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# Mortality Salience In Therapists: Sudden Death of a Patient - An Exploratory Study

Amanda Oliva

MORTALITY SALIENCE IN THERAPISTS: THE SUDDEN DEATH OF A PATIENT – AN

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SPONSORING COMMITTEE:


_____          _____

Eva Feindler, Ph.D. - Dissertation Committee Chair          DATE

_____          _____

Danielle Knafo, Ph.D. - Dissertation Committee Member          DATE

_____          _____

Linnea Mavrides, Psy.D. - Dissertation Committee Member          DATE

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"Man cannot endure his own littleness unless he can translate it into meaningfulness on the largest

possible level."

— Ernest Becker, The Denial of Death

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"We can strengthen our sense of death transcendence in non-destructive ways…creative

transcendence is obtained by contributing to future generations through innovations and teaching."

— Sheldon Solomon, The Worm at the Core

Abstract

The purpose of this qualitative research study is to explore therapists' experiences of the sudden passing of their patient. In particular, the researcher aims to explore the internal and external experiences of the therapist's grief, as well as implications for training and professional life. Seventeen psychotherapists, ranging in professional training, aged 30 to 80, who lived in several states across the country, participated in individual interviews with the principal investigator via online video conferencing. The interviews were transcribed and analyzed, according to the qualitative research method of Auerbach and Silverstein (2003), to extrapolate themes and theoretical constructs from their anecdotal accounts to create a theoretical narrative. Results of the subsequent analysis indicate that the experience of therapists who have had a patient suddenly die can be best understood through the six major constructs (1) the details and circumstances of the patient's death, (2) the therapist's affective reactions, (3) the therapist's views on death and life, (4) the meaning-making process for the therapist, (5) the therapist's coping behaviors and (6) the patient death's impact on the therapist's professional life. The discussion contextualizes the data and proposes a look at these constructs through the lens of terror management theory (TMT), emotional processing theory and meaning making. Additionally, contributions to the field and the profession of clinical psychology are proposed.

Mortality Salience in therapists: Sudden Death of a Patient - An Exploratory Study

**Terror Management Theory (TMT)**

Being a self-aware human being coincides with a consciousness of our impending fate. Once consciously aware of this knowledge, humans experience terror or existential anxiety (Solomon, Greenberg & Pyszczynski, 2015). In our very nature of being human, we must deny the pivotal fact of our impending death in order to live our everyday lives. To protect ourselves from the dread that comes with knowledge of our inevitable nonexistence, humans must repress the fact that death is our fate (Becker, 1973). A prominent existential psychologist, Irvin Yalom (1980) states how death and mortality related concerns have been on the sidelines of psychological teachings and training throughout history. He theorizes that the denial of death may in fact be so prominent, even amongst psychologists, that this topic has effectively been minimized by the field of psychology overall.

Terror Management Theory (TMT) looks at how humans, who are terrified of death, learn to cope with the realization of our impending mortality. This theory was developed in the 1980's by three social psychologists; Jeff Greenberg, Tom Pyszcynski, and Sheldon Solomon, based on the readings of the cultural anthropologist Ernest Becker, in particular his work *The Denial of Death* (1973). Terror management theory (Greenberg & Arndt, 2011) asserts that humans cope with the fear of death by utilizing anxiety buffering mechanisms. This theory suggests that humans buffer existential anxiety in two major ways; by clinging to the way in which they see the world or an individual's "worldview" and by bolstering their self-esteem, in order to view themselves as meaningful members of their respective groups. Through these buffering tactics, humans can keep their existential dread at bay and carry on with activities of daily living.

Cultural worldviews are defined as the ways in which humans perceive reality based on shared beliefs and ideas about the meaning of life (Landau & Sullivan, 2015). These worldviews may include cultural or religious affiliations and as such provide codes of conduct and structure for

daily living. By subscribing to a cultural worldview and adopting the attitudes and beliefs of that structure, they then become an integral part of the individual's personality (Greenberg & Arndt, 2011). An individual's worldview may offer literal or symbolic immortality, which serves the goals of death-transcendence to combat their death anxiety. Cultures offer the possibility of symbolic immortality through monuments, artistic expression, literature, estates etc. Symbolic immortality reflects the idea that humans can become part of something that will live on after they have died, such as having children, forming a legacy, or contributing to a major project. Many major religions offer literal immortality which is derived through promises of everlasting life, reincarnation, or some other form of continued existence. Through subscribing to and upholding one's cultural worldview, humans find a sense of meaning and purpose that will allow them to buffer the fear of death when faced with threats to their mortality (Solomon, Greenberg & Pyszczynski, 1991, Davis & McVean, 2009).

Landau and Sullivan (2015) state that self-esteem has also shown to be a prominent anxiety buffer when humans are faced with mortality threats. According to Terror Management Theory, self-esteem is a cultural construct consisting of two major parts, a meaningful conception of the universe and the belief that as an individual, you are meeting the standards that are valued within yours chosen worldview (Solomon, Greenberg & Pyszczynski, 1991). Self-esteem has been shown to help reduce anxiety overall, outside the context of existential concern and threat. Additionally, self-esteem in terms of TMT has also been shown to be a buffering mechanism related to death anxiety. Solomon, Greenberg & Pyszczynski (1991) suggest that good self-esteem is particularly helpful in buffering death anxiety when individuals perceive themselves as valuable members of a meaningful universe that they exist in. Self-esteem in the context of TMT is highly connected to the ideas of value and meaning. When humans are subscribed to a cultural worldview that gives their life direction and standards to live by, in conjunction with feeling as though they are living up to the standard of their culture, they are hypothesized to be optimally able to buffer death anxiety.

**The Mortality Salience Hypothesis**

In their review of the literature on TMT, Landau and Sullivan (2015) describe the Mortality Salience (MS) hypothesis. This theory states that if an individual's cultural worldviews and self-esteem are in fact used as anxiety buffers, when mortality concerns are salient, individuals should need protection, thereby showing more adherences to their worldviews. By bringing awareness to an individual's impending death, their anxieties would become raised and then individuals should use anxiety buffers to reduce concerns about death anxiety. If an individual begins to defend their worldviews and their place within their culture after mortality is made salient, then it would be hypothesized that the individual is utilizing their worldview as a defense against death anxiety that was brought into conscious awareness.

Greenberg and Arndt (2011) use the example of someone who judges self-worth by his/her ability to drive a car. If someone believes that his/her self-esteem relies on how well they dive, then when faced with thoughts about death, he/she will strive to be the perfect driver. An additional example provided related to self-esteem striving includes seeing a person who is environmentally conscious as someone who is highly regarded within his/her worldview. When faced with reminders of their mortality, this individual would also partake in these environmentally conscious behaviors, to strive for self-esteem bolstering. On the same token, if he/she is using a worldview defense, when faced with MS they may be more judgmental of those who disagree with their worldview. According to Greenberg and Arndt (2011) studies have shown that when cultural worldviews are being used as a defense against death anxiety, there is an increased aggression towards the out-groups and an increased positive affection towards in-group members (Burke, Martens & Faucher, 2010).

According to TMT (Pyszczynski, Greenberg & Solomon, 1999; Landau and Sullivan, 2009) there are two types of defenses that humans use to deal with death related thoughts and anxieties: proximal and distal defenses. Proximal defenses are used when death thoughts are in

conscious awareness and include suppressing the thoughts, making light of the likelihood of death, or taking proactive efforts to avoid issues. Distal defenses are used when death thoughts are unconscious. These defenses include defending worldviews and striving for self-esteem. Terror Management Theory is more concerned with unconscious processes that are at work when mortality is salient, namely distal defenses.

Davis and McVean (2009) write about subliminal and supraliminal priming as the two ways to induce mortality salience in participants during empirical research. Supraliminal priming is when participants are aware that they are thinking about death. For example, Mikulincer and Florian (2000) ask their participants to write about the feelings their death evokes in them as well as what they think will physically happen when they die. This is the most common empirical way to induce mortality salience (Burke, Martens & Faucher, 2010). Since supraliminal priming allows for proximal defenses to take over, a distraction task is needed to allow distal defenses to come into play. Subliminal priming does not bring the thoughts of death to the conscious awareness so distal defenses are automatic and do not require a distraction. For example, subliminal priming involves more subtle acts such as having word searches with death words in them or administering the study close to a funeral home.

Outside of empirical research there are triggers for mortality salience in everyday life just by nature of being alive. Pyszczynski, Wicklund, Floresku, Koch, Gauch, Solomon, and Greenberg (1996) demonstrated that mortality salience effects could be induced just by interviewing participants in front of a funeral home. Mortality salience triggers could include recent life changes such as the death of a loved one or illness (Tomer & Eliason 2000). More removed reminders such as television and news related to death can also induce mortality salience and intense emotions (Pan, Zhou & Hayes, 2018). Research conducted on death anxiety in emergency room workers by Brady (2015) showed that working in an environment in which others are dying can induce mortality salience and bring about death anxiety in workers. This research suggests that the death of others can produce an increase in death anxiety and bring ideas of mortality salient.

Additionally, up and coming research related to the COVID-19 pandemic (Menzies & Menzies, 2020) also indicates how living during the time of a pandemic can induce mortality salience and subsequent fear of death. Exposure to death-related images, reminders, news, and situations can induce mortality salience in humans either unconsciously or consciously and affect human's behaviors in using the anxiety buffers mentioned above.

## Mortality Salience and Death Anxiety in Therapists

In a meta-analysis focused on mortality salience research overall, Burke, Martens and Faucher (2010) found that 90% of all studies included college age participants, thus not including many professionals in their samples. In terms of methodology, nearly 80% of mortality salience research is conducted using essay questions on the topic of their own death. In this method, participants are asked open ended questions about their death, usually being asked to write about what they think will physically happen to them when they die and what emotions their death evokes in them. Around 10% of studies, as did the studies mentioned in this literature review, utilize close-ended survey questions and self-report questionnaires with Likert-scale responses. Lesser utilized methods (9%) for mortality salience include being interviewed in front of a funeral home, watching videos of death-related content, such as a car crash or reading essays about cancer or terrorism. The least utilized methodologies (4%) include more covert priming to get at unconscious death anxieties. These may include reaction time measures and subliminal priming like the word "death" or "death" flashing on a computer screen participant are working on for milliseconds, thus going undetected.

The breadth of literature on mortality salience within health care professions is quite limited, although particularly lacking related to psychotherapists. In a review of the research on death attitudes generally, Neimeyer, Wittkowski and Moser (2004) states that in health care it was found that physicians reported higher levels of death anxiety than their ill patients did, resulting in more testing and longer stays. Medical students were on par with social science students regarding

levels of death anxiety, indicating that increased death anxiety can impact therapy work with patients. Pepitone-Arreola-Rockwell (1981) conducted a study looking at levels of death anxiety amongst health professionals including suicidologists, funeral directors, psychologists, and psychiatrists. The results of this study showed that although all groups scored within the normal range, psychologists had the highest death anxiety, slightly higher than suicidologists. As this study was utilizing a self-report methodology, participants were rating their conscious levels of death anxiety, which may be skewed.

Other studies looking at levels of death anxiety amongst graduate students have shown contradictory results. Jordan, Ellis and Grallo (1986) found that psychology graduate counselors exhibited higher levels of death related anxiety as compared to their medical student counterparts. However, research by Reese, Chan, Perry, Wiersgalla and Schlinger (2005) suggested that social science students had the same level of death anxiety as their medical student counterparts. Similarly, however, both studies indicated that social science students scored higher on particular subscales of death anxiety including thoughts about their own death, the process of dying and the death of others.

Neimeyer, Wittkowski and Moser's (2004) review of the literature also found that counselors with high levels of death anxiety at times waivered in their empathic responses to patients, with the mediator being level of experience in counseling. Research conducted by Terry, Bivens and Neimeyer (1996) indicated that more experienced counselors, particularly with death related issues, showed more empathy in their interactions with patients. Research conducted by Kirchberg, Neimeyer and James (1998) on death anxiety and empathic responses among novice counseling graduate students looked at how mortality salience affects empathic attitudes towards patients in vignettes. This research showed that higher levels of death anxiety predicted distress and discomfort related to attending to death counseling as compared to other topics such as disability or marital conflict. However, mortality salience did not induce less empathic responses in the counselors, although levels of empathy were lower than expected overall.

Research conducted by Worden (2002) focused on grief counselors, suggested that not all counselors were consciously aware of their death anxiety. Out of those who were, a large percentage was not forthcoming with their existential concerns, thus possibly impacting their work with patients. As the noted studies in this literature review are utilizing self-report methodology such as death anxiety questionnaires, true levels of therapist's death anxiety may not be accurate, as it is thought that death anxiety may be unconscious unless brought into conscious awareness. Lacocque and Loeb (1988) assert that a therapist may feel animosity towards a patient and not realize that their aversive feeling towards them is a defense to avoid the existential anxiety that patient brought up for them due to their death anxiety being unconscious.

Therapists may be unconsciously affected by their death anxiety, thus influencing the way they feel and act towards their patients. A study conducted by Woofle (1998) suggests that underlying fears of mortality may affect who therapists choose to work with. This study was a preliminary exploration of assessing attitudes towards working with older patients. Woofle (1998) theorized that younger psychologists may shy away from working with older patients due to the possibility of confronting death, fears of aging and dying and possible countertransference related to therapists' paternal figures and their mortalities. Woofle (1998) aimed to survey former students from a counseling course to see how they felt about working with older clients. Woofle (1998) sent a survey to his 42 former students who graduated two years prior, receiving 19 replies. Those who replied were invited to meet as a group to discuss their experiences working with older clients. However, between the respondents only 8% (86 individuals) of patients seen were aged 60 or older which was seemingly low as most of the participants reported working in primary health care where bereavement services were offered. Woofle (1998) concluded that this preliminary research may speak to the idea that therapists unconsciously avoid working with older people as it may big up issues related to therapists' inevitable transition to later-life stages.

The literature on mortality salience and its effects on therapists is lacking despite some research indicating how increased death anxiety can impact therapists' views of patients, willingness to work with certain populations and the high level of death anxiety in the field of psychology. The general literature on mortality salience indicates that humans may act judgmental towards others to buffer against their own death anxiety, which may be the case for therapists as well. More research related to therapists' views of death can add to this understanding and may help inform future training and education around death in psychology.

**Death Anxiety in Clinical Work**

Moraglia (2004) posits that many psychological theorists, including William James and Carl Rogers, believed that recognizing and confronting one's finitude and mortality, can lead to growth later in life and allow meaning making to occur. However, this recognition is often blocked by defenses and anxieties, making the process more difficult. Although therapists are aware of many of these reactions, they may not be conscious of their own responses when it comes to mortality concerns, as much death anxiety remains unconscious (Terry, 2018).

Robert Langs (2008) posits that unconscious existential dread is ever present in humans, which undoubtedly extends to therapists in clinical practice. He theorizes that there are three forms of death anxiety: predatory, predator and existential, the latter being the most influential in the psychotherapy process. Langs (2008) states that unconscious death anxiety is a universal experience and thus, the endeavor to understand how death anxiety manifests in patients, is just as treacherous of an undertaking for the therapist, due to their own relationship with mortality. Lang goes on to state how, often times, unconscious existential death anxiety is seen consciously in the form as either predatory or predator forms through the way the therapist and patient interact.

Lang (2008) defines predatory death anxiety as the fear of being harmed by others manifesting into overreaction to threat and a tendency to attack before being attacked. Predator death anxiety is defined as the result of guilt from hurting others and inviting harm to the self as a

punishment which may manifest as self-defeat. Lang (2008) posits that one simplistic example of how existential death anxiety can present as predatory or predator death anxiety can be in the event of breaking the therapeutic frame. He suggests that the therapeutic frame provides an unconscious illusion of safety and consistency and thus by breaking this frame it causes disillusionment. This experience can evoke predator death anxiety where the patient believes they deserve the "punishment" because of unconscious guilt or predatory anxiety in which they feel attacked by the therapist. Lang (2008) suggests that unconsciously, this break could be revealing existential death anxiety when the patient recognizes that the safety of therapy does not protect against the inevitability of mortality.

Cowan-Jessen (2014) also writes about how the therapy hour may be conceptualized as a defense against death within both parties of a therapeutic relationship. She poses a question, asking how therapists are able to work on death-related concerns with patients when their own death anxieties are present. She then suggests how the therapy hour serves as an illusion of consistency and safety that provides distraction from those anxieties, but only for so long, as these concerns come into the room eventually and need to be attended to. In a case example, she illustrates how existential concerns may be at the core of treatment, unbeknownst to both parties due to unconscious denial of death, leading to stagnation until that fear becomes conscious.

In her book entitled *Death and Fallibility in the Psychanalytic Encounter*, Ellen Pinsky (2017) writes similarly about the concept of Olympian Delusion. She postulates that within the therapeutic relationship, therapists are often viewed as somehow more than human and in turn therapists may internalize these sentiments. There then becomes an assumption that in some way therapists are exempted from the ordinary plagues of life, such as illness and inevitable death. She suggests that this fantasy may be useful in the psychotherapy relationship to discuss a patient's idealization of the therapist. However, it can be harmful when the therapist adopts the Olympian Stance and is unconsciously using this status as way to deny their own fallibility and mortality. This delusion, that the patient and therapist become a part of, can be painful when shattered by

what she calls an "untimely loss," such as the death of the therapist or even illness that requires temporary separation.

Existential themes and death anxieties are underlying concerns for all human beings, including psychotherapists, although at times a denial of death and related existential anxieties may be present. Understanding which situations within therapeutic relationships and processes serve as mortality salience reminders could aid in the training on awareness of therapists. Additionally, understanding how therapists defend against their own threats of mortality brought up in clinical work with patients can inform how education surrounding death is taught.

### Therapist's Grief and Mortality Salience

Therapists not only have to contend with their own impending mortality, but also the losses that life naturally encompasses, just as all humans do. In Kouriatuis and Brown's (2011) literature review on therapists' experiences of bereavement, mourning and loss, they identify the ways in which therapists cope with the death of a loved one, loss of a patient and other personal loss (e.g., being ill, losing a connection or a divorce). They posit that therapists' mourning processes may fall under the heading of a variety of grief theories, as all humans may.  Therapists may mourn in a staged manner as described by Kubler-Ross (1969) in which they go through the various stages of denial, anger, bargaining, depression, and acceptance.

Kouriatuis and Brown (2011) also reference Freud's (1917) theory on *Mourning and Melancholia*, in which therapists must detach their libidinal energy from the deceased and reinvest it into new relationships to move forward from the losses they have faced. Furthermore, Neimeyer's constructionist view of bereavement (Neimeyer, 1999) may fit in which therapist's aim would not be to return to their "pre-loss" selves but to build a meaningful life and engage in a process of re-developing one's self-concept. Finally, therapists may experience disenfranchised grief, theorized by Doka (1989). This is when the loss endured is not recognized, socially validated, or felt deeply enough, leading to unresolved feelings.

Just as any human who undergoes loss, therapists, when grieving, may be reminded of the finitude of their own lives, thus the loss serving as mortality salience. Plenty of research has been conducted on therapists' experiences of losing a patient to suicide and terminal illness as noted by Kouriatuis and Brown (2011). Regarding a loss of a patient to suicide, such an experience has been shown to conjure up feelings of regret and guilt as well as questioning of professional competencies (Veilleux, 2011). Additionally, therapists who have suffered the loss of a patient due to chronic illness have shown to have difficulty related to depression, helplessness, and burnout (Kouriatuis & Brown, 2011). It appears that therapists are recognized by other mental health professionals as going through legitimate losses regarding patients dying from terminal illness or suicide.

However, there has been a startling lack of research surrounding how therapists' experience and mourn non-suicidal, sudden deaths of patients. This type of loss faced by therapists often falls into the disenfranchised grief theory of mourning by the nature of the intimacy of the relationship yet inability to share that information with others grieving that same loss. Many therapists have written anecdotal accounts of their unexpected loss of a patient and have shared similar themes of sadness, isolation and feeling as though their emotions were "unacceptable" by others (Kouriatuis & Brown, 2011). By the nature of there being so little research on the topic, it appears to not be considered as legitimate of a loss in the professional circles as suicide or chronic illness. This lack of information and research may add to the therapist's feelings of disenfranchised grief.  In the limited literature there is, it was reported that therapists had a variety of reactions to sudden deaths of patients, including feeling more at ease being genuine with patients while others found it difficult to form connections. This appears to be an under-researched area that could use more exploratory research to understand the grief processes in therapists who have experienced such loss.

### Therapist's Anecdotal Experiences of Death of a Patient

When therapists experience the death of a patient, they are left to face the grieving process in an unconventional way due to the guidelines of professionalism and confidentiality (Rubel, 2004). Mourning therapists find themselves in a conundrum in which they held a uniquely intimate relationship with the patient yet are on the outskirts of the patient's social life, often leading them to feel alone and unsupported in their grief. Rubel (2004) explains that an "untimely termination" due to the death of a patient is drastically different than normal termination processes, due to the feeling of incompletion of treatment as well as thwarted fantasies of how a patient's life may have continued after termination. He goes on to suggest that the death of a patient brings up existential questions in the therapist surrounding the meaning of their work. Many mental health professionals who have experienced the death of a patient have taken it upon themselves to write anecdotal accounts of their work with the deceased patient to describe the ways in which they mourned the loss.

