) identified as male and the remaining seven (77.8%) identified as female. All identified as white. The average age of participants was 62.2 years old, with a range from forty-nine to seventy-three years. In terms of theoretical orientation, two (22.2%) identified as Rogerian/humanistic, two (22.2%) identified as psychodynamic/psychoanalytic, two (22.2%) identified as cognitive/behavioral, two (22.2%) identified as systems, and one (11.1%) identified as eclectic/integrative.

In terms of work settings, two of the participants (22.2%) currently worked in hospice and had worked there for ten and fourteen years, respectively. The remaining seven (77.8%) were currently in private practice. Of these seven, four (57.1%) maintained practices with at least half bereavement cases (mean=60%, range=50-80%). The remaining three in private practice (42.9%) maintained more general caseloads with a minority of bereavement cases. However, these three practitioners, along with one in private practice who continued to see a majority of bereavement cases, had all previously worked in settings that provided services to the bereaved. Three participants had worked previously in hospice for an average of fifteen years (range=12 to 20 years) and one worked for eleven years at a non-profit organization providing mental health services to gay men and their families impacted by the HIV/AIDS crisis.

Below are brief descriptions of each of the participants. All names have been changed.

Daniel

Daniel is a 68-year-old male licensed professional counselor currently in private practice. Prior to that, he worked at a hospice for thirteen years and eventually became its director. He has been in practice for a total of thirty years. He identifies as white and practices progressive Judaism.

Diane

Diane is a 62-year-old female licensed clinical social worker. She identifies as white and is Catholic. She has been practicing for over thirty years. Although currently in private practice, she worked for many years in a community mental health agency where she ran a program for survivors of suicide. In addition to doing individual and family therapy, she also did “post-vention” programs in the community and in the schools following a suicide or violent death.

Joyce

Joyce is a 68-year-old female licensed clinical social worker in private practice, where the majority of her clients are bereaved. In practice for approximately 35 years, she previously worked at a hospice for almost twenty years. She identifies as white and although she was raised Christian, she considers herself eclectic in her religious beliefs and incorporates aspects of Judaism and Buddhism.

Laura

Laura is a 57-year-old female licensed clinical social worker. She currently works in a hospice, where she has been working for fourteen years. She has been in practice since the early 1990s. She identifies as white and is Jewish.

Paula

Paula is a 61-year-old female licensed clinical social worker. Initially trained as a nurse, she became a social worker in the late 1980s and has been in practice ever since. She currently works in a private counseling center that is a part of a funeral home. She identifies as white and is a Lutheran. She immigrated from Northern Europe to the United States in the 1970s.

Phyllis

Phyllis is a 72-year-old psychologist who has been in practice for 30 years. She is currently in private practice where she specializes in individuals and their families who have been affected by HIV/AIDS. During the height of the HIV/AIDS crisis in the late 1980s and early 1990s, she worked at a non-profit organization that served gay men with HIV/AIDS or those who were impacted by it. She identifies as white and Catholic.

Stanley

Stanley is a 73-year-old male psychologist who has been in practice for nearly forty years. He worked at a hospice for almost a decade but is now exclusively in private practice. He identifies as white and an atheist.

Susan

Susan is a 49-year-old female licensed clinical social worker who has been practicing for 25 years. She currently works as the bereavement coordinator at a hospice, a position she has held for ten years. She identifies as white and is Jewish.

Victoria

Victoria is a 68-year-old female psychologist who has been in practice for nearly forty years. She identifies as white and is a practicing Protestant. Since obtaining her degree, she has been in private practice, which is made up of half bereavement cases. She also runs grief support groups and grief seminars in the community which are aimed at educating people about how to better deal with and talk about death.

Measures

The current study employed a semi-structured interview protocol in order to collect data. The protocol began with questions about participant demographics, such as age, race, and ethnicity, as well as professional experience, such as number of years in practice, employment settings, professional experience working with grief, and theoretical orientation. The remainder of the protocol consisted of open-ended questions about the participants' experiences working with bereaved clients, with specific emphasis on the role of clients' ongoing relationships to deceased loved ones in treatment. Questions were related to four areas of exploration: 1) Participants' personal and professional education and training in the treatment of grief, 2) Participants' familiarity with and understanding of the theoretical literature on continuing bonds and/or deathecis, 3) Participants' ways of conceptualizing bereavement with respect to the continued relationship to the deceased, and 4) Participants' approach to treatment with respect to bereavement and the continuing bond.

Procedures

Individuals identified as potential subjects through network sampling were contacted by the principal investigator, who provided information about the study's purpose and procedures. The principal investigator assessed the individuals' eligibility based on the study's inclusion criteria. Individuals deemed ineligible were provided with an explanation as to why and were thanked for their time and interest. For those who were interested and eligible for participation, an in-person interview was arranged at a location of the participant's choosing. At the beginning of each interview, the participants' written informed consent for participation and audio-recording was obtained. All participants were interviewed in-person by the principal investigator using the semi-structured interview protocol, and all interviews were audio-taped. Each interview lasted approximately ninety minutes. Participants were assigned a case number in order to protect their identity, and no identifying information was attached to the study data or audiotapes obtained.

Data Analysis

Data were analyzed using a grounded theory approach (Strauss & Corbin, 2007). The work of grounded theory analysis takes place in three phases of coding. In the first phase, called open coding, the data are broken into smaller workable pieces, or categories. As categories are identified, data are grouped according to their similarities and their differences. This is accomplished by repeated reading and re-reading of the data, during which time important categories are identified and sorted. As data are organized into categories, dimensional qualities and subcategories begin to emerge, allowing for a more refined organization of the data. Once the data are grouped through

open coding, the analysis proceeds to axial coding, the second phase of analysis. In axial coding, the relationships between the previously identified categories are determined. This involves laying out the conditions, consequences, and strategies that govern the different categories. The goal of the axial coding phase of data analysis is to identify causal relationships, which ultimately allows the researcher to construct a theory that captures the relationships among the data's categories. The construction of theory takes place during the final phase of data analysis, called selective coding. In this phase, the categories and relationships identified during open and axial coding are combined and abstracted in order to create core categories (Strauss & Corbin, 1990). In the current study, subject responses were collapsed into concepts and categories at the level of open coding, and then further refined at the level of axial coding. Finally, during selective coding, they were developed into more general themes.

Chapter III: Results

Finding 1: Practitioners Identify Post-Graduate Training, Professional Experience, and Personal Losses as Their Greatest Influences

Despite all completing advanced degrees in the fields of psychology, social work, or counseling, the participants did not recall receiving significant training in the area of grief. For seven participants, death and bereavement were not included in their graduate curriculum at all. According to Victoria, “Nobody was talking about [grief] then.” Paula echoes that saying, “I don’t remember [training in grief] from schooling times. I don’t remember that being discussed anywhere.” For these two participants, not only was there a lack of specific training in the area of bereavement, but it was a topic that was not even mentioned as part of their general training.

Two participants recalled discussing bereavement through their coursework, but the discussion was indirect or limited. Phyllis, for instance, learned indirectly about grief issues in working with parents who had children with disabilities. Specifically, “some information was floated around” about parents grieving the “unspeakable loss...of [the imagined] perfect child.” However, “that was it. There really wasn't any bereavement training, per se.” One other participant, Susan, believed she may have completed “one class on death and dying and it was the typical stages of grief and how to respond.” Even though bereavement was included in the curriculum, it was addressed only from the perspective of stage theories for her.

With minimal academic training in working with the bereaved, four participants identified learning through practical experience gained during graduate field work. Two participants, Laura and Joyce, completed clinical placements in nursing homes, and both

point to these experiences as contributing to their understanding of loss. Laura describes some of the lessons she learned during her time in the nursing home:

That was where I learned. It was a placement by chance and somewhat fortuitous and certainly some of my patients died. I would say as a student that I was dealing with my own sense of loss in working with someone who died. A little bit with the families but with my supervisor co-did that. It wasn't the focus of my work but I learned some of that there.

Without identifying the impact of any one specific placement, Daniel also indicates learning about grief from conversations with his supervisor and through self-directed reading. While it preceded her training in social work, Paula cites her hands-on experience in her education as a nurse as foundational to her understanding of death and grief:

I think that those hands-on experiences as a nurse in hospital settings are very powerful experiences...I remember as a student, I was in nursing school in Finland as a[n] LBN and my first experience of the baby dying and there I am. I was barely 20 probably. And to have a beautiful infant, pink and breathing and moving turn purple and become lifeless, it's a startling experience. That's when it starts...And, somewhere in my nursing education I worked with elderly people, worked in home care as a nurse's aide. I got to be really close to people who were in the end of their lives. All that, I think, prepared me more so than any kind of theoretical training.

After graduate school, eight of the participants attended workshops and training on various aspects of death and bereavement. All but one of these eight completed many trainings, sometimes more than they could keep track of. For instance, Joyce recollected,

“I’ve done just tons and tons of workshops, individual workshops on working with complicated grief, working with children who are grieving” and similarly Laura listed a multitude of trainings in different areas: “Working with children in bereavement, multi-cultural bereavement, certainly working with death and dying, a whole lot of different [types].”

Three of the eight who completed post-graduate training identified a particular training or theoretical perspective presented as being singularly influential for them. One of them was Phyllis who was highly influenced by a workshop she attended given by William Worden:

[The training] certainly gave me a very good grounding and, since I had already [seen him speak on a prior occasion] and read his book, it is almost as if that gave me the integration. Now I felt like it was mine. It wasn't just something I heard about over there as a theory, you know, that you learn it the way you do in graduate school. It was something that I can talk about and I understood and I could think it. So that was probably the most significant thing - that week-long program.

Phyllis is in the minority, however, because in considering the greatest influences on their practice, participants were much more likely to cite professional or personal experience than theoretical knowledge. Eight of nine pointed to what they had learned from colleagues, clients, personal losses, or some combination of the three. Seven identified

work experiences, such as working at a hospice or learning from a particular co-worker. For instance, Laura remembers the role of her fellow team members when she began in hospice:

“Well part of it is really learning from a team. I think my nurse manager when I stepped in, was incredibly influential. The way she approached a patient and family was how I want to do it. I learned from all the different team members what their approaches were and you learn from each other.”

In addition to learning from work experience and from professional mentors, four participants also attributed their knowledge of grief and how to approach it to their clients. They described how supporting someone through bereavement could be a mutual process of change and learning, one which ultimately made them into wiser and more empathic clinicians. When considering the most influential experience on her approach to bereavement, Susan spoke of how she has been taught by her clients:

I think it's really more or less my interaction with those that I'm supporting. When I run a support group, I do it with that understanding that I'm being changed also. I'm just in awe of a lot of people that come to my support group. I'm always amazed by the amount of strength that people show. And so that motivates me to be, perhaps, a bit more - I don't want to say sympathetic, but I don't know - I try to get it from their perspective as well.

Victoria also identified her clients as one of her greatest sources of learning because each brings a unique story and experience which she integrates into her knowledge base:

“More than anything, I learn from the people who are the grieverers because everyone is a

little different. And each time [I work with someone], it's different based on the experiences that [they] faced.”

The final common influence on the participants was their own experiences of loss. While only three cited their own losses as having the greatest impact, the remaining six considered personal experiences with grief as important to their approach when working with clients. This was true regardless of whether they had experienced significant losses prior to starting their careers in the field, which was true for seven participants, or if they had not experienced grief firsthand until already in the field. Participants identified how their own losses gave them greater empathy for bereaved clients, and also gave them a deeper understanding of the experience. For instance, both Victoria and Susan described how having lost people dear to them helped them understand that the connection never dies. Susan spoke about how losing her sister-in-law shaped her understanding of grief from multiple angles:

My sister-in-law died suddenly two weeks before her 25th birthday. And my oldest daughter was five months old, at the time. And, to this day, there are plenty of times where I look at my kids and she would have been like this awesome aunt to have in their lives. I see how my in-laws have so dramatically changed as a result of losing a child. So I'm able to, kinda, tap into that in a way. Like when I get a parent who has lost a child, that I can...not that I probably wouldn't be more delicate, but I know first-hand, you know, what they've gone through. And I use the experience also of losing my sister-in-law that it's 21 years later...and I can still vividly remember her. You know you talk about connections. I still hear her voice; I still think about things that I'd done with her.

Victoria poignantly summed it up when describing how losing her husband and two children taught her that “love never dies...If you've loved someone, then that love is the most powerful force in the universe and it will always connect you in some way or another.” Others explicitly connected their experiences with death to some aspect of their practice. For instance, the fact that his grandfather’s death was kept secret while he was at summer camp had a profound effect on Daniel’s approach to clinical work with the bereaved:

The idea that my family was standing at the gravesite burying grandpa and I was swimming at camp at that moment, it just was so jarring that I think that I made up my mind, that moment, that as I grew up, I would see the importance of being there, being present, and being part of what was happening because it was important. It's painful, but it's important. So, validation, I guess, the importance for me to validate for myself that was wrong and excluded and the opportunities that were missed and everything else. So, validation I think became established in my mind as a foundation of what people need when they're going through this.

Diane recounts how the death of her mother impacted how she conceptualizes her role as a clinician when she is with a grieving client: “[My mother’s death] was handled so ridiculously and sensitively...[Because of that] it gives me a sense of satisfaction to be able to walk that journey with the people as they are trying to heal, and being part of that healing.” Diane, like the other participants, connected her practice not only to formal post-graduate training, professional experience, and direct work with clients but also to her own experiences grieving the loss of a loved one.

Finding 2: Despite Limited or No Explicit Knowledge of Continuing Bonds Theory, the Practitioners Work was Highly Consistent with Theory

The participants had extremely limited knowledge of the academic literature on either decathexis or continuing bonds. Some were familiar with the term decathexis but not with the decathexis model or its implications for the grief process. Diane's response was fairly typical when she said, "Well, yes. Decathexis taking back the emotional and psychic energy that you put into the relationship and kind of taking it back and putting into someone or something else in your life. As a model? I don't know that I really know about it as a model." Four participants had both familiarity and an accurate understanding of the term decathexis. One additional participant reported knowing the term but in fact described a process of reorganizing rather than severing ties, which is more akin to continuing bonds: "having a person move to a different place in your life."

Of the nine participants, only one was aware of the literature on continuing bonds or of that specific term. However, she did not describe herself as well-versed in the literature. While the remaining participants had never heard the term continuing bonds and were unaware of the literature on the subject, all of them were able to surmise the term's meaning and endorsed it as something that was part of both the grief process and part of their approach. For instance, when Paula includes the relationship to the deceased as part of the grief process and therapy, her words strongly echo the continuing bonds literature:

In grieving work we often talk about that...even though the physical body is not there [in the relationship], it continues now in a different form and so the bonding that happened is there, it's just in a different form.

This statement was reflective of all of the participants' experiences. With little or no reference to theory, they all recognized a continued, albeit changing, relationship to the deceased as a part of grieving and treating the bereaved.

The participants all had their own language to talk about the phenomenon of continuing bonds. All emphasized a continued but reorganized relationship to the deceased that balanced the bereaved's ongoing connection to the deceased with moving forward in their lives. Some spoke of continuing the bond in a different form or of relocating it. For instance, Victoria described it in these terms:

In their own way, in their own time, people often remove some of the emotional investment and place it somewhere else. But I think anyone who meant something to you in your life, you can always be connected to in some way.

Others used more spiritual language. Laura, for example, described the phenomenon in this way:

How you hold someone's spirit with you so that you don't feel totally cut off and lost. I think that sort of redefining how someone is present for you. Accepting that, the physical person is not going to be there but that doesn't mean they're not present there.

Despite differences in language, however, at the core there was universal agreement that negotiating a continued connection to the lost loved one is a normal part of the grief process.

In addition to recognizing the normalcy of the continued bond, the participants also saw it serving certain adaptive functions that were consistent with the theoretical literature. Five of the nine participants saw the potential for a healthy continued bond to

support functioning of the self. For these participants, the continued bond could improve self-esteem and integration of the self through a continuous life narrative. Paula emphasizes this latter function when she says the following:

I think it supports the idea that our whole life is who we are, that it's kind of like you don't have to slice off memories and then experiences because the person is dead. But it was real. Whatever you had with that person was real and its part of who you are. It's part of your history. That relationship is part of your history and therefore has contributed to who you are today.

In her view, the continued connection serves as a kind of anchor that helps unify a person's sense of continuity in their lives. Diane also sees the continued bond as serving important functions of the self, but with more of a focus on self-esteem:

It can be a source of inner strength where they can draw strength from what that person had and kind of infuse it into themselves. It can be a way of developing some self-esteem when they can say things like, "She'd be really proud of me." Or, "He would never believe that I would have been able to take over the bill paying and I'm doing it." So it could be a sense of "Ha!" or "Do you believe this? Look at what I'm doing."

In her estimation, maintaining a relationship with the lost loved one has the power to buoy self-esteem and increase the sense of self-efficacy.

Four of the participants also recognized the positive influence of the continued bond on attachment. The positive aspects of the relationship can continue to serve important attachment functions and to facilitate other healthy relationships, while the negative aspects may aid in greater growth and insight following the person's death. For

Joyce, a continued connection “is nourishing. It reminds you that you’re loveable. Someone loved you and cherished you. It reminds you that you have the capacity to be loving and to care for another person.” Laura also points to the power of the continued attachment, both its good and bad aspects, on current functioning and relationships:

I just think when somebody has been really important in your life, it [creates] a little bit of [a] base and it helps you in other relationships that you have. Holding the relationship you had in a good place helps you to relate to other people in ways that you want to, even if it’s learning from bad things, how you want it to be different.

For her and others, the continued bond has the potential to serve positive functions in the grief process and beyond. It can play an important role in both the functioning of the self and functioning in other relationships.

Despite viewing a continued bond as normal and potentially adaptive, the participants all recognized certain types of connections as problematic. Rather than facilitating moving through the grief process, these relationships tend to get the bereaved “stuck” and could result in complicated bereavement. Problematic connections were separated into two categories: those that interfered with the bereaved’s connectedness to others in their lives, and those that were maintained through guilt and pain. Five of the participants identified the former as a type of maladaptive bond. When the bereaved is connected to the deceased in such a fashion that the relationship eclipses ties with the living, it can isolate them and keep them from moving forward through their grief. Joyce distinguishes between a healthy and an unhealthy connection where the outward manifestation of the bond is the same, namely maintaining the deceased’s clothes:

You can have your husband's or wife's clothes there for a year, but you're still getting up, you're going to work, you're going to meet with friends, you're going to the golf course, you're going to church, so to me, no problem. If you have the clothes in the closet and ... you stay home because you're going to just sit there and sit in front of the closet...then that says something else.

In this case, the distinguishing feature is whether there is room for other people and activities in the person's life.

Four participants also pointed to relationships that revolve around maintaining a connection through guilt or pain as problematic. In these relationships, the person is only able to feel close to the person through their grief and has limited access to other emotional aspects of the relationship: "It's often a phenomenon where they don't want to relinquish the grief or the intense suffering or sadness...that's their experience of being connected, and to let go of that is like another loss of the person."

The opposite of this would be a connection where the bereaved has access to a full range of emotions, both positive and negative, which is how a majority of the participants characterized a healthy bond. Six of the participants described a flexible and multi-faceted relationship as the hallmark of an adaptive connection. Paula describes such a connection, which often cannot surface until after the initial raw stage of grief: in addition to feeling the sadness associated with the loss, "they can joke and they can talk about the funny memories or the good memories and so [they can experience the] presence [of] that person in their life without being overwhelmed by the emotion." Diane has a similar view: a healthy bond is where "you can think of the person and have

pleasurable memories of the person, where you can think of the person and kind of feel a sense of -- you can remember the connection that you had and take pleasure in that.”

As with other aspects of their understanding of grief and the continuing bond, the conceptualization of an adaptive connection as one with a range of accessible emotions is also reflected in the theoretical literature. The participants' individual ways of conceptualizing the grief process and their work was quite consistent with the literature despite the fact that only one participant had any familiarity with this body of work, and even her familiarity was limited. It would appear that through their experiential learning doing the work, the participants' conceptual frameworks converged on an understanding that matches what is recommended by academics.

Finding 3: Convergence Regarding Focus and Types of Interventions Targeting Continuing Bonds

Drawing on conceptual frameworks which echoed the theoretical literature on bereavement and the continuing bond, the participants were also similar in how they intervened to specifically address clients' ongoing relationship with the deceased. The interventions fell into three main categories and were conceptually grounded in the participants' understandings of adaptive and problematic types of continued bonds.

The first intervention, which was endorsed by eight participants, involved using a variety of techniques to strengthen clients' sense of connection with the deceased. Given the general consensus that a relationship to the deceased is a normal part of grieving and could in fact serve multiple adaptive functions, it follows that the clinicians would intervene to activate it as part of their practice. The participants described two principal techniques they used to accomplish this, including Socratic questioning and

psychoeducation. Laura uses Socratic questioning to explore how her clients can build a connection to someone they have lost:

I might say, "So how do you hold their memory with you? How do you feel some sort of connection that is comforting for you?" I think sometimes [exploring] how that person has impacted who they are as a person, what they have learned from that person [is helpful].