Dr. Rubel (2004) tells the story of three patient deaths he experienced, one being a tremendous shock. He recalls how while he was on vacation, a patient developed cardiac symptoms and did not survive his emergency surgery. He reports being so overwhelmed with grief that he wrote a eulogy and gave it to his family, which was later read at his funeral. Although invited back to the family home, he chose to maintain professional boundaries. He reports that his grief was his alone and he dealt with it in that way, noting that his bond with the patient and his family ended when the patient died.  However, he notes that although their work had ended, their relationship and his patient's impact on him did not, ending on a note regarding his love for all his patients who have died.

Dr. Lyss-Lerman (2017) recounts her experience of discovering that one of her patients died suddenly of unforeseen cardiac complications and her confusion on how to proceed after learning of this news. Similarly, to Rubel (2004) she reports feeling alone as she attempted to

navigate mourning within the confines of psychotherapy boundaries that held her back from sharing in exchanging memories of her patient with the family. She reports a feeling of holding onto unresolved issues due to a lack of closure and feeling confused about how to grieve the life of a person she was intimately connected to while maintaining professional boundaries. Dr. Lyss-Lerman (2017) notes the difficulty navigating speaking with her patient's family, maintaining HIPAA and conflicts around attending the funeral. She reports leaning on her personal culture and religion to grieve as authentically as she was able to during that time.

Dr. Buechler (2000) describes the sudden death of one of her patients as an extreme variation of termination, a phase that naturally occurs with each therapy patient in some way. She recalls this patient as just entering a phase in which she was ready to embark on a journey of true intimacy, when one weekend she received a message that her patient suddenly died. She notes that her training, just as other analysts, did not prepare her for such a loss, speculating that even therapists are apprehensive to speak about death. Once again, reference is made to the idea of mourning in solitude, as it is not advised to speak with the family of the deceased (Buechler, 2000). A halted sense of mourning can occur due to the interpersonal nature of such an endeavor, and Buechler (2000) asserts that this is a common experience amongst analysts who have endured the death of a patient. She asserts that overtime with repeated exposure to such events an analyst can experience burn out, which is a loss within itself, characterized by a loss of confidence and faith in the profession.

In an acquainted fashion, Dr. Aronson (2009) writes about his experience learning about and mourning the death of his long-term patient, whom he had worked with for nearly 12 years. While on a trip, he received a call that this patient was a victim of a hate crime and had been beaten into a coma, consequently dying. Despite his long-term, intimate and close relationship with this patient, he reports feeling out of place and powerless at his funeral. Once again, noting the familiar theme of confidentiality continuing after death and feelings of loneliness while grieving this loss. Aronson (2009) notes a new level of intricacy in this therapeutic relationship, that being a paternal

counter transference as he worked with this patient through his childhood, adolescence, and young adulthood. Aronson (2009) describes his motivation to find ways to symbolize his relationship with this patient to commemorate his loss. He calls for others who have endured similar instances to turn to art and expression to cope with the loss they have faced and the love they still have for their patients.

## Therapists' Grief Process

As exhibited in this literature review, therapists do go through a mourning process related to the sudden death of a patient. It appeared that many of the therapists were describing the theory of disenfranchised grief throughout their mourning process, particularly with the ideas of mourning alone and not having any social support throughout the process. Due to confidentiality and professional boundaries therapists appeared to feel invalidated and unable to gain closure (Rubel, 2004; Lyss-Lerman, 2017; Bucheler, 2000; & Aronson, 2009). The anecdotes also had a recurrent theme of being caught in a hindered phase of mourning that is never quite completed due to the guidelines and professionalism they must adhere to.

Neimeyer's constructionist view of bereavement (Neimeyer, 1999) mentioned as a possible mourning theory for therapists (Kouriatuis & Brown, 2011) suggests that despite the level of privacy surrounding grief, it eventually must be linked with the responses of others for the bereft to reconstruct their world and identity without the deceased. Neimeyer (1999) suggests that the survivors must look to others to validate their changed identities. Understanding the mentioned therapists' anecdotes through this lens, it can be theorized that in writing a narrative about their grieving process to share with the psychology field, these therapists have moved through the stages of Neimeyer's constructionist mourning process. Their grieving process culminating into the meaning-making stage in which they are identifying themselves as changed individuals in front of society, that being the psychology community.

In many of the personal anecdotes provided on therapists' grieving processes, it was often suggested that the death of their patient possibly served as a death reminder for the therapists. These reminders may have conjured up feelings about therapists' own mortality and simultaneously, as Rubel (2004) noted, challenged the meaning of life and their purpose as a therapist. In a critique written regarding Dr. Adam Kaplan's (2014) anecdote of working with a patient terminally ill with cancer, Frommer (2014) questions what impact Kaplan's psychotherapy work had on his own relationship to mortality. The question of how therapists feel about their own mortality, particularly when faced with patients' deaths, which likely make their own mortality more salient, is rarely answered and not at all researched in depth. Although questions appear to be posed regarding therapist's views of their mortality a further dive into those experiences are lacking in the literature. This may be another way in which the psychology field unconsciously denies death as posited by Yalom (1980). In not exploring the ideas about therapists' existential concerns and situations regarding their mortality, the denial of such events continue.

### Therapists' Experiences of Sudden Death of a Patient

A single research study to date has been completed specifically regarding therapists' experiences of a patient sudden death. Schwartz (2004) completed her dissertation entitled *Therapists Experience of Patient Sudden Death*, a qualitative study utilizing semi-structured interviews with nine participants. Schwartz (2004) interviewed therapists including all varieties (MA, MS, MSW, Psy.D., Ph.D.) who had provided individual psychotherapy to a deceased patient using a variety of modalities (psychodynamic, cognitive behavioral, supportive counseling and rational emotive therapy). Additionally, she defined *sudden death* as an unexpected, unanticipated death thereby excluding therapists who have lost patients to chronic illness. Schwartz (2004) also excluded patients who died by suicide, as it was speculated that therapists who have experienced death of a patient by suicide would have unique reactions not being studied in her research.

The results of Schwartz's (2004) qualitative study yielded five major themes revolving around therapists' experiences of the sudden death of a patient. These themes include (1) attachment in the therapeutic relationship, (2) the therapist's own bereavement process (3) the therapist's feeling as though they are "left holding the bag," (4) coping with the sudden death of a patient, and (5) lessons learned from the experience.  Expanding on each theme, Schwartz (2004) reported that it appeared the more significant of an attachment relationship between the therapist and patient, the more grief symptoms were present. In terms of bereavement, results showed that therapists fell in a variety of different grief theories and that bereavement was individual for each therapist. She found that bereavement experiences were influenced by spiritual beliefs, professional role, and current life circumstances. In terms of therapists feeling as though they were "holding the bag," this referred to therapist's feelings of unresolved business in therapy as well as knowing intimate details of the patient's life. Regarding coping skills, results of the interviews yielded experiences such as social support, attending services, creating rituals and an effort to maintain connection with the deceased as most helpful. Lastly, the participants reported a variety of lessons learned from this experience. Some therapists indicated that the loss helped them be more authentic and open with future patients, while others reported learning more about the validity of their feelings and the need to grieve their losses. Some participants reportedly mentioned the impact of their patient's death on their own thoughts about existential concerns and views of death, however, these ideas were not talked about at great length.

The literature regarding the intersection of mortality salience and therapists in clinical practice is quite sparse. How Terror Management Theory research empirically or otherwise relates to mental health professionals has not seemed to be explored in much depth. Similarly, the literature assessing the attitudes and views of therapists who have experienced the death and grieving process around sudden death of their patients is virtually non-existent. As the theoretical constructs of coping with the fears of impending mortality and the grieving process are essential to living within the human condition, this is a worthwhile endeavor to pursue. More pressing is the

understanding of how attitudes towards death and coping with loss in therapists manifest as they

are the clinical professionals working with the public at times exploring these very same inquires.

Therapists' experiences coping with sudden death is grossly under-researched but remains a

possible experience for every therapist who is in practice by the very nature of the human existence

and frailty of life. This study aims to explore in more depth the experience of loss due to sudden

death and the grieving processes for therapists. This study also hopes to explore the ways in which

such deaths relate to therapists' attitudes about their own mortality. A better understanding of the

grieving process in therapists can aid in training protocols for therapists to prepare them in some

ways for such possibilities. Additionally, this understanding can aid in greater transparency about

death anxiety in the field of clinical psychology and its impact on clinical work.

## Methods

### Participants

The principal investigator recruited a sample of 17 licensed, practicing, therapists who

experienced the sudden death of a patient. A recruitment flyer (Appendix A) was sent out by

committee members to psychological organizational listservs in addition to being posted on social

media by the principal investigator (Facebook, Instagram, and Reddit).

The recruitment flyer requested that the possible participant message or email the principal

investigator if interested and a brief screening took place to decipher goodness of fit for the study

based upon inclusion and exclusion criterion. Accepted participants were then emailed an informed

consent document (Appendix B) to be emailed back before the link for tele-conferencing was sent

out to the participant as well as a consent form for audio/video recording (Appendix C). After the

individual interview concluded, participants were emailed a demographics form asking more

specific information about themselves and their work role (Appendix D) which was again emailed

back to the principal investigator.

Inclusion criteria to qualify for participation required that the individuals were a professional psychotherapist (mental health counselor, clinical social worker, or psychologist), had been seeing the deceased patient individually and consistently, and that had been licensed for at least one year. Exclusion criteria were therapists who had experienced the loss of a patient due to a known chronic illness (cancer or other long-term illness) or when the lost patient died by suicide, as it was thought that these experiences conjure up differing feelings than what was being researched. The participants also needed not to be suffering from any of their own major life-threatening illnesses at the time of participation to avoid possible inflated levels of mortality salience due to personal life circumstance.

A total of 17 participants were recruited for the study with a wide range of ages ($M = 43.9$), number of years working as a therapist ($M = 13.6$ years) and number of patients the therapist had pass away over their career ($M = 12$). The sample was mainly female (N = 14, 82%) and white (N = 15, 88%). The sample had varied identifications regarding professional degree (41.2% doctoral degrees), psychotherapy orientation (35.3% psychodynamic and 17.6% CBT), and work placements (70.6% having worked in private practice). Additionally, participants resided all over the United States ranging from Nevada to Florida. Regarding COVID-19, many participants felt affected by the pandemic at the time of interview (82.4%), including those who had experienced a close death due to COVID-19 (35.3%). In addition, many participants (41.2%) reported dealing with their own health problems currently. A full list of demographic characteristics of the sample are displayed below in Table 1.

Table 1. *Demographic Characteristics of Participants*

| Category | N | % |
|---|---|---|
| **Gender** | | |
| Female | 14 | (82.35) |
| Male | 1 | (5.9) |

| | | |
|---|---|---|
| Non-Binary | 2 | (11.8) |
| **Race/Ethnicity** | | |
| White | 15 | (88.2) |
| Latinx | 1 | (5.9) |
| Albanian | 1 | (5.9) |
| **Age** | | |
| 30-40 | 10 | (58.8) |
| 41-65 | 5 | (29.4) |
| 66-80 | 2 | (11.8) |
| **Years Working as Licensed Therapist** | | |
| <1 year | | |
| 1-5 years | 1 | (5.9) |
| 6-10 years | 2 | (11.8) |
| 11-20 years | 7 | (41.2) |
| 21-40 years | 4 | (23.5) |
| >41 years | 2 | (11.8) |
| | 1 | (5.9) |
| **Professional Degree** | | |
| Doctoral | 7 | (41.2) |
| *(Ph.D., Psy.D., DBH)* | | |
| Master's | 10 | (58.8) |
| *(LCSW, MMHC, LMFT, CATC, LPC,* | | |
| *MSW, LMHC, Med)* | | |
| **Placements Participants Have Worked In** | | |
| Inpatient | | |
| Private Practice | 3 | (17.6) |
| DOC | 12 | (70.6) |
| Community MH | 1 | (5.9) |
| Geriatric OP | 11 | (64.7) |

| | | |
|---|---|---|
| Day Program | 1 | (5.9) |
| School Based | 1 | (5.9) |
| Detox/Rehab | 4 | (23.5) |
| Nursing Home | 4 | (23.5) |
| ACT Team | 1 | (5.9) |
| Dialysis Unit | 2 | (11.8) |
| | 1 | (5.9) |
| **Number of Patients They Have Had Die** | | |
| 1 | | |
| 2-5 | 6 | (35.3) |
| 6-10 | 6 | (35.3) |
| >11 | 1 | (5.9) |
| | 4 | (23.5) |
| **Religious Affiliation** | | |
| No Religion | 7 | (41.2) |
| Atheist | 2 | (11.8) |
| Jewish | 1 | (5.9) |
| Roman Catholic | 2 | (11.8) |
| Christian | 1 | (5.9) |
| Muslim | 1 | (5.9) |
| Buddhist | 1 | (5.9) |
| Pagan | 1 | (5.9) |
| Unitarian | 1 | (5.9) |
| **Therapy Orientations** | | |
| Psychodynamic | 6 | (35.3) |
| CBT | 3 | (17.6) |
| DBT | 2 | (11.8) |
| Person-Centered | 4 | (23.5) |
| Solution: Focused | 2 | (11.8) |
| Relational Therapy | 2 | (11.8) |

| | | |
|---|---|---|
| Harm-Reduction | 1 | (5.9) |
| Psychoanalytic | 1 | (5.9) |
| Transpersonal | 1 | (5.9) |
| Trauma-informed | 2 | (11.8) |
| **Location of Practice** | | |
| New York | 5 | (29.4) |
| Virginia | 1 | (5.9) |
| Texas | 1 | (5.9) |
| Massachusetts | 2 | (11.8) |
| New Mexico | 1 | (5.9) |
| Nevada | 1 | (5.9) |
| North Carolina | 3 | (17.6) |
| Florida | 1 | (5.9) |
| Arizona | 1 | (5.9) |
| Ohio | 1 | (5.9) |
| **Recent Death Due to COVID-19 Pandemic** | | |
| Yes | | |
| No | 6 | (35.3) |
| | 11 | (64.7) |
| **Feels Affected by COVID19** | | |
| Yes | 14 | (82.4) |
| No | 3 | (17.6) |
| **Important Personal Death Within the Last Year** | | |
| Yes | | |
| No | 6 | (35.3) |
| | 11 | (64.7) |
| **Personal Health Issues** | | |
| Yes | 7 | (41.2) |
| No | 10 | (58.8) |

**Design**

This study's design was based on Auerbach and Silverstein's (2003) qualitative model, and theoretical saturation was reached after seventeen participant interviews. The primary investigator conducted semi-structured interviews via tele-conferencing utilizing password protected Zoom meetings. Each interview was audio recorded with the consent of each participant and then transcribed by the principal investigator. Two research assistant coders were recruited from the second-year candidates in Long Island University Post's Clinical Psychology Doctoral Program. The principal investigator trained both research assistant coders in the Auerbach and Silverstein (2003) coding method and supervised all subsequent coding. The research team, consisting of all three people, coded all seventeen of the interviews to establish relevant text, repeating ideas, and themes. The principal investigator then coded the theoretical constructs and constructed the theoretical narrative on their own.

The two research assistant coders were assessed for personal biases related to key ideas of this research. Each coder was asked about their personal experiences related to death, as well as the impact of COVID-19 on their lives at the time of coding. Additionally, coders were asked to disclose their motivations for volunteering to work on this project. Coder one stated that they did not have any personally history with death at the time of coding, nor did they experience any death or major impact of COVID-19 during the coding process. Coder one stated that they were interested in pursuing this project due to hopes of personal and professional growth and learning more about a meaningful topic. Coder two stated that they also did not have an extensive history with death in their lifetime or any major impact of COVID-19 at the time of coding. However, coder two stated that they volunteered for a grief network for COVID-19, so they were exposed to other's experiences of loss and grief prior to the coding process. Additionally, coder two stated that they were interested in pursuing this project to learn more about themselves and their own anxiety surrounding the uncertainty of death.

**Procedure**

Participants who were interested in this study were provided with information regarding inclusion and exclusion criteria to gauge goodness of fit. If the prospective participant fit the criteria, they were then emailed a consent form (Appendix B) outlining a description of the study, the rationale as well as information about confidentiality and that their participation was voluntary and that they had the option to withdraw without penalty. Additionally, participants received the audio and recording consent form as well (Appendix C) stating that they were allowing the principal investigator audio record for transcription. Participants then emailed back the signed consent forms and in return were emailed a password protected Zoom link for their individual interview. At the conclusion of their interview, they were emailed a demographics form to fill out and email back. All email correspondence was encrypted via email as possible and if it was not possible, participants gave permission to correspond via email in a non-encrypted fashion. Interviews were approximately one hour (ranging from 40 minutes to 90 minutes) and were recorded over Zoom to be transcribed later.

<div align="center">

**Measures**

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**Individual Interview**

The principal investigator conducted an individual semi-structured interview (Appendix E) consisting of these core questions. The interview was dynamic in nature, meaning the principal investigator followed the participant's lead and as such asked questions in the order the seemed appropriate as well as asked follow-up questions when needed.

1. Please briefly tell me about your patient.

2. Can you describe your relationship with this patient?

3. How would you describe your reaction to this loss?

4. Can you describe what your experience was like with the sudden loss of your patient?

5. How have you made meaning of this loss?

6.  Did your feelings about being in the role of a therapist change after this loss?

7.  In what way did this experience change you?

8.  How did this loss impact the way you feel about death overall?

**Demographic Questionnaire**

At the conclusion of each individual interview, the participant was subsequently emailed the demographics questionnaire (Appendix D). This form asked a variety of questions pertaining to them as professionals as well as basic demographic information. Information asked included their age, gender identity, race, ethnicity, religious affiliation, and number of years since receiving licensure. Participants were also asked professional information such as what degree(s) they hold, how many years they have been practicing, what their therapeutic orientation is and what types of settings they have worked in.

Due to the current COVID-19 pandemic, participants will be asked to note how the pandemic has affected them and if they have experienced the death of a close person due to Coronavirus. Participants will also be asked to report how many clients of theirs have passed away in total as well as their current health status.

**Data Analysis**

This study utilizes a qualitative research design with a grounded theory approach using the Auerbach and Silverstein (2003) method. The principal investigator and two research assistant coders who were selected through the second-year cohort of the LIU Psy.D. program, coded each transcribed interview to identify relevant text, repeating ideas, and themes. Although, Auerbach and Silverstein (2003) recommend a coding team of two experienced researchers and two students, due to the limited availability of coders, the analysis was conducted by the three coders mentioned. The team approach guaranteed that important text was not overlooked and that all repeating ideas are understandable and transparent, each coder providing clear reasoning for each idea coded.

Members of the coding team were trained in the coding method by the principal investigator. Coders read the book Qualitative Data (Auerbach & Silverstein, 2003) each step of the process, and the team met via video chat to review the data analysis method and for coders to ask questions and cross reference each other's coding to reach reliability. Coders were made privy to the overall research ideas and main points of the literature to assess for any biases once the coding team was assembled; as there were no noted biases, coders were encouraged to discuss them if they came up later.

The first step in the data analysis was all three members of the coding team selecting relevant text from each transcribed interview by independently highlighting text from each transcript believed to be pertinent to the research questions. Each coder then had 17 documents of relevant text, one for each participant, resulting in 51 documents. These highlighted documents were then combined by the principal investigator to form 17 master relevant text documents, one for each participant, by keeping text that was highlighted by two or more coders.

From the master relevant text documents, coders then establish repeating ideas by identifying overarching words or phrases that appeared across transcripts, being said by multiple participants. The three coders then met to discuss the repeating ideas and those mentioned by two or more coders or ones that could be easily and transparently explained were added to the master list of repeating ideas. The final number of repeating ideas consisted of 84 different phrases to then be organized for the final group step.

From the final list of 85 repeating ideas, all three coders grouped them together individually into themes, which are overarching ideas each repeating idea has in common with another. The coders then met to discuss the final list of themes, again explaining those what were not agreed upon, thus ending up with 21 themes in the master list. This final list of themes was then taken once more, by the principal investigator and organized further into theoretical constructs. These constructs are more abstract in nature and serve to organize themes into a

theoretical framework to aid in the development of theory. The theoretical constructs were reviewed by Dr. Eva Feindler, the principal investigator's dissertation chair, before being taken together to form the theoretical narrative, which serves as a story of those who participated. A full description of the hierarchical coding is presented below in table 2.