With these interventions, Laura facilitates the client explicitly identifying ways of maintaining a connection while also supporting awareness of the more subtle aspects of the bond, in this case the relationship's impact on identity. Paula takes a more psychoeducational approach when she educates clients about how they can keep the connection alive with others in their lives:

I encourage people to say the name and talk about the person who is dead to anyone who can listen so that they don't have to live trying to forget but it's okay to talk about it. To find a support person whether it is a dating situation or whatever, but somebody that just share your own memories with the deceased and listen to the other person. You are actually combining histories and then you're bringing your beloved people in here and now, without them being present. That's why I think that it's wonderful if you're [an] old widow and widower and then to find each other...[And] you have grown kids and your grandkids. So to incorporate the memory of the lost people through these next generations I think that it is marvelous.

By suggesting ways that the bereaved can foster a bond with the deceased with others, Paula intervenes to help her clients increase the presence of their lost loved ones in their lives and to pass their memory on to future generations.

Although psychoeducation and Socratic questioning were the most popular ways to facilitate a stronger bond with clients, four participants also pointed to more experiential interventions that functioned to “bring the person into the room.” For these participants, sharing the connection with the therapist was itself a way of shoring up the continued bond. The main technique employed to “bring the person into the room” involved bringing in the person’s possessions and sharing them with the therapist through an in-depth discussion of who they were and their relationship with the client. Diane describes how she approaches this process:

Usually I will have people bring in pictures or someone bring in photo albums and we reminisce together and sometimes its tearful and a lot of times it’s just, “You wouldn’t believe what this kid was like or you wouldn’t believe what my husband -- the things that he used to do that just made me laugh.” The thing is helping them to connect with the person and their life rather than the death and I think that some of that really does help...It’s really just walking that journey [with the client], opening it up and saying, "I'm walking down this path with you." I think it does strengthen the relationship. And then people can start conjure up the good and the bad.

From her perspective, sharing the deceased person with the therapist and reflecting on it together strengthens the connection and gives the client greater access to all the facets of the relationship. Stanley echoes this sentiment when he describes how he intervenes to

“bring the person into the room,” which he believes can facilitate a more therapeutic transference:

I usually have them bring in a lot of [stuff]. Pictures, mementos, whatever. “Tell me about them. Show me. Bring in letters”...So a lot of times I'm building a triangulation between the two of us and the deceased person...And its action can be quite helpful. And it actually [opens] people...[Then] you kind of operate in a kind of surrogacy that can be healing.

Susan recounts a poignant example of how this phenomenon played out in a group for widows and widowers that she facilitates. At a recent session, she had asked all of the members to bring in a picture of their deceased spouse. She describes how the intervention successfully facilitated a greater connection in the moment for one of the group members:

One woman, in particular...[is] just really having a hard time...Just really, really, really struggling. And, the first two people went ahead of her and were able to really just speak candidly and just kind of off the cuff. And she was like, "I don't think I can do this." And I said, "You know what? Whatever you can say." She says, "I think I'm going to cry." "Oh all right. Whatever. So just cry."...She showed us a picture and he was a craftsman and she had showed us this box that he had made. And we're ready to go on and she's sitting there and like, "Well wait. Can I just show you one more thing?" It was like she had one more - it gives me the chills when I think about it - and so she showed us this one more thing. And so then the whole group finishes. And I do my whole thing, you know, "Thank you. It was really nice to have all of your spouses"...And at the end, at

that point started crying and was like, "I just want to thank all of you. It was so unbelievably freeing to know that you were all interested to hear what I had to say. And I need you to know that I felt his presence in here today. Like he would have been so proud of me talking about him."

The act of sharing her connection with the therapist and the other group members helped this client not only feel her deceased husband's presence, but also to access a positive and sustaining aspect of their relationship, namely his pride in her. This type of intervention, explicitly identified by four of the participants, uses the power of the therapeutic relationship in individual therapy or group cohesion in group therapy to strengthen and gain greater access to the connection to the deceased loved one.

In cases where the connection to the deceased is problematic, however, other interventions were identified as necessary to facilitate a healthier continued bond. The participants described two types of maladaptive connections: one in which the bereaved is excessively dependent upon the relationship to the point that they do not allow others into their life, and one in which the relationship is maintained through holding onto guilt and pain. Six of the participants spoke specifically about how they work to help the bereaved separate more from the deceased and create a healthier connection. In these cases, they worked to increase the person's sense of self-efficacy and social connectivity so that they did not need to depend so much on their relationship to the deceased in order to function. Victoria emphasizes both greater social connection and an increased ability to self-soothe when she works with people who are overly dependent:

There are more things to work out in terms of developing some of those [skills]. It takes longer to be able to know what to do with those feelings...[We work on

how] to expand the social network basically, to begin to little by little expand...[We work on] how to self-soothe. Often if you say to someone, "Well what would your mother say to you right now?" They would know exactly what that would be. Say, "Well, could you say those words to yourself, could you be the one in your life?" We want to create that inner mature supportive person who knows how to comfort and advise.

In this case, the connection is harnessed in such a way that it can be internalized and can give the bereaved a greater sense of empowerment and self-efficacy. Such interventions are identified as useful in people who are overly dependent on the deceased because as they feel more capable, they will be able to reorganize the connection such that it leaves room others in their lives and moving forward.

When it comes to the second type of problematic bond, one maintained through guilt and pain, all nine participants reported encouraging the bereaved to verbalize the difficult feelings, especially anger, as well as using experiential interventions to work through the unresolved issues in the relationship that continue to impact the connection. Paula describes how by speaking their feelings aloud, her clients are better able to tolerate them:

It's really just trying to help them to say what's true to them. If they have anger, if they have resentment, if they have hard feelings with that person, say it and dispel the myth that something--the ghosts are going to get them or that they shouldn't be so negative about the person. [They realize] "I have the feelings that [I] have so I'm going to stick with that."

Once spoken, the difficult feelings seem more acceptable, and any guilt is lessened.

When verbalizing the difficult feelings is not sufficient, the participants use a number of experiential techniques, including journaling, letter writing, and role playing, in order to resolve complications in the relationship. Victoria specifically asks clients who are holding onto guilt to write letters:

[It helps] writing a letter to the person that you've lost and opening your heart and expressing things....By writing down your feelings and being able to express something you were not able to express when the person was here makes you feel better. And also then sometimes we'll say, "Well you knew that loved one really, really well so imagine they were writing back to you. What do you think they would say to you?" That can be really comforting too because they are imagining it, they know the person well enough to know what they would probably be saying to them."

This intervention allows the bereaved to address difficulties in their continued relationship even though the person is no longer present. In cases where the relationship was colored by excessive guilt, it has the potential to resolve the guilt, perhaps giving the bereaved greater access to the positive aspects of the relationship and transforming it into a more adaptive connection.

Five of the participants identified one additional intervention in which they work with the bereaved to see the deceased as a whole person, learning to hold their good and bad aspects together. This allows for a more integrated connection with access to a greater range of emotions, which was identified as the hallmark of a healthy bond. Diane gives the example of how she might work with a client who had an alcoholic father:

So if somebody grew up with an alcoholic dad [who] was a son of a bitch when he drank but when he wasn't drunk he was like the best father...It's really helping them to hold those two images of the person and put it together into a coherent sense of who that person was, faults and all, family history and all, biological history and all. So even helping to heal some of the wounds even after the person died.

In exploring and integrating the good and bad aspects of the person, the bereaved comes closer to acceptance and is able to resolve some of the difficulties in the connection. This, like the other interventions employed by the participants, is aimed at facilitating a stronger and healthier connection to the deceased, which can serve a number of adaptive functions and help them move through their grief. The focus of their interventions and the interventions themselves are consistent with what is suggested in the literature. This is not surprising given that the participants' theoretical conceptualizations largely matched the literature and their practice followed from their theory when it came to working with continuing bonds.

Finding 4: Societal and Cultural Factors Often Inhibit or Complicate Grieving

In addition to identifying the individual-level factors that they address in therapy, the majority of the participants also pointed to broader societal characteristics that they have seen contribute to their clients' difficulties. Eight of the nine participants spoke about how their clients' grief process can sometimes become more complicated because of the prevailing cultural attitudes towards death and bereavement. They spoke specifically about how the bereaved feel both rushed in their grief and discouraged from

speaking publicly about their lost loved one, which provokes negative feelings for the bereaved and also potentially interferes with their ability to engage in adaptive grieving.

Six of the participants described how their clients feel pressured to move through their grief quickly. According to Diane, the bereaved “pick up the signals from others about where they should be in terms of the process...People say, ‘It’s been a year.’ It’s just things like that when the world is giving them the message, ‘You should be over this.’” Susan describes something similar: “[It’s] society’s expectations...People aren’t comfortable dealing with [death] or talking [about death]. So, you know the expectation is, ‘It’s been a couple of weeks. You should be good to go. You’re over this.’” In the experience of the six participants who identified this phenomenon, there is a lack of support from others in the bereaved’s lives. They tend to communicate the message that grief should be moved through quickly, which leaves little space for the bereaved to openly grieve.

In addition to feeling like they cannot grieve for too long, the bereaved may also feel pressure to hide their connection to the deceased or refrain from speaking about them to others. Six of the participants described a taboo against speaking of the dead in our culture. Diane, for instance, believes that

A lot of times we as a society are phobic about talking about the person, mentioning their name, spending time just reminiscing about the person, because everybody’s so afraid they’re going to upset the person. It’s like, “Oh, yeah because they forgot and you’re going to remind them.” They haven’t forgotten. It’s on their mind constantly.

Paula takes this idea one step farther, explicitly identifying how this societal trend can actually have a negative impact on someone who is grieving:

Most people have a very hard time trusting that people are okay with bringing up the deceased person. Because those of us who meet a person who is grieving many times we say and act in ways that is not okay with that grieving person... We act in ways that communicate our discomfort. So the grieving person has a task trying to take care of us as well as care for themselves and so most of the time they do not [feel] up to the task. So they isolate, they reject the invitations to social gatherings. And so it's complicated and it makes the whole process [more] painful.

Three additional participants specifically connected the perceived prohibition against speaking of the dead with increased isolation and by extension, a more difficult grief process. Even in cases where these messages do not lead to isolation, they could potentially inhibit processes previously identified as adaptive by the participants.

Specifically, when feeling discouraged from speaking about the deceased, the bereaved may opt not to speak about them and may thus lose opportunities to strengthen their connection with the lost loved one. Joyce laments how this unfortunate process sometimes plays out:

You know there are [times when] someone dies and [nobody wants] to talk about it because they think everybody is going to be too upset. So it becomes this collusion... I think we see it's healthier where in fact [people] do talk about and [the person]. "Remember this. Remember that. [My father] would have done this. [My mother] would have said that." That keeps the person alive.

Joyce's description captures how the perceived lack of space and acceptability to keep a person's memory alive in public leads to missed opportunities to maintain a connection to them. Although the bereaved may continue to hold on privately to their relationship with their loved one, they appear to have few opportunities to have that connection validated and strengthened by sharing it more widely.

To a lesser extent, the participants also identified how the lack of ritual in our society can make the grief process more complicated. Five participants endorsed this perspective. Rituals provide both publicly sanctioned opportunities to grieve and a structure for the grief process. Without going through the rituals of death and grief, individuals may be more likely to feel lost and unsure of what to do in order to move forward in their grief. In addition, many rituals are in fact intended to facilitate grief work and help the bereaved work through the process. Laura hits on many of these points when she says, "I think that people have moved away from ritual in their lives. Sometimes they don't know what to do. But I'll say my feeling about Jewish mourning practice [is that] I think it's so wise on some levels." Daniel, who is also Jewish, describes how practicing rituals has personally helped him to engage in important aspects of grieving:

My Jewish upbringing also influenced [me] a lot. The idea that at least once a year on the anniversary of the person's death, you light a candle and the tradition is to actually talk about the person, but then there is also the end of each major holiday, there is a time in synagogue when there is a special service where we remember this person and we commit ourselves to doing good deeds to perpetuate their memory, in honor of them, so that their life has enduring ability to do good in this world because we are doing things.

When he encounters clients who lack rituals, he steps in and functions as the rituals would have in order to strengthen the connection: “when I work with non-religious patients and they're struggling with the loss, I [take] that impulse [present in Jewish rituals] to the person and [help them find] ways to keep that person alive in their life.”

Phyllis too observes that she often encounters client whom she does not believe engaged in sufficient rituals following a death and will encourage them to do more:

Sometimes I have to ask the person about the rituals that they engaged in and that isn't quite the question, but it was, was that enough. If I come across one of these incomplete bereavements, I get the story of what happened and then I will say, "Ok, what did you do at the time that occurred" And I have encouraged people to engage in ritual.

In these participants' view, the lack of ritual is one of the ways in which our culture can complicate the grief process. In this case, the lack of ritual leaves many without a framework for grieving. By contrast, when it comes to a timeline for grief, there is too rigid a framework that pressures the bereaved to move on more quickly than they are ready. In addition, the taboo about speaking of the dead may make some feel the need to hide their connection and miss out on potentially beneficial opportunities to strengthen the bond. All of these societal factors, combined with individual-level factors, risk compounding, complicating, and prolonging the already difficult process of grieving a lost loved one.

Finding 5: Validation and Psychoeducation Play a Central Role in Therapy with the Bereaved

In order to address the frequently negative messages clients received from others, the participants used psychoeducation, normalization, and validation to reassure their clients that they were not grieving for too long or incorrectly. They also worked to provide more accurate information about the grief process. Eight participants endorsed employing such interventions, identifying three distinct purposes: to normalize the range of emotions, to educate the clients about what can be expected during grieving, and to specifically counter negative messages the bereaved receive from others in their lives.

Four participants used psychoeducation in order to normalize all the different feelings clients have following a loss. Paula puts it to her clients plainly: "I always say to people that whatever the feelings are, they are right. There are no wrong feelings and if you need to cry, you cry. If you have something to be happy about, you smile and dance. So, whatever the feelings are, let them be." Victoria makes a similar statement to her clients: "They can tell the story as many times as they need to. And then [I] tell them it's normal for them. 'Whatever you are feeling and experiencing, it's normal to somebody who's grieving', pretty much whatever it is."

Beyond normalizing the sometimes surprising range of emotions following a death, psychoeducation was also used by four of the participants to increase knowledge of the grief process. They did this in order to prepare clients for the process ahead and to assuage fears that they were "going crazy" due to unexpected experiences and symptoms. Diane explains how she uses psychoeducation to normalize a common but sometimes disturbing experience clients report having:

I think [education is] really important because people don't often know.

Sometimes they feel like they are going crazy when they are grieving and they'll say things like, "I swear I hear his footsteps" or, "I swear I heard her call my name". It's not pathology. I mean unless it is, but usually it's not. It's not pathology. It's all the times that you've heard her call your name and the longing for that and that kind of thing. So there is an explanation with that.

Joyce educates her clients about a broad array of experiences a person might have during bereavement by using a handout:

This [handout] is something that I often would start with people, whether I was doing individual work or group work. You know, this is just something little, but it just gives people something to look at, something in black and white and we would spend some time talking about – as you see, physical effects, emotional, cognitive, because grief affects body, mind and spirit. I would often have people start with just taking a look at it. "Are you experiencing any of the physical effects that you see there?" We go to the emotional then we go to the cognitive. We would often start there because it was also a safe place to start and again it would take it out of the realm of "Something must be terribly wrong with me." "I can't stop crying." "I just want to sleep all the time." Or "I can't sleep at all." "I'm isolating myself." "I'm forgetting everything, I can't think straight." We begin to normalize that for people, that these are very common things that happen.

In addition to educating clients about the symptoms of bereavement, these participants also provided a roadmap for what they can expect down the line. Phyllis does this when

she talks to clients about how they can expect their relationship to their lost loved ones to change over time:

I also do a certain amount of education about bereavement and how it manifests. I say to people, "it's not like he or she is ever gone from who you are, as long as they're alive there with you, but if this is where they were right at the time of their death, this is what will have happened by the time you have reached this adjustment: they're still there but no longer [central]. You don't see everything through the lens with that person on it. That person isn't right in front of you all the time."

With this intervention, Phyllis prepares her clients for what they can expect during the grief process while also laying a foundation for the work of relocating the person and transforming the bond.

The other type of psychoeducational intervention, which was endorsed by five of the participants, was aimed specifically at countering negative messages that the bereaved were receiving from others in their lives. The participants, who viewed these messages as potentially harmful, brought in psychoeducation in order to dispel incorrect information circulated by others. Susan, for instance, tells clients to remove the word "should" from their vocabulary because they will be hearing it from many people:

[I tell them] that no one can tell you what you're feeling is right or wrong. And that thousands of people will pass you by and say, "You should be doing this." The word "should" is no longer a part of your vocabulary. That this is your journey and it's going to be whatever you define it to be."

Phyllis also uses validation in order to address internalized negative messages from others:

I think that some of the problem of grief is what happens with the grief [itself] and some of it is how people think about what's happening and how they judge themselves or they feel that they have to hide something or they get a lot of, it's almost as if I want to say, "They get a lot of grief," from other people about it. I think one of the things [to address that] is to validate how they're doing and how they're feeling, the distress they have. Because most people are hearing from somebody, "well you have to get over this. It's time you start dating again or it's time you..." and then imposing this artificial expectation and people feel as if they are doing something wrong. I try to be very gentle with the whole thing because people are being told should, should, should all over the place.

She gives the example of how she might help someone who is feeling pressured to begin dating a year after the death of a spouse:

[Someone might say] "so-and-so has been dead for a year. You should get on match.com" [But] they're not ready to do that so I say, "That's perfectly fine. You're not ready. There may be a time when you are ready. You're ready to go and enjoy a meal with somebody and have conversations. Not instead of, but in addition to the other relationship."

With this intervention, she gives permission for the client to take things at their own pace and validates that there is nothing wrong with where they are at in the process.

Beyond providing a counterpoint to negative messages from others, some interventions also took aim at giving the bereaved tools to teach others how to talk about

grief and pave the way for more successful interactions. Given that they are likely to encounter people who are not equipped to deal with their grief, they would be served well by knowing how to shape those relationships so that rather than complicating their grief process, they could actually help them through it. Paula educates her clients about how to help others in their lives break through the taboo of speaking about the dead:

I encourage [clients] to communicate to anyone in their closest circle of friends or family that it's okay to share the grief. It's okay to cry together, we can cry together, you can let me cry and I'm okay. I don't die because I cry. [The client can] give permission to others to talk about the deceased, to cry about it, to laugh about it

By teaching her clients these valuable skills, she hopes that clients will be able to create other spaces in their lives besides the therapy relationship where they can be open about their experiences, including expressing their continued connection to the deceased through reminiscence. Victoria conceptualizes this work as creating “ambassadors”:

There are very few people who know how to talk to someone who's had a loss. The people I work with, I teach them how to communicate with other people in their lives so that they can better help them. [They're like] ambassadors in a way to sort of train the population of people so they know what to say, what not to say, what's offensive, what can be helpful.

In this instance, psychoeducation actually prepares the bereaved to become educators in their own right. It empowers them to create relationships where they can better get what they need as they grieve.

Chapter IV: Discussion

This study explored the experiences of psychotherapists who specialize in grief with particular emphasis on how they incorporate work with clients' ongoing relationship to the deceased into therapy. Participants were asked questions related to their understanding of and training in continuing bonds, their ways of conceptualizing work with continuing bonds, and their techniques for intervention. The present chapter explores themes which emerged in the data including 1) the limited formal academic training in death and bereavement; 2) the consistency of therapists' conceptual frameworks and modes of intervention with those found in the literature; 3) the importance of psychoeducation in treatment with bereaved clients; 4) the process of knowledge and skill acquisition through practice and experience; and 5) the impact of socio-cultural factors on grief and psychotherapy with the bereaved. Limitations of the present study and directions for future research are discussed, and implications of the current findings for training, practitioners, and the field of psychology are addressed.

Theme 1: Lack of Formal Academic Training in Death and Bereavement

Even though they are universal experiences and play central roles in many psychotherapeutic treatments, death and grief were given little attention in formal academic training for the professionals interviewed in the current study. Only one participant recalled having any coursework in this area, and the material presented was focused exclusively on stage-based theories of bereavement. For the other participants, not only was death not explicitly addressed, but it seemed to some of them that it was intentionally avoided. Though dealing with grief was not specifically incorporated into the academic curriculum, one could reasonably expect that the topic would nonetheless

come up in relation to other issues. However, this was not found to be the case. Rather, as one participant put it, "Nobody was talking about it."

The experiences of the participants are consistent with previous research demonstrating that death and bereavement are more often than not neglected areas during graduate training. Surveys of graduate counseling and psychology programs have repeatedly found that less than half offer formal coursework or training in dealing with death and grief issues (Wass, 2004). A more recent survey (Horn et al., 2013) found that over three-quarters of Masters level counselors did not take a single course on death or bereavement during their graduate training. The absence of this topic in graduate curricula seems especially problematic when considering the finding that among beginning therapists, grief and death provoke some of the most discomfort and anxiety of any topic (Kirchberg & Neimeyer, 1991). Wass (2004) laments what he views as institutional resistance to disseminating the vast knowledge found in the academic literature to the students these very institutions are supposed to be preparing for practice.