**Personal Biases**

As a therapist who works with patients presenting with death related concerns such as chronic illness, aging, and chronic suicidality, I am mindful that I have experienced an increase in awareness regarding death overall. Having death and mortality enter the room often as a topic of discussion leaves me many times reflecting on my own views and concerns about death and meaning making. Additionally, as a therapist who has experienced recent personal loss, I recognize that my mind is often circulating ideas related to grief and bereavement, making it more likely that I assume others are doing the same. I have also had two deaths occur in my professional life, one woman passing suddenly between group sessions and one woman passing between initial contact and intake. I am aware that my own personal reactions may guide my assumptions of others' reactions, anticipating a reflection on the fragility of life. I believe that when death is around us in some capacity it brings awareness to the finitude of life and may increase levels of gratitude for life. Furthermore, I have been researching the topic of mortality salience and Terror Management Theory for years and as such, am aware that I hold strong beliefs that death anxiety and the principles of Terror Management Theory underlie many aspects of human existence.

**Results**

For the seventeen individual interviews conducted, the relevant text from their transcripts was broken down into repeating ideas, subsequently separated into themes and lastly organized into theoretical constructs. In the results presented below, different styles of text are used to indicate the different levels of hierarchical organization. Italics are used to represent repeating ideas, themes are underlined, and theoretical constructs are presented in ALL CAPITALS.

Quotation marks will be used to indicate direct quotes from participants, as Auerbach and

Silverstein (2003) suggested that direct quotes be used to name repeating ideas. Additionally,

brackets will signify words that describe an idea but were not stated verbatim by participants, but

provide important context or information needed for comprehension. The repeating ideas, themes,

and constructs are explained thoroughly in the theoretical narrative below. Presented in Table 2

below is the hierarchical coding including all theoretical constructs, repeating ideas and examples

of relevant text, as well as the percentages of how many participants endorsed each theme and idea.

**Theoretical Narrative**

When psychotherapists recounted their stories of experiencing the sudden death of their

patient in the individual interview process, they spoke about their experiences in terms of six

distinct ideas, including (1) THE DETAILS AND CIRCUMSTANCES OF THEIR PATIENT'S

DEATH, (2) THERAPIST'S AFFECTIVE REACTIONS, (3) THERAPIST'S VIEWS ON

DEATH AND LIFE, (4) THE MEANING MAKING PRCOESS FOR THE THERAPIST, (5)

THERAPIST'S COPING BEHAVIORS and (6) THE DEATH'S IMPACT ON PROFESSIONAL

LIFE.

As the psychotherapists were interviewed for this research, they began to share their

experiences of a patient's sudden passing, thus disclosing THE DETAILS AND

CIRCUMSTANCES OF THEIR PATIENT'S DEATH.  In discussing their patients and recalling

the events leading up to their passing, several therapists (12, 71%) noted that they were unsure

about details of their patient's death. While some therapists found it difficult to remember the

details ("I don't remember the details.") and other therapists reported that they didn't know any

information at all regarding how their patient died, due to not hearing back from them ("It was

really unlike her to no-show, I called and didn't hear back."). It seemed that the abruptness of their

patient's passing, with such little knowledge about the cause, is what struck some of the

participants most ("I had no clue what happened to the person/how they died, it's the suddenness

that hurts the most."). Some of the interviewed therapists recalled a wish to be able to reach out to the family to find out information and possibly gain some closure but were unable to due to confidentiality concerns ("I didn't have any kind of releases to reach out and I wish I could have reached out."). Still, other therapists, were concerned about the possibility that their patient had died by suicide and questioned their judgment ("I was trying to figure out, was their death intentional, or did I just not want it to be that?").

The participants reported that there <u>were a variety of causes of death for the patients, some of which were violent</u>. Many therapists (11, 69%) recounted that their patient's death was related to a medical difficulty or that they suddenly died in their sleep ("It was just ruled a medical reason why they passed away, his heart just gave out and he died in his sleep."). However, other participants (5, 30%) recalled more horrifying causes of death that made the news headlines such as vehicle accidents and murder ("The horrific menace of how she was killed, in such like an unusual, violent way." "The basic facts of how she died made headlines and was on the news."). Some therapists expressed that they also attributed the patient's cause of death to be partially related to systematic and social problems ("His death was also kind of like a failure of our society in some way.").

An overarching experience relayed by many therapists (9, 53%) was the fact that <u>addiction and substance use were involved in their patient's death</u>. A high rate of the participants (8, 47%) reported that their patient had died from an overdose or substance use. Some participants mentioned that their patient was possibly drugged, while other patients were known to be heavy drug users ("She used [drugs] and she died, oxy was probably laced with fentanyl."). Some of the participants who worked specifically within the sphere of addiction and substance use disorders shared that death felt ever-present when working with individuals with such difficulties ("Death is a co-worker when you work in addiction, it's like working in palliative care.").

THERAPIST'S AFFECTIVE REACTIONS appeared to be particularly salient in recounting these experiences. Several participants reported that finding out about the patient's death was difficult and inopportune (14, 82%), finding themselves wishing they had found out in another way or at another time ("Finding out they died was really hard," "About an hour before her session, I got a message saying that she had passed, so I, or she wouldn't be attending," "I wish that [I wasn't told they passed away] right before I had another client, that was horrible."). When participants began to discuss their reactions to finding out that their patient had died, several therapists became emotional. Many (16, 94%) of the therapists experienced strong negative affect after hearing that their patient had died. Several of the therapists remembered having a wide range of intense negative feelings including deep sadness, devastation, anger, shock, and guilt ("I was so absolutely devastated, profoundly sad for them and everybody," "I remember feeling anger, I think that was a really big feeling," "I was really and truly shocked, I couldn't believe it," "I also feel guilty."). Others recall expressing their strong emotions through crying or experiencing denial of their patient's death ("I literally fell to my knees and just started sobbing," "That was the denial of it all, I don't want him to be dead."). Some participants (9, 53%) felt that their loss was so profound that the therapist still feels affected by this death ("Even today, it's still kind of pops up and still hurts," "I just miss him," "I think those of us who are good at what we do, we still hurt every time it happens, it keeps you human.").

Interestingly, some (10, 59%) therapists did not have a strong grief reaction, and instead reported that their patient's death had a low emotional impact on them ("I didn't feel overwhelming grief."). Additionally, some therapists noted that they were not shocked to hear that their patient had died, due to the type of life they led, thus tempering the intensity of their reactions ("It's not a huge shock that somebody who had those sorts of health problems or personal involvement might die."). Furthermore, some participants reported feeling relieved upon learning of their patient's

death due to the pain and suffering their patient was going through ("Also, [I felt] relief, because I do think that they are free of the pain that they were experiencing on this earth.").

A salient theme across participants was therapists feeling that they faced their unique grief process alone. Therapists (4, 24%) reported feeling disconnected from others at their place of work while grieving ("I didn't really feel connectedness in terms of support with colleagues at work, which was frustrating and there was no formal debriefing."). Therapists also reported feeling as though their relationship with their patient and their grief was not being understood fully by others, which contributed to feelings of loneliness ("We may share a bit about what made them special to us, and they get it a little bit, but nobody really gets it, it's just loneliness across the board," "My family and/or husband doesn't get that relationship and you can't really talk about it."). Therapists questioned where their grief process fit in with the larger context of the patient's death, noting that they felt out of place and alone in their grief ("It's kind of like, where is the space for a person like me? When you're in an auxiliary role, there's a boundary, but their death still affects you.").

As the interviews progressed, participants began to share their VIEWS ON DEATH AND LIFE, from the way death had impacted them in the past, to how this experience has caused them to reflect. The therapists came from a variety of different backgrounds related to experiences with death; some therapists had not experienced much death, while others had an extensive history. Some participants (2, 12%) reported having been fortunate to not have dealt with a lot of death in the past ("I've been very lucky to not have a lot of people in my life pass away."). Meanwhile, others (5, 30%) reported extensive histories with death, both in their personal and professional lives ("I definitely have lost more clients than that, there are some that just stick out," "I unfortunately have had a lot of practice dealing with death.").

All of the therapists (17, 100%) went on to reflect on mortality and the uncertainty of life, noticing how this sudden passing prompted them to contemplate their relationship with death and the fragility of life ("Anytime somebody dies a kind of makes you reflect on your own mortality,"

"This death intensified my awareness of the unpredictability and fragility of life," "It makes you appreciate the sudden losses can happen, this is hard, people die," "I don't think it's necessarily changed [the way I feel about death] but it did make me see death as more possible and think more about what it means."). Some therapists shared their fears about death ("So, I definitely have a lot of anxiety about death, it's a scary, unknown thing."), while others explained their outlook on acceptance of death as part of life ("I am not afraid of death, I know it's part of living as is dying, so I'm focusing more on acceptance of what we can't control."). Participants also went on to say that experiencing this death gave them perspective on how to be more focused on the now and living their lives to the fullest ("It gives me the perspective on living rather than just existing.").

Upon further exploration with the participants about how these deaths impacted them, the MEANING MAKING PROCESS FOR THE THERAPISTS was discussed by all the therapists in some way (17, 100%). Several of the therapists (9, 53%) expressed how they felt this death impacted them in a beneficial way ("I feel like [this experience] probably made me a better therapist and has made me a better person." "This [death] made me want to honor my relationships and enjoy them to the fullest," "It's hard to pinpoint how this death changed me, but I do think it did," "I know what to expect if it happens again, I feel more equipped."). All the therapists (17, 100%) reflected on the impact of their client and therapeutic relationships, expressing strong feelings towards their patients. Several therapists commented on how the loss of potential for who the patient could have become and what progress they could have made was particularly difficult for them ("She had life ahead of her, what else could she have accomplished? What other changes in her life could she have made? Death is so final," "They had overcome so much trauma had lived a hard life and didn't trust easily."). Many therapists (9, 53%) reflected on fond memories of their patients and who they were as people ("I described her as luminous, so much vitality that it is hard to think of them as not alive still," "We had a great, special relationship, she was funny and I really liked her."), while others reflected on how their patient was received poorly by others, leaving

them to grieve their patient in a more solitary way ("He was a tough one, people had a negative reaction to him."). Several therapists stated that they wanted to make a difference in their patient's lives, but in reflecting on their work together also saw how impactful their patient has been on their own lives ("It feels important that I make a difference with my patients, but also, they've enhanced my life just as much as I have enhanced theirs.")

While reflecting on their relationships with their late patients, therapist contemplated the meaning of patient's death and their work together. Some therapists (6, 35%) struggled greatly with coming up with meaning related to their patient's death, particularly those who lost a patient in a horrific manner ("As far as meaning, it's hard for me to see why this would happen, it's a senseless loss."). Other therapists (7, 41%), however, appeared to be eager to make meaning out of the experience, indicating that meaning making is part of how they navigate through the world ("I'm a meaning making sort of person and for me it's what is the take home message from this person.").

Another major area of participant's experiences with the sudden death of a patient was the THERAPIST'S COPING BEHAVIORS. It was clear that participants required support and the therapists sought support from a variety of places. Several therapists noted that they looked for support in the therapy community in which they worked, such as co-workers, other therapists and their supervisors ("I spoke to several colleagues about [the death] and they were supportive," Spoke with their supervisor, some were helpful while others were unsympathetic."). Some therapists (10, 59%) reported a focus on self-care in the form of individual therapy or taking leave ("I took time off to intentionally to take care of myself," "My individual therapist/analyst was probably the best support."). While other therapists mentioned speaking with family or friends to get support such as their spouses, children, or close friends ("I made a point to let my friends know that I had a patient pass away and that I am a bit vulnerable right now," "My family were very supportive to me.").

Another source of support appeared to be social media, where some therapists (3, 18%) mentioned they have posted in forums, on support group pages or alumni groups for support from others ("After a loss I kind of post on or search for a social media page for support."). Additionally, a few (2, 12%) therapists thought about or engaged in their religion as a form of support ("I feel a lot of gratitude for my religion with these unexpected things in life."), while other therapists (2, 12%) reported not having any religious affiliation that could comfort them during these times ("I'm not particularly religious.").

In therapists' efforts to engage in coping behaviors to aide in grief, many therapists attended the patient's funeral services (12, 71%). The participants mentioned conflicting feelings around attending services, on one hand finding closure and healing, while on the other feeling uncomfortable and out of place ("The funeral was healing, I feel like it does help with closure," "The funeral is also uncomfortable, you want to say the right things but also have to balance what to say and not say as their therapist."). Some (6, 35%) who were not able to attend services or were unaware if they were happening expressed a desire to have gone to gain closure ("I did not go to the funeral, but I wish that I had gotten to go.").

Both therapists who attended the patient's funerals, as well as those who did not (16, 94%), mentioned creating and engaging with their own personalized rituals and ways of coping and remembering their patient ("I just did my own processing, you know, my own way of coping with grief," "I have my own ritual for myself. Like I talk to them, light a candle or bring things to their grave site. I'd wear one of his sweaters or go to the lake I knew he liked."). More specifically, some therapists recalled making conscious decisions to honor their late patients such as seeing family members for therapy, making active changes at their jobs or sending condolences to the family ("Seeing her mother for those sessions was part of my grieving, a continued connection with her," "That was kind of like the closure that I needed, reaching out or sending a card to the family," "So I think that was another way that I coped by making some changes that I wish I had at

the time."). Some participants (4, 24%) stated that their patient was part of a group while they were being seen, so having to process their death in the group setting and supporting others through their grief was helpful for them ("I also had to process her loss in the group and what that sudden death looked like for them."). Finally, many therapists (7, 41%) pinpointed their preparation and involvement with their interview for this research study as a meaningful way to memorialize and remember their patients ("This interview is a way of honoring her and it was important to revisit this again and talk about losing patients," "It helps to think back to the last session or re-read my notes.").

Finally, therapists reported that they felt that their experience of a PATIENT'S DEATH IMPACTED THEIR PROFESSIONAL LIFE. Several participants reported that they were unhappy with their employer's reaction to and their handling of the patient passing away. Several (7, 41%) therapists felt unsupported in their role ("I did feel so betrayed by my organization around how they handled everything," "I don't think we are ever really allowed to grieve or process anything that we are hearing or feeling as therapists," "Then unfortunately I had to go back on about my day [after finding out they died]. Um, you know, I had 20 other people on my case list."). Many participants mentioned that their views of the mental health field changed after this experience, due to the poor response of their organizations and grief experiences. Several therapists (4, 24%) reported thoughts related to questioning their abilities and interest in pursuing this profession ("I felt like I was just a bad therapist, and I totally lost my confidence in myself, I feel like I have a skewed perspective of things now," "I've certainly said, I don't want to this job anymore, it changed my trajectory," "I remember thinking, this job is tough.").

Similarly, several therapists questioned the appropriateness of their grief reactions, leading to uncertainty about how they were handling their own grief. A few (2, 12%) therapists mentioned searching online to identify what the typical grief reaction for a therapist would be ("I remember Googling things like what is the counselor supposed to feel like when a client dies?"),

while others suggested that a training on losing a patient could be particularly helpful to normalize the grief process in therapists ("Nobody offered any trainings on losing a patient, although it would be helpful."). Although this sample included a variety of levels of training and number of years practicing psychotherapy, several participants (5, 30%) mentioned being in the beginning phases of their career when they suffered this loss ("I was a pretty new therapist, in my formative years,"), indicating that training at this stage may be particularly important to aide therapists in navigating this process.

Lastly, several therapists (13, 76%) expressed being concerned about their impact and doing or saying the right thing, which again relates to questioning themselves and their ability to make decisions during their grief process. Many therapists had mentioned the idea that they asked themselves often if there was something they missed with the patient or something they could have done differently, thus taking on some responsibility for the patient's death ("It's hard not to question if there was anything else you could have done, did you do something wrong or something you missed?"). While other therapists reassured themselves that they did all they could and there was not much else they could have done to save this patient ("I know that it's not my fault. Um, I know that there's not much that I could have done, we can't save everyone."). Some participants also mentioned a hyper-focus on ethics after suffering this loss, due to not wanting to break HIPAA or confidentiality of the deceased ("I was definitely very conscious of the ethical dilemmas and HIPAA.").

Table 2. *Theoretical Constructs and Supporting Data*

| Theoretical Construct #1: THE DETAILS/CIRCUMSTANCES OF PATIENT'S DEATH | | |
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| Theme #1: The therapist was unsure about details of patient's death. (12 participants – 71%) | | |
| **Repeating ideas** | **Relevant text example** | **Relevant text example** |
| Idea #1: *I had no clue what happened [to the person/how they died], it's the suddenness the hurts the most.* **(9 participants – 47%)** | "So later that day we get an email from the company saying it has been reported that X has died. We have no other information. At this time, an incident report will be | "And so, because of COVID and everything autopsies are taking longer than they should. And we're not sure yet [what happened]. |

| | filed. Um, the incident report came shortly thereafter and all it said nothing. It just said deceased - circumstances, unknown. And I was thinking what happened to him? What happened to him? I said, I know his stomach was hurting him, but how, how did he end up dead? I don't get it. Um, and so I ended up calling his mother, I think at the next day I called his mother and she, it was kind of, she was sad, but she was definitely, maybe she knew this was coming or something." (LC) | I think I would be okay not knowing just because I wouldn't have a choice, but, um, I would, I would love to find out what happened. I would love to know just so I can kind of put that to rest." (JB) |
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| Idea #2: *I was trying to figure out, was their death intentional, or did I just not want it to be that?* <br><br> **(3 participants – 18%)** | "But I think that part of it also was when you lose a patient, I think no matter how long you've been doing this, when it's an accidental overdose and there's question whether it was an accident um, it's hard to know" (SD) | "I was trying to figure out like, was it intentional because she was so depressed." (JB) |
| Idea #3: *I didn't have any kind of releases to reach out and I wish I could have reached out.* <br><br> **(2 participants – 12%)** | "Cause I know his mother loved him, adored him. I wonder if he didn't know how much she loved him. Um, so I'm sad for him that he didn't know that I wish I could have that conversation with him. I, uh, maybe write him a letter and let him know." (AW) | "I didn't have releases for the husband, didn't have releases for mom or family members. So I was never able to talk to anybody after she passed away, um, to even really get more information or to kind of get some kind of closure or give any kind of condolences to the family. I didn't have any kind of releases. I do really wish I would have at least had a release. I know I would have wanted to call them and just give condolences, but I don't know if I would have, um, it wasn't an option at the time. I can't reach out to the family, so I have to let that go." (AB) |
| Idea #4: *I don't remember the details.* <br><br> **(3 participants – 18%)** | "I don't even honestly remember their name." (AB) | "I actually have no idea what month or when the anniversary of her passing is. I don't remember the details." (AW) |
| Idea #5: *It was really unlike her to no-show, I called and didn't hear back* <br><br> **(3 participants – 18%)** | "We were doing tele-health and if he didn't come to a session you know, that would happen or he'd come late, but he usually would text me if he was going to be late and he usually would cancel an advanced, but he didn't just come. So, I texted him, you know, some to the session to say, you know, I'm here, are you calling today? And I never heard back." (BG) | "She had missed one group and she hadn't called, so let me know, which was really, really unlike her. Um, so I called her that day. I left a voicemail. I didn't hear back from her. I didn't really think anything of it." (JM) |

Theme #2: <u>There were a variety of causes of death for patients, some of which were violent.</u> (12 participants – 71%)

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| Idea #6: *"It was just ruled a medical reason why they passed away, his heart just gave out and he died in his sleep"*<br><br>**(11 participants – 69%)** | "And she said, you know, she pulled me into another room because we were in the hallway right to protect patient privacy. She pulled me into an empty room and she said that her, you know, Ms. X's son had taken her to the dentist. And while she was getting into the dentist chair, she was able to transfer from a wheelchair to bed. She was able to do those. And with her PT, she had gotten stronger with her hip replacement while she was getting into the dental chair, she fell, hit her head and had a brain bleed and died like that. That was it." (RL) | "But she [his mother] was like, yeah, poor sweet X's his heart just gave out. And I said, can you tell me a little bit about what happened to him? She goes, yeah, we don't really know. She said his home health aid got there that morning and he was sitting in the chair struggling to breathe. So he was alive that morning. When I think his home health aid usually got there about nine. So about an hour before I was set to see him and home health aid ended up calling his mother and then going over to get his mother and pick his mother up and bring him to the apartment. And his mother was like, no, no, no call the police call the ambulance. But I think the home health aid was just, she didn't speak English very well. I think she was panicking herself. So she got their mother, mother came over, she just lived about a mile away. And then they called the police. And apparently the paramedics worked on him for about 45 minutes and they couldn't get his heart to restart and he was declared dead." (LC) |
| Idea #7: *"The horrific menace of how she was killed, in such like an unusual, violent way"*<br><br>**(5 participants – 30%)** | "She was killed, and to me it was such a big difference [that the pt was murdered], like clients pass away. Um, but I had never known anyone who had gotten murdered and um, not being able to share that detail. I felt like it wasn't doing it fully justice. The sudden piece. But for me, um, the, the horrific menace of how she was killed was also a huge part of it." (AW) | "He was actually stabbed to death, and it was, it was tough on me." (SD2) |
| Idea #8: *"The basic facts of how she died made headlines and was on the news"*<br><br>**(3 participants – 18%)** | "I was at home ironing, um, for work the next day. And the TV was on in the background. And I saw my client's face on the news that she had been murdered and that her mother had been murdered. So it was a double homicide. And I gasped because it was so strange to see her face on the TV screen. I was obsessed with the news. I was Googling it constantly at the time. Every there was like definitely articles. Um, and it was all over the news. Um, there was just so many different just I think it, you know, if I had gone to work and got a message, normally, typically what happens is if your client has away, | "Seeing her name in the article, they didn't have a picture of her, but they had like a picture of the intersection. She was crossing and they had her name and her age there. And I just remember just feeling like really jarred by that for some reason, just like seeing her name in it, there was like a coldness about it." (JM) |

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| | um, there's a nurse or somebody who will call you to let you know that your client had passed away, but because I'd seen her on the news and I was at home, like there was so many elements that just made that so difficult." (AW) | |
| Idea #9: *"His death also kind of a failure of our society in some way"*<br><br>**(3 participants – 18%)** | "The only thing that's ever made me question my, uh, if I was a therapist, a question, if I wanted to continue is the system, uh, uh, the consistent DOC broken system and juvenile correction broken system at the the community health centers, you know, throughout the state, uh, the w all this miles and miles of red tape that, uh, are intended, you know, supposedly to protect the, do no harm, but then reality is prevented people from getting the help they need." (SD2) | "And there's, you know, a sense of, of some unfairness in the world that they did not get as many supports." (VL) |
| Theme #3: <u>Addiction and substance use were involved in the patient's death.</u> (9 participants – 53%) | | |
| Idea #10: *"She used [drugs]and she died, oxy was probably laced with fentanyl"*<br><br>**(8 participants – 47%)** | "He finally was brought to treatment and he was someone that was very, very high risk, very, very sick. And he stayed at treatment for 24 hours and then ran away and then overdosed and died. Um, and I was the last clinical person to talk to him before he ran away. And so that sat really heavily with me. And that was probably one of the deaths that I had the most doubt about." (VRF) | "He passed from a drug overdose, but no one knew that he had been doing drugs. He died from methamphetamine, but it was totally a secret from everyone, including from me. I mean, I had assumed he had high blood pressure, so I had assumed that he must've had a heart attack. That's what I assumed that for some reason, his blood pressure got, you know, out of control and he died. I assume he died from a heart attack, but it was really from a drug overdose. Well, I didn't know. He died from a drug overdose really until two weeks ago, but I did find out right away that the police had found meth in his room. So, you know, I had suspicion." (BG) |
| Idea #11: "*Death is a co-worker when you work in addiction, it's like working in palliative care.*"<br><br>**(4 participants – 24%)** | "I think a little bit different than like patient suicides having frequently overdoses, um, you know, it's yeah. I think having spent a number of years in addiction that, that just came up so frequently that I think it was kind of a sink or swim thing where like I had to find something to help me deal with that." (VRF) | "Death is a co-worker when you work in addiction, um, in some way shape or form, you kind of see them every day. Um, the there's even if it's not connected to you directly, um, maybe the statistics are never great, unfortunately." (SD) |
| Theoretical Construct #2: THERAPIST'S AFFECTIVE REACTIONS | | |
| Theme #4: <u>Finding out about the patient death was difficult and inopportune</u> (14 participants – 82%) | | |
| Idea #12: *About an hour before her session, I got a message saying that* | "I got a call from mom, asking have you heard from him? And, uh, she | "Um, she never did that [no showed]. And so I started to get |

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| *she had passed, so I, or she wouldn't be attending.*<br><br>**(13 participants – 76%)** | was crying on the phone and I was like, no, I have not. And I was in session, I didn't get the voicemail until later on. So I called back and then his aunt answered the phone and says the police are here. The coroner's office is right here. And, uh, he, we found him. Dead in his bed." (SD2) | really worried. Um, and I reached out, I think someone had, like, I think our scheduler had like finally like canceled, like future appointments. And I reached out to be like, oh, Hey, like what's going on with X's appointments? And my scheduler was like, oh, you don't know? And I was like, no, what? And she was like, oh, like X passed away." (VRF) |
| Idea #13: *I wish that it wasn't right before I had another client, that was horrible.*<br><br>**(3 participants – 18%)** | "So her session was at two o'clock every Saturday. Um, and so I think I got the call must have been about, I was, I called back in like that, you know, five to 10 minutes that we had between sessions. Um, and it was before it was a like 12:45 or 12:50, something like that before my next session." (JB) | "this email had come through while I was literally like in the middle of another session telling me that my client was dead, which is horrible." (VRF) |
| Idea #14: *Finding out they died was really hard.*<br><br>**(2 participants – 12%)** | "I got a call from another mom in the group who told me that X had died. Um, and that one hit me really hard. Um, it felt really dramatic [finding out she died]." (AH) | "Well, that was the hardest part for me [Finding out she passed away]. Um, so the way I found out was definitely hard." (AB) |
| Theme #5: <u>Therapists experienced strong negative affect</u> (16 participants – 94%) | | |
| Idea #15: *I was really and truly shocked, I couldn't believe it.*<br><br>**(13 participants – 76%)** | "I was in total absolute, total shock, total shock. The feeling of shock, which is just, I, it was complete disbelief. It was, I think that was, that might have been made worse by the fact that I was keys in hand, walking out the door to go see him that, I mean, what are the odds?" (LC) | "When I go to a room and I see that their name is not there. I know when I do find out that they've passed away, I, um, it, I get sad. I mean, I try to, it's hard because then I've got to move on to the next room. So it's a, it's kind of a quick processing of the loss. It's like, okay, wow; it's a shock to the system. Um, so the shock of the loss, you know, and I was surprised at myself. Like I just kind of, um, was, uh, in shock. I mean, I was like, and I literally was like, that was my face. Like, you know, like, what do you mean? Like, I was just, I couldn't believe it." (RL) |
| Idea #16: *I was so absolutely devastated, profoundly sad for them and everybody.*<br><br>**(10 participants – 59%)** | "I just felt sad for him. I felt sorry for him. And I just felt so sad for him just felt sad for everybody. And then, but once I had that five minute cried, I didn't cry anymore. I just felt sad for a couple of days. Cause it just seemed sad." (LC) | "I mean, it's just in my initial, when I remember hearing about it, it was just sadness that it's a loss, um, you know. I think I just remember being sad that her life was gone, it was just more sadness." (AB) |
| Idea #17: *I just remember bursting into tears.*<br><br>**(9 participants – 53%)** | "I still have my keys in my hand. I was going to go see him. And it was so surreal. And, um, I thanked her for calling me and I hung up the phone and I remember kind of standing there for a minute. And | "I was crushed this one. I was actually really crushed. Uh, I cried like a baby." (SD2) |

| | then I just started, I just burst into tears. I just burst into tears. Um, it was, I was like, I had been hit upside the head with some like invisible, like grief wave. And it just, I sat in the chair, I just sat down and I cried really hard for about five minutes. And I said, no, I was like, no X. No, no. And um, about five minutes ago crying. And then I stopped, and I just said, I cannot believe this." (LC) | |
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| Idea #18: *That was the, the denial of it all, I don't want him to be dead*<br><br>**(3 participants – 18%)** | "Our computer system has a little box on the home page of our health record system for deceased. And I just remember feeling like, I don't want to see that box checked. Like that was the, the denial of it all. And I don't want him to be dead. I don't want to see that little box checked when I go to his health record, but it's checked. It happened." (LC) | "And I remember thinking, oh yeah, no, I was thinking, is this some sort of weird test? And he's really still alive and I'm not allowed to, to grieve his death. And I have to be, you know, the really savvy therapist to see through the trick. And I'm like, no, that's, that's crazy. I'm pretty sure that's not how I saw the obituary in the newspaper." (VL) |
| Idea #19: *I remember feeling anger, I think that was a really big feeling.*<br><br>**(6 participants – 35%)** | "I remember being kind of pissed at the universe, like what the heck, why this person, you know, like she was such a good soul why'd you have to take this one. Um, but then I've felt that way a million times before with friends and people that have died young, you know, friendships like in high school and stuff like that. So I just know that there's no rhyme or reason for who gets chosen next. It's just, it's just life." (JB) | "I just wanted a chance to save your life. I was here. I would have fought for you. I wish you had given me chance. Almost a very faint sort of anger. Let me, let me help. And I didn't get a chance to." (VL) |
| Idea #20: *I also feel guilty.*<br><br>**(5 participants – 30%)** | "And, um, that was probably the most difficult part for me is just a lot to reach. And it took a lot for, for her to reach back. So that being kind of taken out of my hands as far as how she was treated, um, made me feel very guilty and aggravated at the same time." (SD) | "I feel defeated, but I also feel guilty. I know I felt guilty at the time for feeling like I needed to talk about these things. And so it almost feels like I feel guilty or selfish for being this upset and having it affect me as much as it does." (SG) |
| Theme #6: <u>The therapist still feels affected by this death</u> (9 participants – 53 %) | | |
| Idea #21: *Even today, it's still kind of pops up and still hurts*<br><br>**(4 participants – 24%)** | "And every, um, year or two, I will Google it again. I don't know why I do that, but not on her Facebook, but just, I don't know. I read the articles again." (AW) | "So I think people have been available and I've talked about it, but it doesn't feel like it's been enough." (BG) |

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| Idea #22: *I think those of us who are good at what we do, we still hurt every time it happens, it keeps you human*<br><br>**(4 participants – 24%)** | "I don't feel like it impacts my kind of my sense of self or it doesn't take away from me caring less. Like I wonder if part of it is like it's hardened me, but not hardened me in a way that is like, I'm, I'm less caring. It's more like I've trained myself to know this is par for the course. This, this is part of the work that I do." (RL) | "I feel fortunate that I haven't been jaded in that it doesn't phase me. Cause I feel like it always phases me." (AH) |
| Idea #23: *I just miss him*<br><br>**(3 participants – 18%)** | "I really miss her. I was like, I looked forward to sessions with her cause she was so fun and we just like would laugh and chat and it was like, it was like, um, she was, she was just hilarious. And so that was the, that was definitely like, I was like, man, Saturdays at two really suck because there was just nothing my Saturdays this morning, like shoot, she lit up my Saturdays." (JB) | "I still miss her. Um, but she was, she was so much fun and I still miss her. I really valued that relationship a lot." (VRF) |
| Theme #7: <u>Some therapists did not have a strong grief reaction</u> (10 participants – 59 %) | | |
| Idea #24: *I didn't feel overwhelming grief*<br><br>**(2 participants – 12%)** | "Um, and I don't feel like it's overwhelming grief, um, or crying still. It wasn't like a long grieving process or very emotional." (AB) | "So I think that it was easier to process and grieve it because of the nature of his involvement [being in a gang]. Then it's so common for people to die in that line of association." (SD2) |
| Idea #25: *It's not a huge shock that somebody who had those sort of health problems or personal involvement might die*<br><br>**(4 participants – 24%)** | "So if I, I think that, [knowing his involvement with MS13] let me not feel as, sad and not to have as a visceral, a reaction, because maybe a little underlying, subconsciously I had a feeling that this could have happened. It could happen anytime." (SD2) | "I mean, he had a, um, excessive substance abuse history and then had gotten clean. I know he had lived very hard. So it's the kind of person that when you hear it, you're like, oh yeah, I could see how he might have worn out his system with all the hard living. So it's not shocking in that sense. I did not have the kind of sense of displacement or shock or unreality that I think many people do." (VL) |
| Idea #26: *Also [felt]relief, because I do think that they are free of the pain that they were experiencing on this earth*<br><br>**(6 participants – 35%)** | "I feel like it was the way that I was able to process it was feeling like this person, you know, working with them for so long. Um, it was like, they really did feel like their body was like a prison to them in some ways, like it just didn't work, so it almost feels like even as hard as it was, you know, this person was kind of, I always thought of them as the butterfly, after that, you know, they could transform." (BB) | "Is it a loss? Yes. While at the same time, like they were suffering too. Like he had, you know, multiple medical, he was very depressed. And sometimes I think maybe this is what was meant to be for them. Maybe this was how long they were supposed to live. Like this was just kind of the stars aligned. And this was what best." (RL) |

| Theme #8: <u>Therapist faced their unique grief process alone</u> (9 participants – 53 %) | | |
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| Idea #27: *We may share a bit about what made them special to us, and they get it a little bit, but nobody really gets it, it's just loneliness across the board*<br><br>**(3 participants – 18%)** | "There were a couple of, a couple of my coworkers who had covered the group on occasion in my absence and they remembered her, but still like not the degree to which I knew her, um, which, you know, what just felt, it felt like a little bit lonely. But you know, regardless, even if someone else had been working with her at same amount of time that I had, they would've had their own relationship their own perspective. I feel like it was going to feel a little lonely regardless, and it just kind of had to go along with it. So there's loneliness across the board." (JM) | "Other therapists, you know, usually we will say it to each other that I had a patient die or something, and we will share a little bit about the patient, um, or what made them special to us. But, and, and they get it a little bit, but nobody really gets it. Um, but ultimately they didn't either know the patient or they didn't know the patient like you did. A mother had written about losing her child and a bereavement group. And she said that the trouble in a bereavement group is - I'm not just a mother who lost a child. I'm a mom who lost Jennifer and you didn't know Jennifer, you didn't know all her quirks and amazingness and stuff like that. And so that kind of struck me that nobody really knows the patient like you did. And so that can be the same feeling." (RR) |
| Idea #28: *I didn't really feel connectedness in terms of support with colleagues at work, which was frustrating and there was no formal debriefing*<br><br>**(4 participants – 24%)** | "Well, the woman who shared the news with me, she's the one who led the program that my patient was in. Um, we had never met before, but we had a lot of mutual patients and, and I asked her, you know, like if she wants it to grab coffee sometime on and she, she politely declined." (JM) | "So my colleagues were helpful. My director was helpful, but they are like, yeah, X, it's really sad. But you know, he had a lot of problems, you know, I was like, because they knew him. They're like, yeah, well I guess I'm not terribly surprised. Cause he was really sick. I'm like, no, no, no. Like that wasn't helpful. It's like, he, it can be sad period. Well, we don't have to rationalize and say, but he was sick, but he was obese, you know? So she didn't know him at all. So she was like, that's really sad. You know, a life cut short at 50, um, uh, you know, she didn't know anything about all who he was. She just knew that it was a client that I was close with them. That was sad." (LC) |
| Idea #29: *My family/husband doesn't get that relationship and you can't really talk about it.*<br><br>**(2 participants – 12%)** | "Even with this, I couldn't go home and talk to my husband and tell him what happened during the day. Um, I think I told him [my husband], you know, I lost a client, Um, but I couldn't share the details so he doesn't get it either. He doesn't get that relationship and you can't really talk about it." (AB) | "It wasn't really something you can kind of carry that home and on a certain level, try to make that make sense, um, to a partner, obviously I couldn't tell him like the details or anything like that, but, you know, and he tried to help, but it's different." (SD) |

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| Idea #30: *It's kind of like, where is the space for a person like me? When you're in an auxiliary role, there's a boundary, but their death still affects you.*<br><br>**(3 participants – 18%)** | "Like in some ways it feels like we are people too, but in some ways it feels like we don't have the right. We're not their family. We're not their friends. What are we? And is it fair? We're sort of like their doctor, is it fair for us to be feeling sadness too, but, um, it's one of those professional ethics things that you're right." (LC) | "It's kind of like, where is the space for a person like me? Like, I mean, I just think of like, what if you're even this person's doctor or like, you know, people who have like auxiliary roles I think are like caregivers as well. Um, for some people it's like, do they have space for grief?" (BB) |
| **Theoretical Construct #3: THERAPIST'S VIEWS ON DEATH AND LIFE** | | |
| Theme #9: <u>Some therapists had not experienced much death, while others had an extensive history </u>(12 participants – 59%) | | |
| Idea #31: *I've been very lucky to not have a lot of people in my life pass away*<br><br>**(2 participants – 12%)** | "Growing up, I didn't experience a whole lot of deaths until I was older. I feel like I've experienced, um, no other losses or deaths. I haven't had a whole lot of deaths, um, in my life." (AB) | "I've been very lucky to not have a lot of close people in my life pass away, especially at that time. So, um, it was also like kind of a newer thing for me to experience grief in a different, in a way that was so horrible. I mean, of course I had some close people pass away, but nothing like that, nothing so sudden." (AW) |
| Idea #32: *I unfortunately have had a lot of practice dealing with death*<br><br>**(5 participants – 30%)** | "And also, you know I'm kind of in the throes of grief right now, I lost my father. And again, I think it's probably because of having another recent loss, even though it's not a client, um, because that roadmap in grief always makes more sense. The longer you look at it. It continually occurs to me that without these experiences, um, I probably wouldn't be able to cope with some of the stuff that I have coped with, um, or help other people, not just clients, but you know, other people in my life who have had tragedy we've had death, um, help them normalize grief. And I mean, I had, there was a lot of [death] around me kind of growing up. Um, so it was just something that was kind of normalized in my life." (SD) | "Well, I have thought about death as sudden before. I mean, that's not, um, no, I'm 72. I'm not young. I know lots of people who've died. Lots of people, I know, know people who have died. I'm at the point where friend's husbands are getting sick and dying." (BG) |
| Idea #33: *I definitely have lost more clients than that, there are some that just stick out*<br><br>**(4 participants – 24%)** | "I can think of, at least I want to say four people. I definitely have lost more clients than that. Um, but some were, you know, long-term illness, one was a suicide. Um, so those are all unexpected, but I would say some of the deaths that, um, come to mind, um, there's, I guess there's a couple that kind of stick out." (BB) | "I actually had four patients pass away in the span of about 16 months. Um, I worked with, um, a lot of people with co-occurring disorders, so substance use and mental health. Not having the support, um, having that patient in particular, but three others pass away. Um, it made me feel really burnt out." (SG) |
| Theme #10: <u>Therapist reflected on mortality and the uncertainty of life </u>(17 participants – 100%) | | |