With little discussion in the classroom, student-therapists may have to rely solely on other sources of learning for information about death and grief. This was true of the sample in the present study. The participants reported their education in this area came from fieldwork placements and clinical supervision. It was through these experiential aspects of their training that the participants gained early exposure to caring for the dying and the bereaved. These experiences were identified as useful not so much for broadening the participants' knowledge of theory and technique, but rather for giving them greater familiarity, comfort, and intimacy with death and grief. It was through seeing patients die

and watching loved ones navigate their grief that the participants began to understand and learn to manage their own attitudes, feelings, and reactions to death.

For the participants, these early experiences in their careers likely represented what Wass (2004) refers to as “the personal dimension” of death education. It is during this component of a professional’s training that the student-therapist is encouraged to “confront, clarify, and share personal understandings and attitudes about death” (298). He asserts that when compared to even the minimal technical and theoretical training provided about death, the personal dimension is yet more neglected by training programs. The lack of training in this area may be especially problematic because it forgoes an opportunity to begin building what Chan and Tin (2012) call self-competence in dealing with death. Self-competence, distinct from knowledge of theory and technique, constitutes the personal and emotional resources that enable a clinician to cope with the particular demands of working with death and bereavement. These include both emotional coping and existential coping. Emotional coping describes the capacity to tolerate the intense feelings evoked by working with clients. Existential coping specifically refers to the capacity to openly face mortality, human suffering and vulnerability, and other existential issues raised when working with death. When rated by a group of seasoned professionals, these competencies were rated as the most important factors in being able to successfully treat dying and bereaved clients, more so than theoretical knowledge or technical mastery (Chan & Tin, 2012).

However, it is important to note that other competencies, including knowledge of theories of grief and techniques for intervention and assessment, are also important and should be taught alongside exploration of the personal aspects of working with death

(Wass, 2004). This was not the case for the participants in the current study, whose primary graduate training in death and bereavement occurred through direct experience and supervision. Perhaps the lack of graduate training, which is likely to be the most academic and theoretical, accounts for why the participants tended not to align themselves with any specific theory or method. One participant summed up the general orientation of the majority of the participants when she said, "I kind of assess where the person is and just adjust my style accordingly. I'm not really one of those book people. I kind of just do it."

While this approach speaks to the participants' ability to learn from their clients and their achievement of advanced clinical wisdom, a lack of familiarity with the literature is not atypical and may leave gaps in clinicians' competence. In a 2011 survey of practicing grief counselors, Breen found that the majority were dissatisfied with their knowledge of the most up-to-date information in their field, and in this sample, this was reflected in their practice. Specifically, the majority of the participants subscribed to stage theories of grief, which have fallen out of favor in the literature. The relationship between formal training and competence, which is hinted at in the Breen study, gains further support from the finding that therapists' specific knowledge and skills about grief, including theories of grief, definitions of types of bereavement, identification of effective and ineffective coping skills, and applying a developmental understanding of grief in work with clients, predicted professional competence and effectiveness (Ober et al., 2012).

As with most areas, competence in the area of grief is multi-faceted and requires development of a broad skill set incorporating a diverse group of abilities. These abilities

include theoretical knowledge, technical mastery, and personal development. While graduate programs could not possibly provide sufficient training for students to achieve competence across all of these domains, they could more purposefully start beginning therapists along the necessary trajectory rather than leaving students to seek out experiences on their own or to happen upon them, as was the case for the majority of the participants in the present study.

Theme 2: Consistency of Participants' Theoretical Approach and Clinical Practice with the Literature

With limited academic exposure to theories of bereavement or specific approach to its treatment, it is not surprising that participants' awareness of the literature on continuing bonds was also limited. One participant had read a book on the topic but had no knowledge beyond that. The rest were entirely unfamiliar with the academic discourse in this area. This could also be explained by the fact that the majority completed their training in the 1970s and 1980s, prior to the paradigm shift from decathexis to continuing bonds. However, despite minimal familiarity with recent theory or research, the participants' orientation towards the relationship with the deceased and their clinical approach largely echoed the literature. While the participants and the literature were in agreement on many points, in other areas they did not overlap. Specifically, the literature described certain themes that were not expressed by the participants, and the participants introduced concepts not found in the literature.

Subtheme 1: Normativity of continuing bonds.

At the time the majority of the participants completed their training, decathexis was the favored model of healthy grieving in the literature. In this model, the goal of grief

is to disengage from the deceased, and continued emotional investment is considered pathological. In the 1980s, some writers began to challenge this notion and assert that a continued connection was both normal and normative, and by the end of the 1990s, the continuing bonds model had eclipsed decathexis (Rubin, Malkinson, & Witztum, 2012; Shear, Boelen, & Neimeyer, 2011; Field, 2006).

The participants reported that their thinking always reflected a continuing bonds orientation. All of the participants stated that a continued connection was a normal adaptation to a loss and described themselves as supportive of clients maintaining a relationship with lost loved ones. Influenced by their intuition, clinical experiences, and personal losses, they all recognized that holding on is not in and of itself a marker of pathological grief. Rather, the continued bond represents a normal adaptation to the loss of the physical presence of the loved one and is to be expected following a death. Their perspective was thus consistent with the thesis of Klass, Silverman, & Nickman's (1996) seminal work, which collected evidence from a variety of sources demonstrating that the vast majority of bereaved individuals, including those with entirely uncomplicated grieving processes, continue the connection in some form.

Subtheme 2: The Adaptive Functions of Continuing Bonds.

In addition to recognizing the normativity of a continued relationship to the deceased, the participants also identified a number of ways in which these relationships could in fact serve adaptive functions for the bereaved. Rather than hindering or complicating the bereaved's grieving, a healthy internal relationship with the lost loved one holds the potential to help someone move through their grief and adjust to life without the deceased. The participants identified two areas of psychological functioning

which can be supported by the continued bond: functions of the self and attachment-related functions.

Regarding self-related functioning, the participants' theoretical framework matched the literature. A healthy ongoing connection is theorized to help maintain self-esteem and to affirm a whole and cohesive self (Rubin, 1996; Rubin, Malkinson, & Witztum, 2012). The participants way of thinking was in agreement with these notions. They described how the bereaved can draw on their relationship to the deceased in order to feel good about themselves. One participant's description of this phenomenon is nearly identical to that found in the literature: "It can be a source of inner strength where they can draw strength from what that person had and kind of infuse it into themselves. It can be a way of developing some self-esteem when they can say things like, "She'd be really proud of me.'" In addition to pointing to the impact of the continued bond on self-esteem, the participants recognized the role the connection can play in maintaining a cohesive sense of self, a function also described in the literature. By continuing to hold onto that connection, the bereaved is able to maintain a whole and continuous narrative of their life and who they are as a person, an essential aspect of healthy self-functioning.

Although both the literature and the participants saw the ongoing connection as continuing to serve important relationship functions, they differed in terms of which relational functions they emphasized. The literature divides attachment-related functioning into the secure base function and identification functions. In the secure base function, the connection to the deceased provides a sense of grounding and of felt security. In relating to the deceased, the bereaved is able to induce a sense of comfort and to self-soothe during times of distress (Rubin, 1996). The identification function

consists of internalizing values and ideals of the deceased, which gives the bereaved a sense of inspiration or guidance as they continue on in their lives (Field & Wogrin, 2011). The participants largely did not conceptualize the continuing bond as serving as a secure base or as a source of identification. Rather, they focused on how the ongoing connection continues to serve as an internal working model of relationships and of the self in relationship to others. In a healthy bond, the relationship reminds the bereaved of themselves as loveable and serves as a blueprint for how to form and engage in healthy relationships with others. As one participant described, the connection “is nourishing. It reminds you that you’re loveable. Someone loved you and cherished you. It reminds you that you have the capacity to be loving and to care for another person.” This aspect of attachment was not discussed in the literature as a distinct function supported by a healthy continued bond.

Subtheme 3: Adaptive and problematic types of bonds.

Although the participants universally viewed a continued connection to the deceased as normal, they distinguished between those that were adaptive and those that were problematic and contributed to more difficult grief. In this respect, the participants’ conceptualization overlapped significantly with the literature. In the participants’ view, the distinguishing factors between adaptive and problematic types of bonds were the extent to which the relationship allowed space for relationships to the living, and the relative range of emotions associated with it. In a healthy continued bond, the relationship to the deceased is just one of many relationships in the person’s life. By contrast, in an unhealthy form of the connection, the bond permits only limited engagement with others and serves somewhat as a replacement for relationships with the

living. This concept was previously put forth by Rubin (1996) who identified the extent of coexistence between the relationship to the deceased and relationships with the living as a key factor distinguishing adaptive and maladaptive bonds.

The participants also believed that a healthy relationship with the deceased includes a full range of emotions, both positive and negative, whereas in a problematic bond, the accessible emotions are limited to one valence. The participants tended to focus on problematic relationships that were limited to negative emotions, especially pain and guilt. Other writers have similarly described the problematic nature of overly rigid relationships in which only some emotions are accessible, but these emotions could be either positive or negative. Consistent with the participants, Field and Wogrin (2011) described how excessive guilt and pain can serve as the link to the deceased. However, overly positive relationships, as in the case of rigid idealization, are also hypothesized to be problematic (Rubin, 1996).

While the participants and the existing literature are in agreement about one of the major distinguishing features between healthy and unhealthy continued bonds, namely the rigidity of the relationship, an additional criterion is identified in the literature which was not discussed by the participants. Specifically, there is emerging consensus within the literature that any form of connection which denies the reality of the death of a loved one is necessarily unhealthy (Field & Wogrin, 2011; Field et al. 2005; Normand, Silverman, & Nickman, 1996; Rubin, 1996). This type of denial frequently manifests as a failure to relinquish attempts to gain physical proximity to the deceased or as a dissociation of the intellectual knowledge that the person has died from the bereaved's behavior. Obvious examples of such a connection might include hallucinations of the

deceased or holding on to the deceased's possessions under the belief that they will be needed upon the person's return. While some participants did describe scenarios such as these as unhealthy, they did not identify denial of the death as a distinguishing factor between adaptive and problematic types of connections to the deceased.

In terms of the mark of a healthy connection to the deceased, the participants and the literature were in agreement that an adaptive bond is flexible and allows access to a full range of emotions. In a healthy ongoing relationship, the bereaved is able to feel both positive and negative emotions, as well as remember both positive and negative aspects of the deceased. The participants tended to emphasize the maladaptive nature of excessive negative emotion, and as such, they also tended to conceptualize a healthy relationship as one where positive emotions were once again accessible. For instance, one participant described a healthy relationship as one in which in addition to experiencing feelings of sadness, the bereaved "can joke and they can talk about the funny memories or the good memories and so [they can experience the] the presence [of] that person in their life without being overwhelmed by the emotion." This participant is describing a relationship in which the bereaved's recollections of the deceased reflect what Rubin (1996) characterizes as the hallmark of an adaptive ongoing relationship: one in which "comfort and fluidity [represent the way in which] the bereaved recollects and remembers the deceased" (p. 220-1).