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| Idea #34: *This death intensified my awareness of the unpredictability and fragility of life*<br><br>**(8 participants – 47%)** | "I know we all could really die at any time we could, but when it really truly happens that somebody who you just dies in front of you, it's like, it's a good reminder to try to live every day, as best as you can, um, do the things that make you happy. Um, I think the first thing that it did for me is, um, it kind of anytime somebody, not anytime, but often I feel like when somebody dies, it kind of gives the people who are still living a nice sort of sense of invigoration in their own lives. Like I need to start doing more things cause like X can't ever do them anymore. And, um, I think it just is like a good reminder that life is very fragile and life is fleeting and he certainly didn't know he was gonna die that day." (LC) | "It was like a sobering kind of reminder of the obvious that like, we don't know what's going to happen day by day, moment by moment, that sort of thing. I'm very lucky right now that like my loved ones, like, like my mom are like, she's in good health. Um, but there's nothing to stop her or anyone from like an awful accident happening. So I do think that those kinds of things are on my mind more often now than, than maybe they used to be just kind of like thinking like, oh, what if this happens? What if that happens? It doesn't have to be an illness. It doesn't have to be something that we kind of see coming from a long way away could just, you know, the fragility of life and especially like throughout the pandemic has all like intensified that for me personally as well. I think losing her in the way that I did intensify my awareness of like the unpredictability of, of life and how we go." (JM) |
| Idea #35: *It makes you appreciate the sudden losses can happen, this is hard, people die*<br><br>**(6 participants – 35%)** | "Certainly being mindful that the suddenness that life can turn on a dime, right? That you can be talking and your Wednesday at nine can, you know, kind of has been for years and will always be your Wednesday at nine, and then she isn't, and, and there's this gap." (RR) | "I think that feeling of like suddenness, um, I think it's easy to take for granted that we expect that things will stick around, you know, that someone will be there that, you know, this thing will keep going and that not only is like death there, but that like stuff can change really suddenly." (VRF) |
| Idea #36: *Anytime somebody dies a kind of makes you reflect on your own mortality*<br><br>**(8 participants – 47%)** | "Um, but it's like a weird little relationship that it has because guess I have a lot, a lot of anxiety about death, but I also know that I have a ton of people on the other side that are going to come get me. So when it's my time (laughing), so I don't feel so terrified. Um, but yes, it's just, I, I, it has caused a lot of anxiety because I do realize how short life is. So, um, I think that's a positive for sure, is that like it's helped me kind of get my affairs in order, somewhat and have those tough conversations that people just typically brief use to have. Cause they don't want to think about it, but it's been, it's happened so often in my life that I'm like, I don't have a choice, I have to." (JB) | "I think this was a really good reminder of like, you don't know how much time you have with anything, you know, whether it's your own like lifespan or how long you'll work with a client. Like, you know, you just don't know. I mean, like my house could burn down tomorrow. I could get hit by a bus. I mean, that's not likely because I there's no buses out here, but a meteor could like blow up the earth, like, who knows? Like, and I think I know for some people that that's not comforting. Um, I know for myself though, that like contextualizing that in the larger scheme of like, um, I think feeling a sense of like smallness and of like, you know, well, this is out of my hands. Like, |

|  |  | we're just all gonna pass away. Like whatever happens happens, I think we can feel so self-important, we can also feel like our problems are so big. Um, and then it's helpful to remember that there's something bigger than us. Like all our problems, you know, in that the sands of time will come for us all." (VRF) |
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| Idea #37: *I don't think it's necessarily changed [the way I feel about death] but it did make me see death as more possible and think more about what it means*<br><br>**(7 participants – 41%)** | "I mean, it's changed my view, um, of death most of my experiences with death have been with older people, grandparents, great, great grandparents. There's something about, you know, her being so young, I don't know if it changed my, my conception or thoughts about death, but, um, I suppose it made, maybe it made me wonder like a bit more about, um, you know, what happens beyond death. I found myself kind of wondering about, I guess, where X's energy went So I don't think it's necessarily changed [the way I feel about death] but it did make me think more about, you know, what does it mean? Are we just, um, flesh and blood, um, are, are we, you know, energy? What is that sort of transformation from life to death and does death really mean, I guess the end? Um, or is it, I mean, it's obviously it's a process, it's a cycle, you know, of life." (EP | "I think about the experience of overdose, um, or dying unexpectedly. Um, and I wonder, you know, what those last moments were like for them. Um, were they scared? Did they have that sense of panic? Couldn't breathe? Was it quick? Was it peaceful? Um, I don't know. And just thinking about somebody that you care about having those feelings of panic before they pass, um, is really scary to me." (SG) |
| Idea #38: So I definitely have a lot of anxiety about death, it's a scary, unknown thing<br><br>**(3 participants – 18%)** | "I think death is difficult for me anyway. So talking about it is a little uncomfortable for me." (AB) | "So I definitely have a lot of anxiety, um, about death. Um, I have, I have pretty severe anxiety anyway, and death is like a big one." (JB) |
| Idea #39: *I am not afraid of death, I know it's part of living as is dying, so I'm focusing more on acceptance of what we can't control*<br><br>**(9 participants – 53%)** | "I'm not afraid of death. I believe that we're worm food and that's a comforting thought to me. It doesn't that doesn't feel dark or scary. It just feels like you're returning to the earth." (AH) | "I have a relatively, I don't know if it's healthy or not, but it was very accepting relationship with death. Um, I'm not, not really afraid of it. I understand that it's a natural process. I think death is normal. Um, even when it's sudden, um, there's something to be said about the impact of death and dying and how that kind of works. Um, as I, I'm a firm believer that death is kind of an end to pain, you know, I don't have any antagonistic relationship with death." (SD) |
| Idea #40: *It gives me the perspective on living rather than just existing* | "I just feel like it gives me the perspective on living rather than just existing. And that's something that I | "Um, I think it kind of makes you take a pause and look at your life and are you really living it, you |

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| **(5 participants – 30%)** | talked to, like my, more to my private patients about private practice patients about, you know, not being so passive in our lives, like taking those chances. And that's something for myself too, like, like living your best life, I guess, just to sound cliche. Um, so it's just a reminder of, this is the only chance that I think I've got at this one life. So I'm going to try, and it's something that I have to work on. Try to live it as best as I can with some fun thrown in there." (RL) | know, or are you doing what you want to be doing right now in this moment?" (AH) |

| Theoretical Construct #4: MEANING MAKING PROCESS FOR THE THERAPISTS |
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| Theme #11: <u>Therapist felt this death impacted them in a positive way</u> (14 participants – 82%) |
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| Idea #41: *I feel like it's probably made me a better therapist and has made me a better person.*<br><br>**(9 participants – 53%)** | "And so now I feel like it's probably made me a better therapist, if anything, because I have experienced that loss of that, that client and a client that mint meant a lot to me. And, um, I, I think going through grief makes you more empathetic to when you are helping those with grief." (LC) | "If anything I think I'm more genuine, um, because you never know how much time you're going to know for somebody. So I think that I try to support more. Um, I do think that I try to pick up more on different cues. Um, I do a lot more, uh, risk assessment that I did before when I was an outpatient before all this." (SD) |
| Idea #42: *This made me want to honor my relationships and enjoy them to the fullest*<br><br>**(2 participants – 12%)** | "Um, and I, and I would say in my personal relationships as well, like I say, I love you frequently, and often. I tell people what I appreciate about them. I tell people what I'm grateful for about them. I tell people what I admire about them." (AH) | "I think, um, you know, it made me, um, it's hard to say not value my, my relationships, um, you know, completely more, but I think I was, there was some, a sense of, um, not wanting to, um, take anything for granted, you know, especially in with enjoying my kids, and other family members, friends as well. I think, you know, as I'm thinking about it now, um, I think that point, um, I realized that that's something that kind of, um, maybe, um, not lessons, like the point that the poignancy of, of, you know, that I felt about my relationships and want and just sort of wanting to like honor them and really enjoy them to the fullest." (EP) |
| Idea #43: *I feel like it's hard to pinpoint how it's changed me, but I do think it did*<br><br>**(5 participants – 30%)** | "No, I don't know why, but it hasn't [changed the way she feels about death] well, well, well maybe that's not exactly accurate. I think the most important thing is to, to make sure that there are no missed opportunities with people and to not regret their loss, because you didn't provide for spending time with that person and gaining from that relationship and being present in that | "I can't imagine it hasn't, but it's not like I have, um, very much the way it is. It's not like I came out of it and said, oh yeah, no, I have to do this differently now because of these experiences." (VL) |

| | relationship as much as you could." (MW) | |
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| Idea #44: *It's hard to pinpoint how this death changed my personal life, but it did*<br><br>**(7 participants – 41%)** | "I can't remember exactly, but I'm sure I thought a lot about, oh my God, what if something like that happened to one of my children? Um, you know, so I had a very, um, like, I didn't feel like X was my daughter, but I could, um, you know, I guess I could really feel the imagine, I guess, and it was certainly empathize, but really also imagine just how, um, overwhelming doesn't even begin to cover it. Just, you know, how, um, grief stricken her parents had to be. Um, it was just sort of like an incomprehensible loss. Yeah. Um I mean it must've [affected her personally], um, but I, I'm not sure I can put my finger on it." (EP) | "And, um, I certainly, I mean, take less risk. I mean, not that I take a lot of risks anyway, but yeah, she could makes me more cautious and it makes things seem more frightening. So that makes me want to be even more cautious, not taking risks. I'm not driving as much because I'm more cautious when I drive I'm usually really a total, not at all afraid of driving and a dry, I love to drive. I used to drive a lot. Um, but I'm much more cautious driving out. Like, don't speed. I don't take risks. I, whatever. It's just like, I can see the difference in that. Um, if I'm tired, I won't push myself to do something that might be risky in any way. Um, just more cautious." (BG) |
| Theme #12: <u>Therapist reflected on impact of client and therapeutic relationships</u> (17 participants – 100%) | | |
| Idea #45: *I described her as luminous, so much vitality that it is hard to think of them as not alive still*<br><br>**(5 participants – 30%)** | "She was wonderful. She was a very vibrant soul. Right. Very, um, well, I mean, there were times where she might not be where she was really anxious or sad about something, but by, I think of her though is just being, she was very kind of petite, but she kind of had a somewhat larger than life kind of presence, um, kind of, yeah. Um, she was more know, she was very engaged. It was very easy to, um, develop a good relationship with her. Um, she, um, you know, was kind of one of those people who was naturally self-reflective and so it, wasn't hard to get her to be introspective, um, and go places that not, you know, not every patient, um, goes to so easily. I remember using the word to describe her as luminous." (EP) | "He was such an alive person. He had so much energy and so much vitality that it is hard to think of him as not alive still." (BG) |
| Idea #46: *We had a good, special relationship*<br><br>**(9 participants – 53%)** | "Um, so that being said definitely had a very, um, yeah, big relationship with this client, big support to them and, you know, yeah. So it kind of felt like my relationship with them wasn't just as a therapist, it was kind of, you know, I obviously did therapy work with them and I also did the psychosocial rehab. So if in addition to that, it was also helping them kind of get back to doing these creative things that, that they | "Um, so I had, um, like a great relationship with her. We, we joked a lot. We used humor and a great way. She was funny. She, um, she was a character sometimes she'd come in with like off like a Harley or a motorcycle, um, kind of a look. And she, she was hardworking. She tried really, really hard to forgive herself. We talked a lot about self-forgiveness she apologized to her kids profusely. Um, so that was a big part of the work that we did was |

| | really were limited by being able to do, like, they didn't have anybody who would be patient enough with them and to go, to take them out and take pictures." (BB) | around self-forgiveness around her years of substance abuse." (AW) |
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| Idea #47: *He was a tough one, people had a negative reaction to him*<br><br>**(4 participants – 24%)** | "Uh, it became clear that in the course of working with him and his many very conflictual relationships that he was behaving at least verbally abusively to his wife, this is a person who was, uh, often very challenging to deal with, um, could be very charming. He's a kind of bastard that I really got on well with (laughing), he is somebody that I could like, even while I'm appreciating how you sometimes behaved in appalling ways. He was not hugely uncooperative. He was sometimes argumentative. Um, it was more of an issue. Sometimes I found out he did really horrifying things or had done really horrifying." (VL) | "yeah, I remember X, he was, he was, um, that one was a tough one cause he went and he, he, everybody didn't really like him cause he was grumpy. But of course he was grumpy because he felt like crap all the time. And so when he died, I was the only one that really felt kind of sad for him and grieved for him." (JB) |
| Idea #48: *They had overcome so much trauma, had lived a hard life and didn't trust easily*<br><br>**(7 participants – 41%)** | "She had lived a very hard life growing up in a very dysfunctional family and, um, married a guy who at best you could say was a diamond in the rough. Um, she had two sons and she was in my group basically for parents, with adult children with severe mental illness. And she talked about how she was glad that with her son's dying, that when she would die, it would be the end of the line that this very dysfunctional family and this mental illness would die out with her death. Um, she was, you know, kind of very blue collar, uh, good sense of humor, but had lived a hard life and didn't trust easily." (RR) | "People create these detachments that they're inmates, they're cartels, they're Mexican mafia, they're this they're that, that, uh, they're convicts, you know, and to me it was, and it was just a human being that I was helping know process through their traumas and just, you know, explore their ACEs and process to that. So I think that that was the reaction was very different." (SD2) |
| Idea #49: *She had life ahead of her, what else could she have accomplished? What other changes in her life could she have made? Death is so final.*<br><br>**(9 participants – 53%)** | "And then the whole death is so final. There was never a chance for anything to get any better. You know, he had talked about Gastric bypass surgery. Um, you know, he was like, I think I can do it. He had started to get a meal service delivered that portioned out his food. So he was trying to lose weight and like all the hopes were gone. All the things that could have been were gone, he never had a chance to get better. He never had a chance to have the surgery to be able to walk upstairs or take a bath. That's I think death is so final. It is so final, and it's makes you feel so | "I think that all kind of like people are candlelight. We each have an individual flame and, um, when they go out they're unique and they can't be replaced. So that that's usually the hard part for me (crying) is that you, so some of that potential, um, and I think that's what I'm saddest about when I think about her, that there was so much there, but it just, it's gone. (SD" |

|  | helpless because there's nothing you can do about it. And all the plans that you had, all the things that you were going to do, can't do them anymore. And it's, um, it's challenging to accept that." (LC) |  |
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| Idea #50: *It feels important that I make a difference with my patients, but also they've enhanced my life just as much as I have enhanced theirs*<br><br>**(7 participants – 41%)** | "Was there something about knowing them that, that changed me or could impact me and then hold onto that to kind of improve my own life and, and to kind of honor the fact that our lives crossed. I want, if a patient's going to cross my paths path, they've made a difference to me in one way or another. And so I'd like to make a difference for them. And so the patients that I continue to have, um, it feels important that I make a difference. (RR) | "It was that it [her death] kind of opened a door for me to do more work on myself, which is a gift that she gave me Um, I think that even though I'm very sad about her loss, um, she taught me more about believing in myself and my own instincts and my intuition just by being my client. And then her passing helps me understand that side of it." (SD) |
| Theme #13: <u>Therapist contemplated the meaning of patient's death and their work together</u> (10 participants – 59%) | | |
| Idea #51: *As far as meaning, it's hard for me to see why this would happen, it's a senseless loss*<br><br>**(6 participants – 35%)** | "I don't necessarily believe that we have some like crazy higher meaning and purpose. I think that for some people they need to make meaning out of it. I feel like we're, we're just other animals that happen to have a larger frontal cortex and can self-reflect on ourselves, which gives us the ability to make meaning." (AH) | "but as far as like, meaning in the, in the grand scheme of things, I don't, it's hard for me to see why this would happen. Um, and I don't feel like, oh, well, I've learned some things like, that's not enough. Um, I had a really close family member, um, unexpectedly pass away from overdose. Um, during the time I was in school. Um, and I think it was easier for me to make meaning out of that. And just knowing that, you know, life can end at any moment. Um, and it might be really painful not only for, you know, the person passing, but for everyone else. And to know that that's what happened. It's really hard for me to make meaning from that. Um, in a way that does it seem like it's not genuine or selfish." (SG) |
| Idea #52: *I'm a meaning making sort of person and for me it's what is the take home message from this person*<br>**(7 participants – 41%)** | "So I want to say that I definitely found meaning in that it makes me more happy to be alive and, uh, do a lot of the things that X can no longer do." (LC) | "I think the most important thing is to, to make sure that there are no missed opportunities with people and to not regret their loss, because you didn't provide for spending time with that person and gaining from that relationship and being present in that relationship as much as you could." (MW) |
| Theoretical Construct #5: THERAPIST'S COPING BEHAVIORS. | | |
| Theme #14: <u>Therapists sought support from a variety of places</u> (17 participants – 100%) | | |

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| Idea #53: *I spoke to several colleagues about it and they were supportive*<br><br>**(5 participants – 30%)** | "Yes [felt there was support], a lot of my colleagues, whether they were coworkers or just colleagues from other programs that also knew the kid, or also knew the family, they [co-workers] just know the work because they also do it, we've kind of all lost people. And so we all know how that goes, what we go through. I typically have people reach out and reach out to me, um, and see how I'm doing and things like that." (AH) | "I think, uh, having a colleague, I think it's so critical to be able to vent. And, uh, obviously a couple of other therapists in the practice had heard about it and they approached me and they're like, Hey, are you okay? Like, I deal with that. That's gotta be tough. I'm sorry you're going through, you know, that happened to you. Uh, so definitely, you know, having that support, you know, and them say, you know, we know you, like you give a hundred percent. I can just, I think we need that reaffirmation at the time that we did what we could, um, was very helpful." (SD2) |
| Idea #54: *My family were very supportive to me*<br><br>**(7 participants – 41%)** | "There is a layer of support, but it's not a lot. I think I get more when I come home and talk to my spouse. Um, or sometimes my kids will notice I'm sad. And I will say I lost someone who I really liked working with today. Um, yeah. So I, I get more of it, I think, on the home front and I, well, another layer that helps." (RR) | "My husband and daughter were actually there when I got the phone call. I think they were a little freaked out. I think they thought like, you know, my mom had died or something. Unfortunately my husband and my daughter are a little bit used to me getting these phone calls, which sucks, but after doing this for 10 years, it probably happens maybe once or twice a year. My husband is very supportive. He, knows that, cause I'm usually down for about a week, not crying all the time and stuff, but just like, it feels like the air got taken out of my tires. My kid, she's 15, she'll like put her hand on my arm and just say, it's okay to feel your feelings. And like, you can talk about it if you want." (AH) |
| Idea #55: *My individual therapist was probably the best support*<br><br>**(10 participants – 59%)** | "So with my own analyst, I spoke about my feelings and all of that, which is probably why the grieving process wasn't as traumatic as It might've been because I had a place to go with my feelings and, um, and when they veered in a direction that wasn't so terrific, my analyst was able to help me get out of that spot. So to speak. With my analyst, I was able to come to terms with the fact that that wasn't my job [to be angry at the mother]."  (MW) | "I almost always, I schedule a therapy session like for myself, like pretty much right away. I think really me going to my individual therapist is probably the best support where I get to just really kind of feel all my feelings and have it out in a very safe, contained space. Um, I'm fortunate too, that my therapist at the time, um, was also very familiar with young people in recovery. And so she could really commiserate." (AH) |
| Idea #56*: Spoke with their supervisor, some were helpful while others were unsympathetic*<br><br>**(6 participants – 35%)** | "They [my supervisor] were supportive and kind of helped me navigate through all of that too. I think definitely having that good supportive supervisor, um, ethically, legally kind of walking me through what is appropriate. What's not appropriate. Um, but I | "I spoke up and said, yes, I am feeling upset. And it still took me a few weeks to get in, to talk to my supervisor. And then when I did, she wasn't very sympathetic. She was rushed. She was, you know, wanting me to get out of her office |

| | don't remember specifically if my supervisor reached out or offered anything." (AB) | and I felt that, um, so I almost wish I hadn't reached out anyway." (SG) |
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| Idea #57: *I made a point to let my friends know that I had a patient pass away and that I am a bit vulnerable right now*<br><br>**(3 participants – 18%)** | "Um, so I think having a good friend to talk to and taking, taking a walk really was what helped me and that that happened right afterwards a day or two. So it was still fresh. So that's what helped the most." (LC) | "Um, I did make a point of letting my friends know, Hey, I've just had a patient pass away. So I'm a little bit vulnerable right now. And just want to let you know if this is the thing I am going through.<br>I, again, I let my friends know in a very vague way, by the way, I've had the death of a patient. It's a thing I'm going through. It's really bad this time. And I can tell you nothing about it because everything is identifying about this case." (VL) |
| Idea #58: *After a loss I kind of post/search for a social media page for support*<br><br>**(3 participants – 18%)** | "Almost every time after I lose someone, I kind of post [on school's social media page] and I'm just like, Hey, like I lost someone. These are the things that I'm feeling like I'm just fucked up about it. I needed to just say that to you guys. And like, they're so cool about just holding that, you know? And um, that just feels like a good place to kind of release. And so they had tagged me in this post cause they knew it, it just happened." (AH) | "There was a murder support group at some point that I found online. Um, but I remember, and I, and I remember reading about it, like how it was a unique experience. So, um, certainly that was my experience and it was definitely, um, unique, thankfully. Maybe I was trying to understand it more [on social media]. I wanted to be with people who were as equally horrified by what happened and understood. So I think I was reading the articles, reading the Facebook pages because those people knew how horrible it was." (AW) |
| Theme #15: <u>Religion played a role in grieving for some and not for others</u> (4 participants – 24%) | | |
| Idea #59: *I feel a lot of gratitude for Buddhism/religion with these unexpected things in life*<br><br>**(2 participants – 12%)** | "I never really, you know, I'm very spiritual person and there was a time when I was very religious. Uh, but so I'm not as religious anymore, but I'm still spiritual. I always just, I pray." (SD2) | "So like alongside Buddhism, I also am involved in like various like, um, practices relating to animism. And so both of those traditions and certainly they're not always mutually exclusive, um, depending on what kind of Buddhism you're talking about, have a sense of like, we're all connected, you know, and that we are often caught up in this like illusion of separateness and that all of these people who have been here who have passed away, it's like, I don't have to, I can, I can see past the illusion of separateness, which helps me to feel like, you know, there's some way in which I'm still tied to those stories and to those energies and to those people. Um, and that, you know, I'm like, it's like, they become like a part of me kind of, you know, and I'm like living on with them along side me. Um, you know, and I feel a lot of gratitude for Buddhism and the practices that it's offered me to be |