Subtheme 4: Clinical intervention with grief and the continuing bond.

The participants identified working with the relationship to the deceased as one of the crucial elements of treatment with bereaved clients. One participant explicitly stated this belief when she said, "Bonding is bereavement therapy...In grieving work we often

talk about how even though the physical body is not there [the relationship] continues now in a different form and so the bonding that happened is there.” All of the clinicians identified some aspect of continuing bonds work as part of their approach to treatment. Their incorporation of continuing bonds work reflects the growing realization that “reworking relationships...can function as an important key to allowing people to live on. This [work] assists [the bereaved] in taking up authorship of their life narratives, living fully in the world with themselves and others, and retaining the connection to the deceased” (Rubin, Malkinson, & Witztum, 2012, p. 84). The participants tended to view their main task as supporting their clients in transforming the connection to account for the absence of the deceased’s physical presence and to work through any negative aspects of the bond, a task which Rubin, Malkinson, and Witztum (2012) identify as one of the primary tasks of the grief therapist.

The participants largely divided their work into two areas: strengthening the positive aspects of the ongoing relationship, and reorganizing the negative ones. This first goal reflects one of the five shared components of prominent bereavement treatments identified by Shear, Boelen, and Neimeyer (2011), namely the “[encouragement of] engagement with the image, voice, or memory of the deceased to facilitate a sense of ongoing attachment while allowing for the development of other relationships” (158-9). The participants employed both Socratic questioning and psychoeducation with their clients in order to strengthen the sense of ongoing attachment to the deceased. By asking clients how they continue to connect to their lost loved ones and exploring the deceased’s continued impact on their clients’ lives, the clinicians facilitate that very connection. In a

more direct fashion, psychoeducation about how to maintain a relationship also serves this function.

The participants also described how simply sharing their connection to the deceased with the therapist and “bringing them into the room” strengthened the bond. This was frequently accomplished by having the client bring in photos or belongings of the deceased, which can facilitate an important therapeutic process. One participant describes how she engages in this process with her bereaved clients:

Usually I will have people bring in pictures or someone bring in photo albums and we reminisce together and sometimes its tearful and a lot of times it's just, “You wouldn't believe what this kid was like or you wouldn't believe what my husband -- the things that he used to do that just made me laugh.” The thing is helping them to connect with the person and their life rather than the death and I think that some of that really does help...It's really just walking that journey [with the client], opening it up and saying, "I'm walking down this path with you." I think it does strengthen the relationship. And then people can start conjure up the good and the bad.

This aspect of treatment is similar to what Klass (1997) believes to be the primary mechanism of healing in bereavement groups. In these groups, the affirmation the bereaved receives for their continued connection to the deceased legitimizes and strengthens that relationship. A stronger relationship facilitated by social affirmation allows the bereaved to eventually find sufficient comfort and connection with the lost loved one that they no longer feel the raw grief of yearning for their physical presence.

Although Klass studied this phenomenon in groups only, the responses of the participants indicate that it may take place in individual therapy as well.

While one of the therapist's primary tasks is to support and strengthen the positive aspects of the ongoing relationship, they must also attend to negative aspects that need reworking. The participants reported that they intervened specifically in order to reorganize bonds marked by excessive dependency and guilt. Although none subscribed to any specific treatment protocol, some of their techniques are found in other treatments described in the literature. When working with someone excessively dependent on the relationship to the deceased, the clinicians favored problem-solving interventions to increase social connectivity, as well as cognitive restructuring to challenge beliefs about oneself and increase sense of self-efficacy. These two interventions are similar to those employed in CBT for bereaved clients (Shear, Boelen, & Neimeyer, 2011).

The participants tended to borrow from both the Two-Track Model and CGT when working with continued bonds characterized by a high degree of guilt. One intervention was to encourage clients to express a broader range of feelings about the deceased in order to help them gain greater acceptance of their varied emotions. This intervention is similar to working on Track II in the Two-Track Model, where the aim is to alter the cognitive and affective content and organization of how the deceased is remembered (Rubin, Malkin, & Witztum, 2012). The participants specifically focused on intervening in cases of range of emotion was restricted for clients when recollecting the deceased. In addition, experiential interventions, such as letter-writing and imagined conversations, were identified as especially helpful in facilitating resolution of conflicts within the relationship. These interventions are also used in CGT, although with the

express purpose of restoring a sense of meaning in the bereaved's life (Shear, Boelen, & Neimeyer, 2011).

The final type of intervention the participants endorsed was that of broadening the bereaved's experience of the deceased so that they were experienced as a whole person. This was usually accomplished through exploring multiple aspects of the deceased's life and the bereaved's relationship with them in order to help the bereaved integrate both the good and bad aspects of the deceased. One participant describes how this intervention might appear with a hypothetical client whose deceased parent was an alcoholic:

So if somebody grew up with an alcoholic dad [who] was a son of a bitch when he drank but when he wasn't drunk he was like the best father...It's really helping them to hold those two images of the person and put it together into a coherent sense of who that person was, faults and all, family history and all, biological history and all. So even helping to heal some of the wounds even after the person died.

This intervention fits well into the general framework found in the Two Track model where the therapist endeavors to broaden the client's experience of the deceased at points where overly restricted, and to integrate aspects of the relationship experienced as disparate.

Subtheme 5: Psychoeducation

In addition to work with the continuing bond, the participants identified psychoeducation as a key aspect of therapy with bereaved clients. They reported that many clients were disturbed by what they were experiencing or had minimal knowledge of what to expect during grief. The participants employed psychoeducational

interventions in order to reassure clients that their experiences were normal and to prepare them for what they might experience in the future during the course of their grief. Psychoeducation was also frequently used in order to counter the negative impact of messages from others in the bereaved's life and from society more generally. The participants reported that their clients frequently received the message that they should be "getting over" their grief more quickly or that they should not publicly talk about their lost loved ones. This prohibition was perceived as harmful because it cut the bereaved off from important sources of support and made them feel more isolated in their grief. The therapists thus viewed themselves as responsible for correcting inaccurate information, such as that the bereaved should be "over" the loss after one year, and for validating the importance of the relationship to the deceased instead of discouraging them from talking about it. They also sometimes educated clients specifically about how to interact with or train others to be more supportive of them in their grief so that they could get more of their needs met outside of the therapeutic relationship.

While the participants identify psychoeducation as a central component of treatment with the bereaved, it is relatively neglected in the literature. Both CGT and the Two-Track Model emphasize more reflective and process-oriented interventions, perhaps overlooking clients' need for greater information about the grieving process and what to expect. CBT for grief does include more psychoeducational interventions, but these are limited towards understanding the relationship between thoughts, feelings, and symptoms. The treatment does not incorporate any psychoeducation to deal specifically with negative the impact of societal factors or the messages the bereaved receive from

others in their lives (Rubin, Malkinson, & Witztum, 2012; Shear, Boelen, & Neimeyer, 2011).

Theme 3: Knowledge and Skill Acquisition Through Practice

With minimal exposure to the conceptual framework or recommended techniques found in the literature, the practitioners interviewed for the current study largely arrived at ways of thinking and intervening that were similar to those in the literature nonetheless. Their knowledge and orientation developed in parallel fashion to the literature rather than through direct consultation, with both the participants and academics drawing similar conclusions about the issues and needs of the bereaved.

The convergence of the literature and the participants' practice may partially be explained by the dominance of attachment theory in approaches to grief and within the field of psychology more broadly. The shift towards a continuing bonds paradigm coincided with a general relational turn within the field (Boerner & Heckhausen, 2003). The participants' orientation and practice have likely been heavily influenced by attachment theory, including their approach to grief. Specifically, the pervasiveness of attachment theory may have led the participants to intuitively adapt a continuing bonds framework, recognizing the importance of attending to client attachment whether to the living or to the dead.

The wide overlap between participant responses and the literature also lends support to theories of professional development that suggest a shift over time from externally-based knowing to internal expertise. Over time, the experienced practitioner comes to rely less on outside sources such as what they learned during their training or current literature, and instead adapt concepts and techniques based on the wisdom they

have accumulated through their vast experience (Ronnestad & Skovholt, 2003). One participant described how she experienced this process after attending a workshop with William Worden: "Now I felt like it was mine. It wasn't just something I heard about over there and a theory, you know, that you learn it the way you do in graduate school. It was something that I can talk about and I understood and I could think it." This wisdom, which has been described as "a parsimonious set of deep-level schemata that can be activated consistently to assess in conceptualizing individual clients," (Cummings et al., 1990, p. 132) is reflected in another participant's response to a question about how she understands her clients "I just do it, yes. How do you know how to dance?"

This type of wisdom comes about through years of practice combined with extensive and constant reflection, where reflection describes "a continuous and focused search for a more comprehensive, nuanced and in-depth understanding of oneself and others, and of the processes and phenomena that the practitioner meets in his/her work" (Ronnestad & Skovholt, 2003, p. 29). By working with and reflecting on experiences with clients, the participants appear to have been able to generalize their experiences into theories and techniques matching those developed by academics by different means. Several of the participants described their clients as one of their primary sources of learning. For instance, one participant said "More than anything, I learn from the people who are the grievors because everyone is a little different. And each time [I work with someone], it's different based on the experiences that [they] faced." This is consistent with Skovholt and Ronnestad's (1992) finding that among therapists, clients "are a continuous and major source of influence and serve as primary teachers" (p. 512). By reflecting and adapting their approach based on experience with clients, the participants

were able to develop a rich conceptual framework and approach to treatment that closely matched the literature.

Theme 4: The Influence of Socio-cultural Factors

The large majority of the participants identified certain socio-cultural factors as negatively impacting their clients' ability to adapt to a death. Specifically, they describe our society as one in which open discussion of death and displays of grief are discouraged. One way in which death denial manifests is through a lack of public ritual around death. Unlike in other cultures, there are few opportunities to engage in socially-sanctioned grieving after the funeral (Klass & Chow, 2011). As such, the bereaved are much more likely to engage in private displays of grief in which they receive limited social support (Conant, 1996; Valentine, 2008). The participants observed this phenomenon as well, and viewed it as problematic. They believed that without the structure and social sanction provided by ritual, the bereaved felt more lost and isolated. One participant lamented this when she said, "I think that people have moved away from ritual in their lives. Sometimes they don't know what to do. But I'll say my feeling about Jewish mourning practice [is that] I think it's so wise on some levels." As a result of this line of thinking, several of the participants actively encouraged clients to engage in greater ritual in order to increase their opportunities for open grieving and social support.