|  |  | able to roll with like these unexpected things in life and these like losses that we really don't have control over." (VRF) |
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| Idea #60: *I'm not particularly religious*<br><br>**(2 participants – 12%)** | "Uh, I'm not religious, first of all, in any capacity. Um, I grew up in a religious household. I don't really believe in an afterlife." (AH) | "I certainly am not a person that I'm not particularly religious, so I don't have a sense of God, you know, is out there and that there's some point to it or there's some, you know. I can't sit here and say, well, you know, it happened for a reason. Some people feel even though they're in pain about something, they feel like there's a, a larger plan, you know, in the religious sense. So they can maybe come to terms with that. I don't have that kind of faith." (EP) |
| Theme #16: <u>The patient's funeral was healing but also uncomfortable</u> (12 participants – 71%) | | |
| Idea #61: *The funeral was healing, I feel like it does help with closure*<br><br>**(5 participants – 30%)** | "In some ways, it didn't feel that I had done them justice by not going to the funeral, um, that I almost owed it to them. Uh, you know, that I had been, and they had been, our lives have been so intertwined for so long. And they had been so courageous in the kinds of things that they had shared and frankly, for some even just getting themselves to the hospital. I was really glad I had gone to that. Um, and to be able to bring that back to the group also, for me, it felt like a little bit of closure. Um, I was more happy that she had had this support system in place that I didn't know about as well. Um, and that those women took the time to get themselves to this funeral. Uh, also that, that meant something." (RR) | "Um, I was able to go to their funeral services. Um, I felt like I was able to fully grieve that because I like, once again, I was able to go to the services, you know, we were invited to go anybody that works with her, some of her, you know, some people that were in the groups went to the ceremony. It was pretty. Yeah. I mean, I think that was helpful because I haven't been able to do that with any other loss." (BB) |
| Idea #62: *The funeral is also uncomfortable, you want to say the right things but also have to balance what to say and not say as their therapist*<br><br>**(6 participants – 35%)** | "Um, so like I said, being invited by the family system, um, or that kind of thing, that's, that's unique, but it's, it's like, they're there. Where do you go to grieve this person when you're not really a part of this person's like inner circle in that way, you know, you just know them in a professional way, but yet therapy is one profession of many that I think, you know, you get, you can get to know a person and it really in depth way. And yet you're not really, you know, you can't really have that relationship, um, with those other | "Um, and that part [celebration of life], I wish I hadn't done because I had that family members and kids from his school were like, oh, so, you know, he used to mention you like, say, you know, your therapist. Oh my God. You know, so I didn't like that attention because then you're just putting this uncomfortable position. What do you share? What you not share? What do you say? What do you not say?" (SD2) |

| | individuals, if that makes sense." (BB) | |
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| Idea #63: *I did not go to the funeral but I wish that I had gotten to go*<br><br>**(6 participants – 35%)** | "No [no services]. And I think that's part of the difficulty because I'm Trying to think. There was nothing that I was made privy to about, you know, attending, um, sometimes there's memorials like at the hospital itself, like if they had, if the patient like had a sense of community at the hospital. Um, but, but there was nothing, nothing that I was made aware of. And, and that was kind of, you know, that was frustrating. I didn't have a funeral or Memorial that, that I was, you know, privy to. Um, and so kind of thinking about like how all the different ways like grief happens, whether the rituals are available to you or not." (JM) | "I wish that I had gotten to go to the service. Um, you know, I had been to a service for another patient who passed away that I worked with extensively. Um, and that was, that was good for me to be able to, you know, um, kind of put everything where it needed to go. I mean, I wasn't able to do that here." (SG) |
| Theme #17: <u>Therapists had their own personalized ways of rituals and ways of coping</u> (16 participants – 94%) | | |
| Idea #64: *Seeing her mother for those sessions was part of my grieving, a continued connection with her*<br><br>**(6 participants – 35%)** | "And I saw the mother for seven sessions. I know I was angry with her mother. I know I was blameful of the mother, but I think during those sessions, I, my anger wasn't present as I recall, because I was doing it for X and X have wanted that. I think by, by seeing her mother for those sessions, that was part of my grieving. I felt that it gave me a connect, a continued connection with X and, um, maybe it was my fantasy, but my thoughts were that she would have wanted me to do this. She would have wanted this. And it was time limited. I, I knew I couldn't do this forever. Certainly I wasn't going to take that mother on as my patient and with the cousin the same held true. But, you know, I invited the therapist to contact me, you know, when she wanted, if, if she thought I could be helpful and I shared whatever I could with her, but it was clear to me and to that therapist that this was not going to be, you know, I wasn't going to be a supervisory consultant or anything like that." (MW) | "And then they told me they were going to let me continue to work with not work with him. He was deceased, but work on his case a little bit to help his mother, um, like help, uh, turn loose his apartment because we found out that because he was a Medicaid holder, Medicaid will pay the, after a sudden death like that they'll pay the apartment rent for 15 days after the date of death to give the loved one time to clean it out. And his mother was like very frail and not able to do that. So I was able to, that that helped me as well. I was able to help his mother coordinate with the leasing company to get somebody to come in and haul out his stuff. Um, so it helped, I think that was like nice closure for me as well, um, to just kind of help cook close out his, his chapter, that nasty apartment, but it was like his, you know, so we got it, we got it taken care of and his mother was medically fragile. Didn't have to worry about it." (LC) |
| Idea #65: *I just did my own processing, you know, my own way of coping with grief*<br><br>**(8 participants – 47%)** | "And so I suppose that, that was part of my grieving process though. It didn't necessarily feel like a grieving process in the sense of there being a lot of grief, but just sort of in the, in our minds, from a | "Um, and so I feel like on a personal level, I just did my own processing, you know, my own way of coping with grief around that situation." (BB) |

|  | present person to someone who has gone." (VL) |  |
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| Idea #66: *I have my own ritual for myself, just my own memorial and ways of remembering them*<br><br>**(7 participants – 41%)** | "And I knew where they were buried. Um, you know, I took it, I took some stuff sometimes I would go over there and just bring some things, either their grave site, because yeah. It was usually not much there. Um, and it was nearby my job, you know, that's not something I still do, but at the time that was, that helped me.<br>I just kind of had to have my, like I said, have my own ritual for myself, um, which I just kind of did, um, just my own Memorial, like, you know, saying my peace to them and just that kind of thing. Yeah, I think I did my best in that regard .Um, I I'm also like a Reiki practitioner, so, um, I just kind of, I may like, I have like a box it's just like putting images. I had some pictures of X, um, had pictures from my so I feel like doing that process with myself, like having this space also create alters. Um, have an altar in my home where I can, that's just like where I pray. Um, not necessarily Christian per se, but that I, you know, I feel like that's part of my, um, you know, my own culture and what I was brought up with this to honor people that have passed away and just to talk to them and give yourself, give yourself a space for that. And that's pretty much what I did on my own terms in my own time was just that I, you know, I would talk to them or just, you know, do whatever like, you know, loving kindness to them." (BB) | "We decided to actually start, uh, like a scholarship, at our practice, uh, providing for three to four, like free treatments for the people that, from the school that he went to and the people that he played sports with, um, that needed that help with couldn't afford it. And she had brought me a couple of his favorite sweaters and she was like, uh, I think he would want you to have this because he was always like, every time Christmas came, he was like, can you buy SD2 a blanket? Or like a nice sweater, because he's always cold. So I still have those, the sweaters, but it, it took me in a few days, you know, took a really work through that. And it was very healing for the mother as well. So I think it was healing for me because, uh, seeing like mom felt like, uh, her son didn't die in vain, uh, despite his challenges, you know, he impacted, uh, a lot of people. And so, uh, I think, yeah, it definitely had that, uh, positive impact that fact that the, uh, he didn't die in vain. There's something, yeah. His name is having some impact, you know, because when people come in or when people are referred for that program, uh, they, they would come through his name, you know." (SD2) |
| Idea #67: *This interview is a way of honoring her and it was important to revisit this again and talk about losing patients*<br><br>**(7 participants – 41%)** | "So I think that part of why I wrote, back, wrote to you and replied back, like I wanted to, because I think it's like a way of honoring her and her name being, not her name, but her memory being talked about again." (AW) | "I mean, I think I'm actually surprised that I'm not more teary right now because, I think probably there's something about, you know, being in this interview setting where, um, I'm kind of keeping myself part of it is that this has been time has passed. I guess my one last comment would be, is like, um, this is really helpful in terms of, um, working through, um, the, the experience. Um, and, you know, I'm kind of glad to, um, even though it's a tough thing to talk about, um, I'm kind of, I feel like your questions helped me, um, |

| | | think more deeply and, um, I dunno if it figure out some things, but at least sort of keep like open things up for myself. So I appreciate it." (EP) |
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| Idea #68: *So I think that was another way that I coped by making some changes that I wish I had at the time.*<br><br>**(4 participants – 24%)** | "I now work at the, at the school where I graduated from. So my role here, um, I teach a course for current interns and we talk about, um, what to do when your client dies and people talk about like experiences. So, um, I, that's part of a way, I think I've, um, coped by giving some resources and support, um, that I wouldn't have liked to have had. And we did. I was one of the people on it offer a staff training at the agency may be a year later on want to do when a client passes away. So I think that was another way that I coped by making some changes that I wish I had at the time." (AW) | "And so when I train other providers, you know, and when we onboard them, I do talk to them about, this is the one, you know, face where you're going to have professional losses and it's important, you know, to contact me if it's something that you, you're having a hard time processing. Um, it's important to talk about it." (RL) |
| Idea #69: *That was kind of like the closure that I needed, reaching out or sending a card to the family.*<br><br>**(5 participants – 30%)** | "I got a card for the family cause because she was a minor I could. And so, um, I did send a card to the family. Like I think two days later I went to the store, grabbed a card that I liked and then I just wrote and wrote down my thoughts and then sent it to grandma. Um, and that was kind of like the closure that I needed [sending a card]. I wonder if it would be weird to like reach back out and just say, Hey, you know, I was just checking in, how are you?" (JB) | "Um, we played phone tag a couple of times, left a couple of voicemails, um, but never, never called each other to speak on the phone. Um, and I basically just let him know that, you know, that, that we had heard and that, and that we were missing her and, um, you know, he wanted touch base, or to talk to give me a call, but we never got on the phone really to have a conversation." (JM) |
| Idea #70: *It helps to think back to the last session or re-read my notes*<br><br>**(4 participants – 24%)** | "So what are the impacts after losing a patient is I always think back to the last session, you know, what did we talk about? What could I have done differently? What, um, you know, that was our last conversation and that was the last thing they got from me." (RR) | "Um, and with this stuff being like a really like a medical, and I think, I think for me it was also comforting, like reading the discharge summary because I got to read like everything that happened in the hospital. Um, and it really does sound like this was just, there was, there was nothing that anyone could have done to prevented this, which can be comforting to think about." (VRF) |
| Idea #71: *I also had to process her loss in the group and what that sudden death looked like for them*<br><br>**(4 participants – 24%)** | "I get a grief group for the inmates that were very close to him that were in his unit for a long time. And that we're in the same group as him, because I was, I was doing a lot of groups with them as well. Uh, so I noticed that it was, uh, a lot easier for me to do that." (SD2) | "And so rather than like shoving that all aside each Wednesday, when I went to get group, I just kind of what, let myself kind of have those, those memories or those feelings, but, but it never, it never got to a point where, where I was like tearful or unable to carry on with group. I found that it was |

| | | actually more relieving to let myself have some of those feelings and thoughts rather than trying to be like, okay, gotta be strong and stuff like that. So it helped me be stronger by like, just like letting it come in versus like pushing it away." (JM) |
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**Theoretical Construct #6: PATIENT'S DEATH IMPACTED THEIR PROFESSIONAL LIFE**

**Theme #18: Therapist felt unsupported (7 participants – 41%)**

| Idea #72: *then unfortunately I had to go back on about my day. Um, you know, I had 20 other people on my case list*<br><br>**(5 participants – 30%)** | "Um, and so then [after finding out X died] I had to go into an individual session with a group member who knew her from group and was talking about her stuff, which happened to be kind of lighter that day, but it felt very weird for me to be, um, I don't know, uh, pleasant and normal with this patient knowing I was going to go into group and shatter her world and tell her that this other one had died. So, then I went into group, um, and I still hadn't felt like I had fully, uh, certainly hadn't gotten to process fully that the issue myself." (RR) | "And I just remember telling my next client, like, I'm so sorry. I just had a client pass away. And he was like, oh my God, like, do we need to, we need to not do session today. And I was like, no, I think I'm good, so we moved through that session. He asked me like, are you okay? I'm like, yeah, yeah, let's move right on. Let's go. That was kind of what I thought. And I remember thinking like, Ooh, I don't really like that. Like that doesn't feel good to me, but I don't have a choice. Like I have to, I have to keep going. So, um, I think it probably hurt, but it was like that I just had to push through that hour and then I had an hour to find a decompress." (JB) |
| Idea #73: *I don't think we are ever really allowed to grieve or process anything that we are hearing or feeling as therapists*<br><br>**(4 participants – 24%)** | "It's just said that you can [reach out for help], and I think there's a culture in community, mental health too, where like, if something bothers you, then you're weak, but it's almost like if something bothers you, you need to get over it really quickly. Um, I think this person passing was compounded by the fact that I had also lost some other patients, um, in a short time span and not really having any, anyone to talk to about it. Um, it was just kind of like, okay, well, this is what happened. So let's move on. You have patients to see, and I'm scared of that stress. Um, and not being able to express my emotions or feel like I'm understood with my grief." (SG) | "And of course, you know, I don't talk about this. I'm like, yeah, what everybody to talk about it, but I don't talk about it. Um, I don't, I don't know. I, I'm very internal. I'm very, um, I kind of process my stuff by myself. Um, and I wonder how many other therapists probably doing the same thing, you know, we, we give and we pull, you know, we contain a lot, but then when it comes to us, we don't necessarily do the same emoting or processing. So I don't know. Um, so I think, and maybe I compartmentalize it in a way that is safe for me." (RL) |
| Idea #74: *I did feel so betrayed by my organization around how they handled everything*<br>**(2 participants – 12%)** | "Just to contextualize, I am a behavioral health provider within a medical clinic. Um, so she also received primary care services. Um, and none of the primary care providers thought to reach out to me to tell me that my patient who was also their patient, who they | "Um, but even right now, just the circumstances, um, both at the facility and for me personally in that moment were really terrible as far as how it was handled. And then I was also very angry because of the way that things were being handled. And then I was eventually asked to |

| | knew was my patient had died, which was really not cool. Um, and so I was understandably like really upset about this. And so mishandled by the organization, there was just a whole lot there. Um, and it was a really difficult thing to process in part, because I did feel so betrayed by my organization around how they handled that."(VRF) | change records, um, which I didn't do, but there was a pressure from the director in the organization to like, make it look good on paper that they didn't do anything wrong. So it was a very complicated, just complicated and aggravating. The impact was definitely seeing the true colors of working at this type of agency. Um, like I'd run into similar things like that before, but this was probably the most extreme, um, for me, I know it's not most extreme for other people." (SD) |
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| **Theme #19:** <u>Therapist's views of the mental health field changed</u> (12 participants – 71%) | | |
| Idea #75: *I've certainly said, I don't want to this job anymore, it changed my trajectory.*<br><br>**(8 participants – 47%)** | "Um, I definitely had secondary trauma. I thought I was going to leave the field and not continue being a psychologist because it was so hard." (AW) | "Totally [impacted feelings about being a therapist]. I left my job. So during that, what basically prompted me to leave was, you know, X passed away, then this client had ended his life. And I thought like, okay, well, like this isn't sustainable for me." (BB) |
| Idea #76: *I remember thinking, this job is tough.*<br><br>**(2 participants – 12%)** | "I do remember that being one of the moments thinking, wow, this job is tough. I think it was just one of those hard moments that hit you, that this job is hard. It's emotional. That's what we sign up for. Like I said, it's another reminder how tough this field is. It's another one of those moments or reminders where, um, this is tough work, its privileged work." (AB) | "And I will say, I felt relieved no longer working in some of these nonprofits and being in a private practice. Cause I was like, oh, maybe that'll happen less [sudden death].And then X died and I was like, fuck, you know, um, this sucks." (AH) |
| Idea #77: *I took time off to intentionally to take care of myself*<br><br>**(7 participants – 41%)** | "So anyway, so then I took off six days from, I just took a break. I took days off last week and that was very, very helpful. It was really, it really made a huge difference. Um, and right before that is when I got heard the result of that he did die from a drug overdose anyway. So that helped, I think, you know, kind of realized that, that that was what I was reacting to was his death. And then having time off." (BG) | "And then I had like a bunch of other sessions scheduled that day and I was just like, I cannot, like, I like contacted and was like, I'm sorry, like I have to cancel today. Um, so like I, yeah, I think like I did my best to kind of take some time and to make a little bit of space." (VRF) |
| Idea #78: *I felt like I was just a bad therapist and I totally lost my confidence in myself, I feel like I have a skewed perspective of things now*<br><br>**(4 participants – 24%)** | "I noticed like I had trepidation working with suicidal clients initially, for the most part, it's, it's just been like a slow rebuilding of like my confidence in those areas. Like now I even like, just look at the world in general, like, and I feel like I have a skewed perspective of things now. Like, you know, I see something or I, something is set off | "I felt like I was just a bad therapist and I totally lost my confidence in myself as a therapist. And, um, usually I'm pretty, you know more or less grounded, you know, I've been a therapist for a long time. I don't get that thrown by the ups and downs of practice. So I don't usually think of my role is something that has life and death |

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| | to where I just, I'm going straight to like worst case scenario or like a negative viewpoint and, you know, to the point where like, yeah, right. My partner notices it. Um, and that's part of the thing that I feel like is, is challenging, is like now that I've seen and experienced and work with like all kinds of experiences, that shape is also my view of things. Like I no longer have a view of like, okay, everything could be, be great or change, you know, like this positive idea of like change kind of motivation." (BB) | implications, because I don't think most of the people that I see are at that crisis point, but I didn't think he was either. So I guess I see it, um, that there's more risk involved. Um, so that, I feel like I'm always preserving the hope for my patients and that maybe I need to get more into feeling their hopelessness in some way. Um, because I think, you know, with X, I didn't, I minimized along with him, the despair that he felt." (BG) |
| Idea #79: *I know what to expect if it happens again, I feel more equipped*<br><br>**(3 participants – 18%)** | "I'm more aware now these days that my clients can die, if that makes sense. Like it's always sort of unexpected and in some ways I think I'm glad, I'm glad. Like I got that first, first death of my career, like out of the way. So like I know what to expect if it happens again, because some of the people we work with are medically fragile. So I think I can be thankful for that in the sense that I'm not thankful that he's gone, but that it kind of happened early. I learned how to deal with it. I learned how to cope. I got the support that I needed. And now, um, I can know, I can probably know what to expect more if it happens again, when, when it happens again." (LC) | "So my intake paperwork has some things in it. I have some things that very specifically say they, I describe a scenario. If you don't come for your appointment, I try to reach out to you by the normal channels of communication you've given me and the phone's disconnected or the email doesn't work, or I don't hear back from you. Is there somebody that I can contact to find out if you're okay? And I very explicitly described that scenario and because I've had other therapists consult with me and say, I have this patient, they disappeared. Another phone number doesn't work. What do you think I should do? And I'm like, well, you know, my intake paperwork. And we discussed this scenario because it's happened and I don't want to be in that situation of not knowing what do I do? Who do I talk to?" (VL) |
| Theme #20: <u>The therapist felt uncertainty about how to feel/grieve</u> (6 participants – 35%) | | |
| Idea #80: *I remember Googling things like what is the counselor supposed to feel like when a client dies*<br><br>**(2 participants – 12%)** | "Um, so normalizing that we can grieve over our clients I don't know. What's normal and what's appropriate? Is me just being sad for one day and kind of thinking about it at other times, is that appropriate and normal?" (AB) | "I remember Googling things like, you know, what is the counselor supposed to feel like when a client dies, just to make sure, you know, am I internalizing this too much? And I got confirmation from everybody that, um, I wasn't that it was normal to grieve and it was normal to feel sadness and feel pain when somebody you work really close with die, especially so suddenly. Um, so that, that was kind of my grief process." (LC) |

| Idea #81: *Nobody offered any trainings on losing a patient, although it would be helpful*<br><br>**(3 participants – 18%)** | "There isn't [trainings or preparation]. Nobody offered any of that. Even thinking now, obviously CEs that I have to do every year and looking through different things. I don't think, nothing sticking out about any kind of training or support systems for this. And I do think that probably would have been beneficial. And I guess that might be why there should be a training or something." (AB | "That's the secondary trauma kind of stuff. Like I, I remember like, you know, obviously we learned, about it in my undergrad all this stuff and I don't feel like that was enough. (BB) |
| Idea #82: *I was a pretty new therapist, in my formative years*<br><br>**(5 participants – 30%)** | "I guess it was towards the end of my second year being licensed and I was working with her. I was only second year. I don't know if that matters being a new therapist or not." (AB) | "It was my fourth month maybe on that job. So it happened to me like right away." (LC) |

| Theme #21: <u>Therapist was concerned about their impact and doing/saying the right thing </u>(13 participants – 76%) |

| Idea #83: *I was definitely very conscious of the ethical dilemmas and HIPAA*<br><br>**(5 participants – 30%)** | "That was one thing that I was like, am I breaking the rules? Because if I send a card, because is that a HIPAA violation? Like, and then they were like, no, because she's under 17, but you couldn't, if the person was over 18 and I was like, this is so complicated, you know?" (JB) | "X's mom wanted me to give a speech, but I didn't, uh, uh, just kind of like still kind of making sure some of those boundaries are in place, you know, and I'd say it because by HIPAA you know, the HIPAA applies about 50 years after the passing." (SD2) |
| Idea #84: *It's hard not to question if there was anything else you could have done, did you do something wrong or something you missed?*<br><br>**(9 participants – 53%)** | "I think I'm at a place where I find it more accessible to not like second guess myself, or be like, oh, did I do something wrong? Did I do something wrong or was there something else I could have said that would have convinced X to just stay?" (VRF) | "Was there something I didn't see? Was there something I could have said differently? Um, should I have pushed harder? Should I have not pushed as hard? Um, was I there enough? Were my boundaries, the right boundary?" (AH) |
| Idea #85: *I know that it's not my fault. Um, I know that there's not much that I could have done, we can't save everyone*<br><br>**(5 participants – 30%)** | "so, I grieved hard for the 17 year old, but then, uh, it took me a few days. So it was a Saturday. Uh, I was back to work on Tuesday. So just kind of being able to, uh, process through it and recognize really going back to what we teach, you know, that there's circumstances, we just couldn't control. And going back to my philosophy that all we can do is support our clients where they're at. Just really kind of reflect that, you know, we can't, uh, save everybody. Just a decision people can make one single decision, one single silly decision and, uh, and cost their lives. And, uh, that's not really on us." (SD2) | "don't even really know how to put that feeling into words, but like, oh, it's done now, it's done. I walked this one all the way to the end. This is the conclusion I saw this case to the very, very end. I suppose that I saw him to his last, that I didn't stop probably to help him have the relationships he wanted to have the positive relationships until, until I couldn't, until he could not come anymore until he was gone. And we kept fighting for a better life for change all the way up to the end. I sat and realized, you know, we don't always get a chance to, we can't catch all of the birds as they fall out of the sky." (VL) |

**Discussion**

Six overarching theoretical constructs were generated from the seventeen participant interviews including (1) THE DETAILS AND CIRCUMSTANCES OF THEIR PATIENT'S DEATH, (2) THERAPIST'S AFFECTIVE REACTIONS, (3) THERAPIST'S VIEWS ON DEATH AND LIFE, (4) THE MEANING MAKING PRCOESS FOR THE THERAPIST, (5) THERAPIST'S COPING BEHAVIORS and (6) THE PATIENT DEATH'S IMPACT ON PROFESSIONAL LIFE.  Each theoretical construct will be discussed in detail through the lens of Terror Management Theory (Greenberg, Pyszczynski & Solomon, 1986). Additionally, some these constructs will be analyzed supplementally through the lens of disenfranchised grief (Doka, 1989) with some discussion on meaning making and trauma. These theories were chosen to serve as lenses through which to explore the major focus of this study – therapists' grief processes and personal reactions to a sudden death. As one of the main areas of exploration in this study was how therapist view their own mortality, Terror Management Theory (TMT) serves as a lens through which to understand how reminders of death (i.e., the patient's passing) may serve as mortality salience for the therapists and impact subsequent behaviors. Due to the emerging themes related to therapists' questioning their place in the grief process, disenfranchised grief appears to align well with these ideas, serving as a means to comprehend their stated difficulties. Lastly, the concept of meaning making was chosen to explain some of the participant's engagement with symbolism, ritual and perceived lessons learned through this experience.

**Mortality Salience and Death Anxiety in Therapists**

As this study aims to address the experience of sudden death, all the patients discussed passed without warning, thus leaving several of the therapists with unanswered questions regarding the nature of their death. A major construct that emerged from the data was THE DETAILS AND CIRCUMSTANCES OF THE PATIENT'S DEATH, where many of the therapists endorsed the theme that they had no clue what happened [to the person/how they died]. However, several

therapists did know the cause of death for the patient, leading them to question their own safety and the possibility of something horrific happening to them or their family.

One major example of this was therapists' noting that their patients were killed in car accidents, leading them to be more aware of the possibility of what could happen. Participants shared fears about their families, stating "I thought a lot about, oh my God, what if something like that [getting hit by a truck] happened to one of my children?" (EP) and "Like my mom, she's in good health. Um, but there's nothing to stop her or anyone from like an awful accident happening. So, I do think that those kinds of things are on my mind more often now than, than maybe they used to be (JM)." While another therapist noted fears about her own safety, stating "I'm not driving as much because I'm more cautious when I drive, I'm usually not at all afraid of driving and I love to drive. But now, like I don't speed. I don't take risks. It's just like, I can see the difference in that (BG)." TMT research has indicated that sudden death can often serve as mortality salience in others, thus increasing one's conscious death anxiety (Tomer & Eliason, 2000; Brady, 2015). These results suggest that the patient deaths may have served as a salient reminder of mortality overall, thus increasing awareness of the possibly of anyone being killed in an accident, causing increased worry and cautionary behavior.

Strengthening the notation that these deaths served as mortality salience for therapists, was the emerging theme endorsed by all the therapists, stating that they were reminded of their own mortality and the fragility of life. This idea was just one of the several themes that comprised the theoretical construct of THERAPIST'S VIEWS ON DEATH AND LIFE. Some therapists shared realizations that sudden death can happen to anyone at any time, sharing that it served as a motivation to live life to the fullest. Therapists shared ideas like "It just helps me remember that nothing is guaranteed, so it's kind of like the universe is reminding me, 'Hey, don't forget, like life is still short, it's still precious, say what you need to say.' It's like a reminder (JB)," as well as "I know we all could really die at any time, but when it really truly happens, that somebody just dies

in front of you, it's like, it's a good reminder to try to live every day, as best as you can (LC)" and "So it's just a reminder of this is the only chance that I think I've got at this one life. So, I'm going to try to live it as best as I can with some fun thrown in there (RL)."

While other participants shared a similar realization, they indicated a grimmer lesson filled with anxiety, stating "I think the goal is to live a long and happy life and do the things that you want to do, but knowing that you don't have control over that. You don't have a say in it, is scary. I've always kind of had the same feeling about death, where it's a scary, unknown thing. And I think this just kind of magnified those feelings for me (SG)," and "So I definitely have a lot of anxiety about death. Um, I have pretty severe anxiety anyway, and death is like a big one (JB)."

These two opposing reactions to a sudden death may serve as examples of how different people react to mortality salience and increased death anxiety. TMT posits two main types of defenses at work when mortality concerns are salient, those being proximal and distal defenses (Pyszczynski, Greenberg & Solomon, 1999; Landau and Sullivan, 2009). Proximal defenses usually entail a change in behavior to preserve oneself or repression of death anxiety thoughts, which may explain the behaviors and thoughts of those speaking about car accidents. Distal defenses are typically at play when death anxiety is unconscious, and no longer at the forefront of one's mind. These defenses may be at play with those seemingly making meaning of these deaths, as they have now been removed from their immediate shock and grief and are recounting their experiences several months or years later. These defenses entail utilizing self-esteem and worldview buffers, which in this case may be comprised of therapist's inspiration to be more present and live a more valued life, ideas typically respected within the profession of psychology. Those who spoke about anxiety related to death are participants who lost patients within the last year, which may account for more difficulty with utilizing distal defenses as buffers, as mortality may be more salient in their conscious awareness.

**The Denial of Death and Denial of Anxiety**

TMT and Ernest Becker, the author of *The Denial of Death* (1973) posit that death anxiety is part of the human condition and that it emerges as a byproduct of our very existence. Throughout the data analysis there were a few instances in which conscious denial of death and fear mortality were stated. Another theme that arose from the data underneath the construct of THERAPIST'S VIEWS ON DEATH AND LIFE, was that some therapists had not experienced much death, while others had an extensive history of loss.

There was a variety of personal views on death as well, with many therapists stating that they were not afraid of death. These therapists reported things like "I just have an acceptance of death. I think that I'm not afraid of it. I know it's part of living, as is dying. I think it's part of the work that I do. I've come to expect it" (RL), and "I'm not afraid of death. I believe that we're worm food and that's a comforting thought to me. It doesn't that doesn't feel dark or scary. It just feels like you're returning to the earth" (AH). While others stated that they were consciously aware of their own denial of death, stating "I just remember feeling like, I don't want to see that box checked. Like that was the, the denial of it off. And I, I don't want him to be dead. I don't want to say that little box checked" (LC), as well as "I mean, I think because in my mind I kept thinking, 'Oh, he's coming back.' I think I was tricking myself into thinking that Mr. X was coming back" (RL), and "I remember thinking, oh yeah, no, I was thinking, is this some sort of weird test? And he's really still alive and I'm not allowed to, to grieve his death. And I have to be, you know, the really savvy therapist to see through the trick" (VL).

Some of these results suggested that those who had a long relationship with death and grief were not as impacted by this sudden death as those who hadn't experienced significant loss. However, TMT would suggest that a denial of death and pushing up against one's fears of death is a natural occurrence to the experience of mortality salience, thus suggesting that those who reported defenses of denial were attempting to buffer against death anxiety consciously, through

proximal defenses. While those who consciously state that they are accepting of death may be buffering against mortality salience in a more distal way by bolstering their self-esteem as a capable, accepting professional – thus utilizing more unconscious or distal defenses against unconscious fears of death.

However, the construct of THERAPISTS AFFECTIVE REACTIONS indicated that nearly all the therapists experienced <u>strong negative affect</u> after learning about their patient's death. Major emotions included sadness, anger, guilt, and shock. TMT would posit that the shock and realization that sudden death can happen, even with an extensive history of death, would have an initial strong impact due to fears of death lying beneath conscious awareness on a day-to-day basis. TMT states that for humans to be able to live an effective life, we must push away the constant realization that death is impending (Solomon, Greenberg & Pyszczynski, 2015), suggesting that sudden and unexpected deaths will then serve as a salient event, once again bringing the realization of our mortality to our conscious awareness.

Therapists stated that shock was one of the most intense emotions they had felt, along with sadness. Some participants shared "And I was just shocked. I mean, I was just so shocked, you know, I couldn't believe it" (BG), and "Shocking. And, and I think devastation, I think like, I, I mean, I don't know if I'd just been shocked that I would have burst into tears. Um, I was, it, it immediately, um, just, you know, just sort of cut very deep, you know, but, yes, there was shock" (EP). Therapists also shared the initial emotional response, some quite intense, indicating how shattering this realization can be when brought to the forefront of reality, including "I got the phone call, um, and she said X had died and I literally fell to my knees and just started sobbing" (AH), and "It was like, I had been hit upside the head with some like invisible, like grief wave. And it just, I sat in the chair, I just sat down, and I cried really hard for about five minutes" (LC).

However, others reported that they did not have a strong reaction to the death, and some even noted feeling as though it was inevitable. Some therapists stating "So if I, I think that

[knowing his involvement with MS13] let me not feel as, sad and not to have as a visceral, a reaction, because maybe a little underlying, subconsciously I had a feeling that this could have happened. It could happen anytime." (SD2) and "had no reason to expect him to die. in some sense, it's not a huge shock that somebody who had those sort of health problems might die, but I certainly wasn't thinking last time I saw him that it was the last time I'd ever seen him, it was surprising but not exactly that I was shocked because his health was as poor as it was." (VL). These reactions could be due to the fact that death was thought or talked about often in their work together and therefore was in their conscious awareness when the patient had passed away.

### Legacy, The "Good" Therapist and Defenses Against Death

Ernest Becker discusses the idea of symbolic heroism in the *Denial of Death* (1973), in which he argues that humans have an innate need to create something that will outlast themselves in a way to obtain permanence. He suggests that humans create "immortality projects," to maintain meaning and leave behind a legacy. TMT takes this idea further when discussing buffers against death anxieties. TMT suggests that by the pursuit of these legacies through humans' environments, groups, and professions, we can find meaning in these areas, which we then cling to when we are reminded of mortality. When humans adhere to their worldview, we are able buffer these threats of death through feeling secure and important. These ideas, I believe emerged within the therapists interviewed for this study. The theoretical constructs of THE MEANING MAKING PRCOESS FOR THE THERAPIST, THERAPIST'S COPING BEHAVIORS and THE PATIENT DEATH'S IMPACT ON PROFESSIONAL LIFE all show some evidence of these theoretical ideas within TMT and Becker's writings.

Taking first the ideas within THE MEANING MAKING PRCOESS FOR THE THERAPIST, there is the major theme of <u>I am a meaning making sort of person and for me it's what is the take home message from this person.</u> Therapists stated things such as "I definitely found meaning in that it makes me more happy to be alive and, do a lot of the things that X can no

longer do," (LC), as well as, "I think the most important thing is to make sure that there are no missed opportunities with people and to not regret their loss ," (MW) and lastly "Um, you know, what will I remember? What would I, um, keep, uh, as a take home message from this person? Sometimes it's way they live their lives that I absolutely wouldn't want and so I think I like to um, kind of encapsulate, was there something about knowing them that, that changed me or could impact me and then hold onto that to kind of improve my own life and, and to kind of honor the fact that our lives crossed" (RR). These responses focus on what the perceived lasting idea is from their patient and how they can then take those lessons and put them into action.

Meaning making is a way to synthesize together experiences in life with thoughts and ideas about how these experiences fit into one's narrative and worldview (Taves, Asprem & Ihm, 2018). Some of the participants noted engaging in this process, while others did not. Those who were not may have been more entrenched in the grief process and not yet able to move to move into making meaning. One participant who very recently lost a patient shared "I guess I'll have some perspective on it at some point, but two months down the road. No, not yet. It's very new, still right there" (BG).

Another theme that emerged from the data in terms of meaning-making was that of the death impacting the therapist in a beneficial way. Therapists endorsed ideas of feeling as though the death helped them become a more empathic therapist and person, feeling more inclined to be in the moment and present with others and appreciate life more fully. Others had a difficult time pinpointing ways in which the death changed them but felt that somehow it did. However, all the therapists reflected on impact of client and therapeutic relationships, stating that they felt as though their patients gave them as much as they hoped to give them. Some therapists reflected on their work stating how much they cared for and enjoyed working with their patients, "We had a great relationship, we joked a lot. We used humor in a great way. She was funny. She, um, she was a character sometimes" (AW), and "She was wonderful. She was a very vibrant soul" (EP). Still,

others mentioned more tenuous relationships such as "she was not the easiest patient to work with. Um, she was very stubborn, and it was just, it was hard" (SD). Therapist's reflections on the relationship and what they meant to them seemed to really add to the meaning-making process of why this person was so important and impactful to them.

Therapists were also highly aware and concerned about their impact on the patient, one person stating, "I hope he's not one of the patients that has given me more than I gave him. Oh God, that's always such a bad feeling. I think he has had a big impact on me. And so, I helped him in little. I know I helped a little way, but I help them in a profound way. I don't know that" (BG), and another stating "I'm also thinking part of what is so sad for me about this is I didn't feel, I really had much chance to make a difference in this person's life. Um, I don't have the opportunity" (VL), and lastly "Um, and that feels so meaningful to me and so helpful to like recognize my own contribution, um, rather than fixating on like what I did or what I didn't do, if that makes sense" (VRF). These concerns may be indicative of the therapists engaging in self-esteem boosting to cope with fears of death – thus coping more effectively if they feel they were able to make a difference and uphold what therapists are "meant to do," from a societal and worldview standpoint.

Similar ideas emerged within the construct of THERAPIST'S AFFECTIVE REACTIONS, where many therapists reported feeling guilt as a major emotion following learning of the patient's death, as they assumed responsibility for the patient, but also guilt regarding appearing weak as a therapist. One therapist stated "At first until I kind of walked myself through almost every single one of her sessions to just kind of like, not miss anything, like she wasn't, she wasn't a drug user, you know, like you didn't miss it. Um, but I think that was the hardest emotion was the guilt" (JB), and another shared, "I feel defeated, but I also feel guilty. I know I felt guilty at the time for feeling like I needed to talk about these things" (SG).

This emotion coming up may be a manifestation of again wanting to be seen as a valuable member of the therapist community, both in terms of being an effective therapist with your

patients, but also being able to handle things on your own. A theme under the construct of THE PATIENTS DEATH'S IMPACT ON PROFESSIONAL LIFE was the idea of <u>questioning the grief process as a therapist.</u> Therapists found themselves searching the internet for what was appropriate and questioning if they were overreacting, especially those who were earlier in their career or felt like they did not receive adequate training. Once again, through the lens of TMT, this could be seen as an effort to uphold the ideals of a therapist and grieve in the right way, as to not lose status or esteem in the eyes of other psychology professionals.

Ideas of buffering against mortality are also apparent within the construct of the THERAPIST'S COPING BEHAVIORS, in which the therapists engaged in a variety of rituals, sharing with others and symbolism to cope with their patient's passing. Moving towards the symbolic realm to cope with these experiences may be an effort to bond with those who are part of a larger group (worldview buffer) or may be an effort to create something that will continue to last beyond their patient's life (legacy building). All the therapists endorsed the theme of <u>seeking support from a variety of places.</u> Support was sought out from community (place of work, online, religion) and social circles (family, friends, and spouses), this type of behavior may be contextualized through TMT as buffering against death by clinging to one's worldview or environment in which they are a valued member. Therapists commented on seeking support in multiple places including, "I feel a lot of gratitude for Buddhism and the practices that it's offered me to be able to roll with like these unexpected things in life and these like losses that we really don't have control over" (VRF), as well as "Maybe I was trying to understand it more [on social media]. I wanted to be with people who were as equally horrified by what happened and understood" (AW), "So my husband talks about it. I talk about it with him" (BG), and "I think, uh, having a colleague, I think it's so critical to be able to vent" (SD2).

Additionally, many therapists reported <u>attending the patient's funeral services,</u> where once again they found community of those also grieving their patient: "I felt like I was able to fully

grieve that because I like, once again, I was able to go to the services, you know, we were invited to go, anybody that works with her, some of her, you know, some people that were in the groups went to the ceremony. It was pretty. Yeah. I mean, I think that was helpful because I haven't been able to do that with any other loss" (BB). However, on the contrary, many therapists reported feeling uncomfortable at the funeral, due to being concerned about ethics and HIPAA, not wanting to share inappropriate information about their patients, including "[Her mom] invited me to attend, um, uh, the Shivah, it was moving to be there, and a little uncomfortable, I didn't, you know, it was an awkward, um, awkward for me to be there. And, um, but I wanted to sort of, I guess, pay my respects or, uh, you know, be, be part of it in some small way"  (EP), as well as "You also have to kind of think about how much do I say, and how much do I not say, because as a therapist, I don't want to put all their business out there. I still kind of want to protect client confidentiality, um, even after their passing" (AH). This idea may point more towards buffering against mortality threats through self-esteem boosting, in which the therapists found themselves wanting to uphold their status as a professional and unconsciously wanting to be seen as a "good therapist," similarly with making a noticeable difference with their patients.

Similarly, when therapists began to discuss ideas of ethics and concerns around having releases of information to speak with patients' families, sending cards for condolences or continuing to see patients' family members as clients, there was an ongoing concern with ethics and moral obligations. Some of the therapists shared ideas on this including "I do really wish I would have at least had a release. I know I would have wanted to call them and just give condolences, but I don't know if I would have, um, it wasn't an option at the time. I can't reach out to the family, so I have to let that go" (AB). The THERAPISTS COPING BEHAVIORS seemed to be intertwined with the idea of doing and saying the right thing, as to not engage in a behavior that would be looked down upon. TMT would interpret these concerns as efforts to uphold a high sense of self-esteem within the therapist community, to feel secure and safe within that role.

However, therapists did have their own personalized ways of coping and many therapists discussed ways they honored the patient more symbolically from items of clothing they wore ["I guess, uh, maybe times that were important to her, I would always wear a blue scarf. The blue was always her color. And so, I had shared that with the group that, that, that was kind of one of my tributes to her and my kind of remembering her" (RR)] and donations they gave ["We decided to actually start like a scholarship, at our practice, in X's name, providing for three to four, free treatments for the people that, from the school that he went to and the people that he played sports with, um, that needed that help with couldn't afford it" (SD2)] to making changes in the system ["Now work at the, at the school where I graduated from. I teach a course for current interns, and we talk about what to do when your client dies, and people talk about experiences. That's part of a way, I think I've coped, by giving some resources and support, um, that I wouldn't have liked to have had" (AW)]. Another idea was engaging in this interview to memorialize their patient, as one therapist stated, "I think that part of why I wrote, but wrote to you and replied back, like I wanted to, because I think it's like a way of honoring her and her name being, not her name, but her memory being talked about again" (AW).

The variety of different coping behaviors show how through symbolism as well as lasting change (i.e., mentoring new generations), therapists have attempted transcend these deaths. Although this behavior may be unconscious, these therapists are creating legacies for their patients who have died and possibly themselves, leaving behind important and meaningful traditions. Through these ways of making meaning and coping with loss the therapists are also finding ways to create immortality and buffer against existential threats. Additionally, many therapists continued then to work with family members of the deceased patient, thus keeping a perceived connection with the patient after their death and bolstering their sense of self as a therapist who is able to in a way, aide them even after death. Some therapists commented on this process stating "I think by, by seeing her mother for those sessions, that was part of my grieving. I felt that it gave me a connect,

a continued connection with X and, um, maybe it was my fantasy, but my thoughts were that she would have wanted me to do this. She would have wanted this" (MW), and "They told me they were going to let me continue to work with not work with him. He was deceased, but work on his case a little bit to help his mother" (LC).