Society's discomfort with death is also communicated through messages about both how long is it acceptable to grieve and how grief should be publicly manifested. A common response clients receive from others is summed up by one participant: "[It's] society's expectations...People aren't comfortable dealing with [death] or talking [about death]. So, you know the expectation is, 'It's been a couple of weeks. You should be good

to go. You're over this.” When it comes to publicly talking about the death or the connection to the deceased, the bereaved come up against a similar taboo: according to one participant, “a lot of times we as a society are phobic about talking about the person, mentioning their name, spending time just reminiscing about the person.”

This phenomenon has been referred to elsewhere as the rules of grief, rules which “are implicit and imbued with a great amount of power in their ability to ascribe legitimacy to the grief response in a mourner” (Harris, 2009, p. 244). These rules dictate who is permitted to grieve, for how long, and how. In Western society, grief lasting beyond three months is often deemed abnormal or problematic, and public displays of emotion are discouraged. These rules of grief are one aspect of our generally death-denying culture in which death is hidden and reminders of mortality are avoided (Harris, 2009). In such a society, the bereaved face a conflict between their desire to grieve and the pressure for social conformity. When the threat of losing social support due to violation of grief rules wins out, the bereaved are forced to hide their grief (Klass & Walter, 2001). This can lead to isolation and other problems, which the participants addressed with psychoeducation and validation, as described above.

Klass and Chow (2011) speculated that the taboo against speaking about one's ongoing relationship with the deceased might extend to the consultation room, leading some clients to hide their connection to lost loved ones out of fear of being labeled “crazy” or “pathological.” In the participants' experience, however, this was not the case. In fact, the participants observed that their clients were mostly open about their experiences of a continued relationship, and that they found it a relief to be able to speak about the relationship with an accepting and trustworthy other. Even the hesitancy to

speak of a connection observed by Valentine (2008) and Bennett and Bennett (2000) in their studies of the bereaved was not found by the participants. Rather, people frequently brought up the subject on their own without the need for much reassurance. The participants attributed this to their open and positive stance in which they normalized whatever their clients experienced. Within the context of this type of relationship, clients felt free to discard the rules of grief and express their genuine experience.

Limitations of the Present Study

Several limitations must be considered in interpreting and applying the results of the current study. Firstly, the generalizability of the results obtained is potentially negatively impacted by a small sample size, selection bias, and a nonrandom sample. The present study included a small sample of nine licensed psychotherapists who specialized in the treatment of grief. All of the psychotherapists were white and practicing in New Jersey, and all had been in practice for over twenty years. The racial and geographic homogeneity may limit generalizability of the findings when comparing them with the more diverse population of psychotherapists treating bereaved clients. In addition, the relatively older average age and greater years in practice may bias the results of the study due to cohort effects. The majority of the participants completed their training in the 1970s and 1980s, and they were likely exposed to a particular set of theories and practices that were prominent at that time. Therapists trained at other times may have different experiences and approaches to grief.

Selection bias may also have impacted the findings. Participants were recruited through a networking sample, perhaps biasing the sample towards greater similarity than would be found in the general population of grief psychotherapists. Specifically, subjects

who referred others to participate in the study may have selected other professionals who shared their orientation and approach. In addition, therapists who agreed to participate in the study may have had both greater experience and training in working with the bereaved and may have felt more comfortable reflecting on their work. Current findings, therefore, may not be representative of the average psychotherapist specializing in working with the bereaved. Furthermore, because this study employed a qualitative research design, it did not use a random sample or a control group, which may also reduce the generalizability of the results.

Implications

Implication 1: Future research.

The findings of the current study suggest several directions for future research. Little research has been conducted on the experiences, orientations, and approaches of therapists who specialize in treating the bereaved, and research on the use of continuing bonds theory is even more limited. As Klass and Walter (2001) wrote, "Whether counseling practice overall reflects the textbooks' silence about interacting with the dead is not known because there has been no systematic research into what actually happens in one-to-one bereavement counseling" (p. 443). This gap in the literature leaves the field open for further inquiry.

First, as the current study is one of the only studies examining the experiences of grief therapists with respect to using continuing bonds, replication of its findings is warranted. Larger qualitative studies as well as quantitative research would be useful in testing the theories obtained from the data and in gauging the generalizability of the current findings.

A second area of inquiry should involve broadening the population studied to include a larger swath of clinicians beyond those who specialize in bereavement. As death and grief are universally experienced phenomena, the majority of therapists are likely to treat bereavement at some point, whether they specialize in this area or not. It would be useful to understand how the larger community of psychotherapists approaches working with the bereaved, as well as their familiarity with continuing bonds. This would extend understanding beyond the specialized subset of professionals who are likely the best trained in this area to include other professionals who provide services to the bereaved.

A third direction for future research would look at the experience of therapy for bereavement from the perspective of clients who have experienced it. In the current study, the participants viewed their interventions and work with continuing bonds as beneficial and therapeutic. It was beyond the scope of the study to examine how such interventions were received by clients. Future research focusing on clients' experiences in treatment could further clarify the needs of bereaved populations. In addition, examination of the concurrent experiences of client and therapist through close study of transcripts could prove useful in further elucidating how treatment unfolds when working with the bereaved, as well as clarifying which factors or techniques affect client satisfaction and treatment outcomes. Results of such research could play a critical role in advancing the field's understanding of which factors are essential to the successful resolution of grief in psychotherapy.

Finally, while the current study did not distinguish between the participants' general theoretical orientations and their approaches to working with grief and continuing

bonds, it would be interesting to examine whether there are significant points of divergence for therapists who adhere to different theoretical orientations. The current study included therapists of diverse theoretical orientations, including psychodynamic, family systems, CBT, and humanistic, and the findings suggested that despite their different orientations, the participants held very similar conceptual frameworks and employed similar techniques when working with the bereaved. However, future research should explore this topic further using a larger sample size more suitable for purposes of comparison along theoretical lines. Examining how theoretical orientation can impact working with grief and continuing bonds would serve to broaden our understanding of therapeutic intervention with the bereaved from a variety of perspectives. It could also help distinguish between universal aspects of the therapeutic process which transcend orientation, leading clinicians to gravitate toward similar interventions, and those aspects of the process which are differentially conceptualized based on orientation.

Implication 2: Education and training.

The current study suggests several implications for the training of mental health practitioners working with bereaved clients. Implications include both a need for more formal academic training in treating the bereaved, as well as more experiential work around death. The participants all noted the highly limited training they received in working with death and bereavement during their graduate training. Only one participant partook in any formal coursework on the matter, and the course focused on outdated stage theories of grief. The remaining participants were left to seek opportunities through fieldwork, with supervisors, and post-graduate workshops. Their experiences were consistent with previous studies which found formal education about dealing with death

and grief severely lacking in training programs for mental health practitioners (Wass, 2004; Horn et al., 2013).

Given that death and grief are universal aspects of human experiences that all psychotherapists are likely to encounter in their work, training programs should incorporate coursework in this area that presents up-to-date theoretical writings and empirical findings on intervention with bereaved clients. In addition, courses should include an experiential component in which students begin to explore their own personal reactions, attitudes, and beliefs about death. Through such activities, student-therapists can begin to develop the “self-competence” necessary for coping with the unique issues presented by work with bereaved clients (Chan & Tin, 2012). It is the combination of such experiential training coupled with a strong grasp of the literature which creates competent clinicians (Ober et al., 2012; Ronnestad & Skovholt, 2003). Broadening and deepening training in these areas would have a positive impact on the delivery of competent treatment services to bereaved clients.

Implication 3: The practice of psychotherapy with the bereaved.

The current study offers several implications for therapists working with bereaved clients. With regard to therapeutic stance, the participants in the current study noted the importance of maintaining an accepting and validating stance in order to engage clients who have elsewhere been discouraged from sharing their experiences of grief. Therapists observed that most of their clients received messages that public expressions of grief or talking about lost loved ones was not welcome, an observation noted elsewhere in the literature (Bennett & Bennett, 2000; Valentine, 2008; Klass & Chow, 2011). As such, they took especial care to signal that clients' experiences were normal and acceptable.

Practitioners should be aware of and sensitive to the negative experiences bereaved clients have had when sharing their grief with others in their lives, and take special care to present an open accepting stance in which they validate and normalize client experiences.

In a similar vein, the participants also emphasized the importance of incorporating psychoeducation into therapy with bereaved clients. One of the principal purposes such interventions served was to provide accurate information to counter incorrect messages clients received from others, such as that they should be “over their grief” in a timely fashion. Psychoeducation also served to fill gaps in clients’ knowledge about the process of grieving and what to expect. This was especially helpful in reassuring clients that their experiences were normal and non-pathological. Psychoeducation about how to speak to others about their grief can also be useful for clients who feel isolated with their experiences. Practitioners should be sure to provide psychoeducation to their clients and should not assume that their clients are knowledgeable about death and grief. Given the death-denying nature of the broader culture, death may frequently be an area in which clients are especially unknowledgeable.

Finally, with regard to incorporating continuing bonds into treatment, several recommendations can be derived from the current study. First and foremost, practitioners should attend to the ongoing relationship to the deceased. All of the participants endorsed that this was an important aspect of working effectively with the bereaved. Specific interventions in this area should include facilitating a stronger connection to the positive aspects of the relationship through Socratic questioning, psychoeducation, and “bringing the deceased into the room.” Negative aspects of the relationship must be equally

attended to and worked through. This can be accomplished by encouraging further separation and increased self-efficacy in cases of excessive dependency, and by employing experiential interventions and emotional catharsis where the connection is predominated by guilt and conflict. Finally, the therapist should work to facilitate a more integrated experience of the relationship in which the deceased is experienced as a whole person.

Implication 4: The field of psychology.

An important recommendation for the field lies in bridging the gap between the practice and research communities. As Klass & Marwit (1996) noted, there has historically been a mismatch between the field of psychology and the public in terms of what is deemed unhealthy versus healthy when it comes to grief. They attribute the mismatch to the development of theoretical models without adequate attention to the experiences of the bereaved. Practitioners, who have had contact with vast numbers of bereaved individuals, can make significant contributions to the field's understanding of what is normative and what is helpful when treating bereaved individuals. As noted in this study, the participants, none of whom participated in research or academic activities, reached the same conclusions as researchers and theoreticians through practice and experience, and even introduced novel concepts, such as the importance of psychoeducation. At the same time, practitioners could benefit from greater access and exposure to empirical literature in order to assess their practice through other means besides self-evaluation. Although none of the participants in the current study specifically stated a desire to increase their familiarity with the literature, this has been noted elsewhere (Breen, 2011). In addition, optimal competence has been related to a

combination of self-reflective practice and a strong grounding in the available literature (Ober et al., 2012; Ronnestad & Skovholt, 2003).

A second recommendation is related to the beneficial role psychology might play as a field in disseminating information about death and grief, and in combating the negative effects of a death-denying culture. Several of the subjects participated in professional activities beyond psychotherapy which were aimed at this ends. For instance, one participant held community seminars on how to talk about death and grief, while another organized school-based interventions for students, faculty, and staff about how to deal with grieving students. Given their broad reach, professional organizations of mental health practitioners should consider taking a more active role in disseminating accurate information about death and grief and in correcting inaccurate information among the public, while also encouraging their members to do the same.

Chapter V: Conclusion

The current study sought to illuminate how psychotherapists specializing in grief work with bereaved clients in treatment. Specifically, it hoped to explore how therapists work with clients around the issues of continuing bonds and the ongoing relationship to the deceased. While participant responses were largely consistent with the literature on continuing bonds, the present study is one of the few, if not the only, study of the experiences and approaches of grief therapists which focuses specifically on continuing bonds.

This study revealed that though the present sample considered working with continuing bonds as an essential component to treating bereaved clients, the available training at the graduate level is significantly lacking in this area and in the area of death and grief more generally. As such, the participants tended to seek out additional training experiences at the post-graduate level and to learn largely through experience with clients. Contrary to trends in the literature, which are marked by a shift from deactivation to continuing bonds, the participants endorsed adhering to a continuing bonds framework throughout their careers. With regard to therapy process, all subjects described how work with the ongoing relationship to the deceased permeated the treatment process and informed their conceptualization of clients and interventions. The participants' focus in treatment was on strengthening positive aspects of the continued connection while resolving and reorganizing conflictual or problematic aspects of the relationship. An unexpected finding of the current study was on the importance of utilizing psychoeducation to deal with the effects of a death-denying culture. While the impact of death-denial has been discussed in the literature, proposed interventions to ameliorate its

effects are limited. The participants emphasized both the gap in clients' knowledge of grief and the deleterious effects of the broader culture, which discourages public expression of grief or connection to deceased loved ones. They viewed educating clients in order to counter such messages as an essential ingredient in treating the bereaved.

Appendix A

Semi-Structured Interview

Demographic Information

Age: _____

Gender: _____

Racial and Ethnic Background: _____

Religious/Spiritual Identification: _____

Professional degree(s) & Year(s) Attained: _____

Years in practice:

Professional settings worked in throughout career:

Percentage of current clients that are bereavement cases:

Percentage of typical caseload that is bereavement focused:

Breakdown of typical bereavement caseload in terms of length of time post-loss:

Percentage of typical bereavement caseload with complicated versus uncomplicated bereavement:

Three most common diagnoses in caseload:

What is the average length of treatment for your typical client?

Theoretical orientation and specialization:

Treatment specialty/focus:

A. Background, Training, and Understanding

1. Please describe the experiences you completed during your graduate education addressing loss and bereavement in therapy.
 - a. Prompt: didactic/non-practicum, supervision, practicum? Personal?
2. Please describe the experiences you completed during your post-graduate education addressing loss and bereavement in therapy.
 - a. Prompt: didactic/non-practicum, supervision? Continuing Education? Personal?
3. What experiences have been most influential in your understanding of bereavement therapy?
4. What are the core components to your approach to working with bereavement?
 - a. Prompt: what are the most important foci and areas for intervention?
What do you see as a successful outcome to a bereavement treatment?
5. What is your familiarity with the concepts of Decathexis, Continuing Bonds, and the relevant discourses?
6. Please describe any training/educational experiences on bereavement in which the relationship to the deceased was specifically addressed.
 - a. Prompt: if none, why do you think these issues were not addressed in your training?

B. Working with the Relationship in Bereavement Therapy

1. Before getting into the nitty gritty of how you approach and conceptualize this stuff I find it helps to begin with a case to flesh it out a little more:

Please describe what you consider to be a successful treatment where a focus on the relationship to the deceased was central and a treatment in which working with the relationship to the deceased was either not necessary or unsuccessful.

- a. PROMPT: specific interventions used, changes in the relationship over the course of treatment, treatment outcome

2. What role do you think the bereaved's relationship to the deceased plays in a client's mourning process and grief?
 - b. Prompt: consider both optimal and suboptimal adaptation to loss
3. How do you distinguish between adaptive and maladaptive aspects of the relationship?
4. How do you assess the nature/quality of a client's relationship to the deceased?
5. When conceptualizing a client and developing a treatment plan, how do you incorporate their relationship to the deceased?
6. What are the benefits of addressing clients' relationship to the deceased in terms of adaptation to loss?

C. The Therapy Process

7. What dimensions of the relationship to the deceased do you think about and tend to work with?
 - c. Prompt: object relations, self-related functions, spiritual components
8. How does the relationship enter into the treatment?
 - d. Who typically brings up the topic? When is it typically addressed? (beginning, middle, end of tx)? What types of issues are addressed?
9. What factors do you consider when deciding whether/when to explicitly address the relationship in the treatment?
10. Have you ever purposely not addressed the issue of the relationship to the deceased in a treatment? If so, what were the circumstances and how did you make that decision?
11. How does working with the relationship to the deceased affect the therapeutic alliance and/or the transference/countertransference?

12. What kind of resistance do you typically encounter when working in this area and how do you work through that resistance?

D. Cultural Considerations

13. What considerations do you give to a client's cultural or spiritual beliefs when working with the relationship to the deceased?
14. What are your own beliefs about relationships with the deceased and how do they impact your approach to treatment?
15. How have your beliefs and approach to treatment been influenced by your personal experiences of loss?

E. Concluding Questions

1. What do you enjoy about working with the bereaved?
2. What has been challenging about this work?
3. How have your thoughts, feelings and approach to bereavement changed throughout the course of your career?
4. Is there anything I didn't ask you about your experience with bereavement in therapy that would be helpful to know or consider?
5. What has been your experience of participating in this interview?

Appendix B

Informed Consent

INFORMED CONSENT AGREEMENT AND PRIVACY STATEMENT

You are invited to participate in a research study entitled “Therapists’ Approaches to Relational Aspects of the Treatment of Bereavement: An Exploratory Study” conducted by Melissa Frankford, Psy.M. Before you agree to participate in this study, you should know enough about it to make an informed decision. If you have any questions, ask the investigator. You should be satisfied with the answers before you agree to be in the study.

Purpose of the Study:

This study explores the experience of treating bereavement from the perspective of psychotherapists who specialize in this area. The study aims to understand specifically your experiences and methods of working with your clients’ internal relationship to the lost person during the course of therapy. There is currently limited clinical research in this area despite its growing theoretical prominence. This study will be used to enhance understanding of the clinical application of relational theories of bereavement. A doctoral student at the Graduate School of Applied and Professional Psychology (GSAPP) at Rutgers University is conducting this study as a fulfillment of dissertation and doctoral requirements. It is anticipated that including you, 8 to 10 individuals will participate in this study.

Study Procedures:

You will be interviewed about your experiences, thoughts, and opinions in regards to how you incorporate relational work into your treatment of the bereaved. The interview will take approximately **sixty to ninety minutes**. Interviews will be audio taped to contribute to the authenticity of the study.

Risks:

The interview focuses on your experience and thoughts as a therapist. It is my hope that the interview will be a positive experience for you. However, recalling some professional experiences may be unpleasant for you and you may experience some discomfort when answering questions. If you experience emotional distress related to the study, please contact the researcher and discuss this with her, so that she can assist you and help provide you with referrals as necessary.

Benefits:

Participation in this study may not benefit you directly. However, the knowledge that we obtain from your participation, and the participation of other volunteers, may help us create a more comprehensive understanding of clinical applications of bereavement

theories. Sharing your experience as a clinician may also provide a valuable opportunity to reflect on various aspects of this experience.

Confidentiality:

This research is confidential. This means that that the research records will include some information about you, including your age, gender, job title, and years of experience working with bereaved clients. Your name will only appear on consent forms and will be kept separate from research records. I will keep this information confidential by limiting access to the research data and keeping it in a secure locked location. The research team and the Institutional Review Board at Rutgers University are the only parties that will be allowed to see the data, except as may be required by law. Your responses will be grouped with other participants' responses and analyzed collectively. All common identifying information will be disguised to protect your confidentiality. This will include changing your name and other demographic information (i.e. job title, experience level).

Interviews will be transcribed, and audio recordings will be destroyed three years after the study. All audio recordings, transcripts of interviews, or other data collected from you will be maintained in a locked file cabinet and destroyed three years after the study. Audio recordings will be assigned a case number.

Compensation:

There is no compensation for participation in this study.

Contact:

I understand that I may contact the investigator or the investigator's faculty advisor at any time at the addresses, telephone numbers, or emails listed below if I have any questions, concerns or comments regarding my participation in this study.

Melissa Frankford, Psy.M.
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If you have any questions about your rights as a research subject, you may contact the IRB Administrator at Rutgers University at:

Arts and Sciences Institutional Review Board for the Protection of Human Subjects
Office of Research and Regulatory Affairs
Rutgers University, the State University of New Jersey
335 George Street
Liberty Plaza / 3rd Floor / Suite 3200
New Brunswick, NJ 08901

Tel: (848) 932-0150

Email: humansubjects@orsp.rutgers.edu

Rights as a Participant: **Participation in this study is voluntary.** If you decide to participate, you may withdraw from the study at any time without penalty and without loss of benefits to which you are otherwise entitled. If you withdraw from the study before data collection is completed your data will be removed from the data set and destroyed. Also, if you refer other individuals for participation in this study, your name may be used as the referral source only with your permission

I have read and understood the contents of this consent form and have received a copy of it for my files. By signing below, I consent to participate in this research project.

Subject Name (Print) _____

Subject Signature _____ Date _____

Principal Investigator Signature _____ Date _____

CONSENT FOR AUDIO TAPING

You have already agreed to participate in the research study titled Therapists' Approaches to Relational Aspects of Bereavement Therapy: An Exploratory Study, conducted by Melissa Frankford, Psy.M. We are asking for your permission to allow us to audiotape (make a sound recording) as part of that research study.

The recording(s) will be used for analysis by the principal investigator.

The recording(s) will be distinguished from one another by an identifying case number not your name.

The recording (s) will be stored either as a password protected digital file or on audio-cassette tapes stored in a locked filing cabinet, and transcribed by the principal investigator.

All audio recordings will be maintained in a password protected digital file or a locked filing cabinet and deleted three years after the study is completed. All transcripts of interviews will be maintained in a password protected electronic document or in a locked file cabinet. All transcripts will be destroyed three years after the study.

Your signature on this form grants the investigator named above permission to record you as described above during participation in the above-referenced study. The investigator will not use the recording(s) for any other reason than that/those stated in the consent form without your written permission.

Subject Name (Print) _____

Subject Signature _____ Date _____

Principal Investigator Signature _____ Date _____

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