TMT suggests that bolstering one's status in a group we feel valued is another major effort in distal defenses against mortality concerns. This was seen in other ways as well under the theoretical construct of THE PATIENTS DEATH'S IMPACT ON PROFESSIONAL LIFE, in which many therapists endorsed the theme of therapist's views of the mental health field changed after the patient's death. It appeared that therapists were more scrutinizing to the agencies policies and lack of support for their staff, resulting in many participants leaving their positions due to disgust of the administration. Although many participants shared that they were already planning on leaving the agency before the death, their patient's death was the final push they needed to leave: "The morning that I found out that she died, I was going into hand in my resignation. All of it kind of sealed the deal for me as far as like, I just don't want to work at this place" (SD), it was suggested that the death was the final push they needed to leave. TMT research has shown that after being faced with mortality salience, people tend to be stricter with their judgements of others regarding ethics and morals as well as wanting to uphold more pro-social behavior (Kirchmeier, 2009; Burke, Martens & Faucher, 2010), this may be part of an explanation of why people decided to follow through on these decisions.

Similarly, another theme under the construct of THE PATIENTS DEATH'S IMPACT ON PROFESSIONAL LIFE, is therapists being concerned about their impact and doing/saying the right thing, including questioning one's own judgment and effectiveness as a professional. As mentioned earlier related to reaching out and HIPPA, many therapists were concerned with confidentiality. However, other ideas emerged under this theme including questioning if there was anything else they could have done, or something they did wrong or missed and reassurance that

the therapists <u>weren't at fault and did all they could but can't save everyone.</u> Regarding this first theme, many therapists endorsed the idea of being afraid they missed something and second guessing their work. Therapists stated "Was there something I didn't see? Was there something I could have said differently? Um, should I have pushed harder? Should I have not pushed as hard? Um, was I there enough? Were my boundaries, the right boundary?" (AH) and "Did I do something wrong? Cause I think that's where I always go. Is it, is it, was it something that I missed?" (JB). In looking through our theory of TMT as well as the idea of meaning making, these questions could be in an effort to control the narrative and not have to accept that these sudden deaths happen, to find an alternative to an inevitable outcome.

The second theme of fault and not being able to help everyone, I believe serves the opposite function, in that it allows for the therapist to preserve their identity as the professional that attempted all they could and therefore remains effective and "good" in the eyes of society. This could serve as an unconscious attempt to cope with existential fear brought up by the revelation of this sudden death, buffering against mortality in the form of self-esteem in the therapist community. Some quotes related to this theme include therapists stating "So just kind of being able to, uh, process through it and recognize really going back to what we teach, you know, that there's circumstances, we just couldn't control. And going back to my philosophy that all we can do is support our clients where they're at. Just really kind of reflect that, you know, we can't, uh, save everybody." (SD2) and "I think because this was completely unrelated to my scope of practice in a way, or as unrelated as it can be a mix, like there is nothing that I know that there's nothing that I could have done to have like, helped change that outcome." (VRF).

### Disenfranchised Grief – Where Does the Therapist Fit In?

Doka's (1989) most simple explanation of disenfranchised grief is that some grieving people are not afforded the right to grieve. Often this concept applies to those suffering a loss that is non-death related or non-traditional, such as the loss of health, loss of a relationship or even

miscarriages fall in this category. In this context, the theory and concept of disenfranchised grief is applicable because many of the therapists in this study identified themselves as not knowing if they have the "right" to be upset and were not allotted the space to experience their grief. Attig (2004) builds upon Doka's theory stating that disenfranchised grief can come about when others do not see or validate the mourners suffering, resulting in empathic failure, making it less likely that those mourning get the support they need. Based upon the results of this study, it is fair to say that several of the participants would fall into the category of disenfranchised grief, given their experiences within their agencies and workplace environment.

Several of the major themes under the theoretical construct of THERAPISTS AFFECTIVE REACTIONS, MEANING MAKING PROCESS FOR THE THERAPISTS and PATIENT'S DEATH IMPACTED THEIR PROFESSIONAL LIFE can be analyzed through the lens of disenfranchised grief. Beginning with THERAPISTS AFFECTIVE REACTIONS, the first theme that falls under this heading would be that of <u>finding out about the patient death was difficult and inopportune.</u> Several of the therapists reported that they were made aware of their patient's passing in a non-sensitive way and at an inappropriate time. One therapist stated "So one day, um, just kind of in between clients [I was told they died]. I do wish she wouldn't have been kind of nonchalant when she told me and do wish that it wasn't right before I had another client. Um, so she could have waited until the end of the day or kind of told me, um, the next day when we had more time. I wish she would have told me at a different time." (AB). Another therapist states "This email had come through while I was literally like in the middle of another session telling me that my client was dead, which is horrible." (VRF). Another recalling "I found out, um, one of my coworkers had posted something on social media about someone passing, um, didn't say who it was, but, um, and I texted her because I kind of was worried that it was her. Um, and it was, and so that's kinda how I found out." (SG).

Another major theme under the THERAPISTS AFFECTIVE REACTIONS construct is the experience of <u>facing their unique grieving process alone.</u> Several therapists recall feeling misunderstood throughout their grief process both professionally and personally. Therapists reported feeling as though there is no place for them to grieve, "it's kind of like, where is the space for a person like me? Like, I mean, I just think of like, what if you're even this person's doctor or like, you know, people who have like auxiliary roles I think are like caregivers as well. Um, for some people it's like, do they have space for grief?" (BB), "And so you're not close to them in the same way that you are a family member. Um, but their death still affects you." (SG) and "Like in some ways it feels like we are people too, but in some ways, it feels like we don't have the right. We're not their family. We're not their friends. What are we? And is it fair? We're sort of like their doctor, is it fair for us to be feeling sadness too, but, um, it's one of those professional ethics things." (LC). In these quotes we can see the idea of questioning if they have the" right" to grieve their patients and whether their emotions are appropriate, which then in turn stunts their grief process by not allowing themselves to fully engage with the emotions.

Additionally, therapists report feeling disconnected within their professional agencies and not having much direction on how to proceed with their grief process, isolating them further from their grief process. Therapists report not feeling allowed to process emotions "I feel like not just with grief of somebody dying, but just about like what we just heard or what we just, you know, experienced or what just brought up what was just brought up for us from the previous session. Like it's kind of like, Nope, box it up. Let's go." (JB) Therapists also recall needing support but not finding it, "I was super needy and just trying to kind of like deal with it, um, on my own and then, you know, like with my colleagues." (JM), as well as unsympathetic colleagues attempting to invalidate grief experiences, "Like that wasn't helpful. It's like, it can be sad, period. Well, we don't have to rationalize and say, but he was sick, but he was obese, you know? So, she didn't know him at all. She didn't know anything about all who he was. She just knew that it was a client that I was

close with them. That was sad." (LC). All these situations exhibit some sort of empathic failure, leading professionals to question the appropriateness of their experiences.

Regarding MEANING MAKING PROCESS FOR THE THERAPISTS, several participants shared that some of most difficult parts of mourning this loss was simultaneously mourning the loss of potential each patient had, as well as coming to terms with how much trauma they overcame. Attig (2004) discusses how Doka's original theory of disenfranchised grief also included complicated presentations of people, such as alcoholics, as their functioning was also something to be mourned. There is a parallel here with many of the patients discussed in this study, both within substance use as well as long standing trauma. Regarding the loss of potential, therapists recalled "I know she dreamed of having children, you know, of her own. Um, like I said, she was, um, she loved visiting her, her niece and, um, yeah, so there were so many possibilities beyond obviously just her art career. There was like, you know, all of, so much of her life was still ahead of her." (EP), "I think death is so final. It is so final, and it's makes you feel so helpless because there's nothing you can do about it. And all the plans that you had, all the things that you were going to do, can't do them anymore. And it is it's, it's, um, it's challenging to accept that." (LC) and "So it was, uh, one of those moments and, uh, uh, it's just kind of feel like your heart drops here. Like, you know, why, you know, like, uh, we were making some progress and we were. We were, uh, going in the right direction." (SD2).

Regarding a history of substance use and trauma, many therapists discussed how these experiences impacted their patient's lives. Stating, "I just felt a fondness for her because she was such a good kid and she had worked so hard. she had overcome so much trauma, like, and she was still so strong and so fun and so intelligent" (JB), "We were able to kind of help her somewhat with the opiates, at least while she was in, but she refused to come off of the benzos. Um, one because of the physical issues, but also because she did not want to work on her severe trauma. Um, really afraid that if she stopped taking benzos, that she would not be able to function at all." (SD). The

quotes go to show that in addition to their death, the therapists were most likely dealing with grief related to a variety of other things throughout their work together.

However, under the major construct of PATIENT'S DEATH IMPACTED THEIR PROFESSIONAL LIFE many therapists reported feeling unsupported by their agencies. Therapists reported feeling betrayed by their organization, stating, "Just the circumstances, um, both at the facility and for me personally in that moment were really terrible as far as how it was handled." (SD) and "None of the primary care providers thought to reach out to me to tell me that my patient who was also their patient, who they knew was my patient had died, which was really not cool and so mishandled by the organization, there was just a whole lot there." (VRF). Additionally, therapists recall having to go about their day after learning about the loss, "And it's just like, okay, well, get it together because you need to move on to the next person. So, it's almost like putting it in your back pocket. Um, so you can function for the next person." (RL), "Like I didn't have any space because I think it was also like the beginning of the session. And so, then I had to just like, pretend like everything was fine for like 40 minutes, which was horrible." (VRF).

Due to a major lack of support and major mishandlings of some of the therapists' experiences with the sudden death of a patient, it appears that many of them may be experiencing disenfranchised grief. When therapists find themselves questioning their "right" to feel sad or mourn the loss of a patient, it begs the question of whether there was an empathic failure that occurred along the way. Given the quotes above and other parts of the interviews, I would argue that this is the case. Disenfranchised grief can eventually turn into shame and resentment overtime, if it is not appropriately addressed (Bento, 1994), leading to more complicated emotions and hostile work environments. Further work needs to be done to allow for proper grieving and support.

**Sudden Death as Trauma**

Taking together the accounts of the interviewed therapists, several participants reported lasting emotional impacts of the sudden deaths suffered, indicating possible trauma responses. Trauma has been broadly defined as an aversive experience accompanied by enduring subjective feelings of intense fear, helplessness, or horror (Dalenberg, Straus, & Carlson, 2017). Some of the interviewed therapists reported still feeling affected by the death ["And every, um, year or two, I will Google it again. I don't know why I do that, but not on her Facebook, but just, I don't know. I read the articles again" (AW); "Um, so even today, you know, it's still kind of pops up, just different thoughts." (AB)]. Additionally, several therapists reported that the horrific nature by which their patient died, was particularly salient for them ["Yes, there was the shock, but also the horrific menace of how she was killed was also a huge part of it." (AW); "He was actually stabbed to death, and it was, it was tough on me" (SD2)].

Moreover, several participants recalled such a significant impact that they either contemplated or quit their jobs due to perceived ongoing emotional difficulty ["I definitely had secondary trauma. I thought I was going to leave the field and not continue being a psychologist. Cause it was so hard" (AW); "I took a break. Um, I didn't go back to counseling clients for about six months. Part of that was the pandemic. Um, so part of that was also because, um, the feelings that I was having kind of brought up some of my own, um, PTSD" (SD); "Now that I'm not working [left my job] and I've had time to reflect, like, I, I know that's part of what's going on with me, the grief and the fear of not having any support" (SG)]. The experience of trauma related to the loss suffered may have increased the likelihood for some of the therapists to experience disenfranchised grief, as discussed above. As many of their experiences were isolative, unique, and poorly supported within their organizations, the possibility of feeling misunderstood and being unable to process the loss increased.

Due to the high intensity of emotionally latent content that was discussed in the individual interviews, the principal investigator experienced some instances of vicarious trauma. Vicarious trauma has been thought of as an experience by which unique, negative, and accumulative changes can occur to clinicians who engage in an empathetic relationship with clients (Branson, 2019). Although these interviews were not meant to be therapeutic sessions, many of the participants stated that they had not discussed their experiences of sudden loss in depth with another person before ["Um, and we never talked about me losing my first client." (AB); "Very rarely do I talk about this, this [interview] is probably the most I've ever talked to somebody about my experience with, with losing, um, patients" (RL)]. As this was the case for many, the individual interviews often became a place of processing through the loss the therapist suffered.

Several participants felt as though this interview was a good opportunity to revisit and explore their emotions and they were grateful for the opportunity to do so ["I need to talk about him. So when I saw the announcement [for your study], I was just like really happy about it too. So thank you." (BG); "This is really helpful in terms of working through the experience. I'm kind of glad to, um, even though it's a tough thing to talk about, I feel like your questions helped me think more deeply and, um, I dunno if it figure out some things, but at least sort of keep like open things up for myself. So I appreciate it" (EP); "You know, like there was a part of me that was like, perfect. I don't want to talk about this right now. But at the same time I was like, no, this study will probably be really good for you" (AH)]. Many of the interviews served as a processing space for the participants to explore intense emotions and complex ideas related to their experiences. The principal investigator often served as a containing space and therapeutic force in the room throughout the interviews.

With such intense emotional content, it was observed that the principal investigator experienced feelings of burn out, compassion fatigue and ultimately vicarious trauma during both the interviewing phase as well as the coding phases while revisiting the interviews. This experience

serves as a reminder that instances of sudden death, if left untreated or discussed can become emotionally burdensome for the therapists' who suffered the loss and consequently, the provider treating them. One participant recalled meeting with a therapist after finding out her patient was murdered and feeling guilty for her level of emotionality ("It was really therapeutic for me to go see that therapist. Um, I feel bad for her that she had to hear, oh, I totally dumped her and dumped it all on her and then walked out the door. Um, I think I went through two boxes of tissues" (AW)]. This experience reiterates the importance of giving ample space to process intense grief, so that it does not become traumatizing or disenfranchised for the therapists or their providers.

**Clinical Implications**

The area of mortality salience research has mainly been conducted in a social science context, with its prime focus on controlled research design (Burke, 2010). However, it is worthwhile to begin to look at the clinical implications of how death of patients, as well as universal human experiences of grief and loss impact professionals, not only within the psychology field, but across health care. There is little literature pertaining to therapists' views of mortality, death and loss and even less research assessing how unconscious processes, such as death anxiety impact and may subsequently impede the practice of therapy.

Results of this study indicate how mortality salience can be induced from the death of a patient and does have impactful influence on the therapists. The overarching theoretical constructs that came from this research indicate that the details, as well as the lack thereof, of a patient's death are highly impactful to the therapist and their grief process. Additionally, sudden passing results in high levels of emotionality and observable affect within the therapist that they then need ample time to work through. Therapists attempt to go through their own meaning making processes through the way in which they think about the patient, the rituals they engage in as well as the support in which they seek. Results of this study show the immense importance of community and workplace availability and acceptance of therapists' grief processes for therapists to feel fully

supported. Furthermore, the theoretical constructs of therapists' views on death and life and the death's impact on professional life, show the ability of a death of this nature to impact therapists profoundly, both personally and as a working professional.

More specifically, pertaining to the construct of the patient's death's impact on professional life, results highly suggest a needed level of support from within the agencies in which these therapists work. Several therapists named more in-depth trainings, CE credits and debriefing sessions as possible avenues to begin to bridge the gap of severely lacking bereavement and grief support in the mental health and psychology fields. Graduate school curriculums within psychology are also lacking education regarding how to work with bereavement in clients, let alone curricula on how to cope with professional losses during a career as a therapist.

Results of this study indicate that from a conscious, needs based approach, a wide majority of the participants in this study felt they would have benefited from increased education and support with their grief. Similarly, from a theoretical approach, analyzing these results through the lens of Terror Management Theory and disenfranchised grief, the inevitability of these losses coupled with the sorely lacking support, will continue to breed shame and difficulty around how mental health professionals cope with significant losses. If as a field were able to better understand the theory behind how death impedes so many of our decisions and begin to see grief as an inevitability of life, these experiences wouldn't be as stigmatized and under discussed. With more candid discussions around death and its impact on psychology as a field, professionals will be better equipped to effectively mourn and have a more efficient return to baseline.

**Limitations, Critiques and Further Research**

Although this study holds great value in adding to a scarce body of literature through its cohesive narrative of therapists' firsthand experiences, there are of course limitations consider. The first major critique would be the demographics of this study. With the sample identifying predominantly as white (88%) and female (82%) there is not much diversity in those being

interviewed, thus not allowing the findings from these data to be generalizable to a larger group. Similarly, the sample is not diverse in terms of religious affiliation, and I did not assess for sexual orientation. Although I did attempt to recruit participants through minority specific platforms (i.e., Black Analysts and Latinx Mental Health Professionals groups on social media) a more inclusive and accessible recruitment strategy should be utilized to obtain a more diverse sample that would encapsulate a larger experience.

Another limitation pertains to the overall size of the sample (N = 17). An increase in the sample size would help with the ability to extrapolate findings. There may also be more room to reach further theoretical saturation, as a more inclusive sample, particularly those with varying religious and cultural backgrounds pertaining to beliefs about death could increase the number of ideas, themes, and overall theoretical constructs. Similarly, interviewing therapists from other theoretical orientations or backgrounds in training may also yield further themes.

Additionally, due to the COVID-19 pandemic, the interviews took place via tele-conferencing platforms (i.e., Zoom). With the sample being a wide range in terms of ages and years in the field of psychology, there was difficulty regarding accessing platforms and completing paperwork in a HIPAA compliant way, at times participants needed to give permission to email through non-encrypted platforms to access documents. Some participants also requested to speak over the phone instead of on Zoom due to connection difficulties or being a technological novice. Additionally, due to the nature of the sensitivity of this topic and level of emotion, in person interviews would be preferred and may give more ample opportunity to connect and process through emotions.

Furthermore, several people requested to partake in the study who did not qualify due to not yet being licensed or their patient having passed away after they were no longer working together. Depending on what the interests are for future researchers, it may be worthwhile to expand inclusion criteria to allow for psychologists in training, as well as those who found out a

former patient died to increase sample size and diversity. One disqualified participant was selected to be interviewed; however mid-interview disclosed that the patient died after they were no longer working together, thus hindering his data from being included. A final limitation for this study is the overall method of qualitative research. As this study serves as an introduction to the experiences of grief and bereavement in therapists, it was meant to be exploratory research for future empirical studies to build upon. Although there are significant qualitative findings, more specific measures including quantitative research designs may be employed to gain more specific data and results that may inform us about how therapists are affected by mortality salience.

Regarding future research on this topic, there are several routes one can take to begin to bring in empirical evidence and test Terror Management Theory on therapists. Most of the current Terror Management research is focused on death priming (Burke, 2010) to show effects of mortality salience on behavior, as such, it would be suggested to begin in this manner. Experimental studies may be focused on having therapists being primed with reminders of death and then have them rate adherence to the field of psychology or discuss ethical concerns. It would be hypothesized that studies of this nature would likely yield results indicating that therapists were clinging to the ideal therapist image to bolster their cultural worldview in the face of death. Additionally, to build upon this current study, some of the anecdotes mentioned in the interviews could be used to prime for death through reading vignettes of finding out that a patient died and then having therapists rate a variety of items. In this experimental design the qualitative data collected in this current study would serve as a death prime in quantitative research. The hypothesis would be that the anecdotes would serve as adequate death prime, thus making mortality salient enough for the participants to show significant changes in their responses, such as social responsibility or cautionary behavior. If these proposed studies were to be conducted it would be suspected that results would show a similar pattern to the literature review of TMT, indicating that when people are reminded of death, they uphold their values more strongly. It

would be hypothesized that therapists would attempt to become the ideal therapist with their thinking and actions post mortality salience.

**Conclusion**

This study sought to address the ways in which the sudden death of a patient served as mortality salience in therapists, thus bringing to their conscious awareness the fragility and unpredictability of life. Using qualitative research and a grounded theory method, this paper attempted to look at the experiences of therapists who had a patient suddenly pass away and better understand how this experience changed and affected their personal views of death and their professional role as a therapist. This topic proved to be invaluable in terms of giving space and a voice to those who have experienced such a loss and have had little to no opportunity to express their experiences. Many participants shared their appreciation for such an opportunity to openly discuss such an impactful and distressing event.

This study has implications for how thoughts about mortality and death impact therapists personally and professionally, as well as main areas in the field that can be changed to better accommodate those coping with these loses. There may not be an ideal method of teaching others or personally practicing sitting with the gravity and inevitability of death, however, in holding a space to begin this conversation we can move away from a denial of death within the field of psychology. In withholding training on grief, bereavement and loss, the field attempts to erase the inevitability and common place death and loss holds. This study serves as just a small steppingstone to normalize tough conversations and acceptance around loss, grief, and the inescapability of death.

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Appendix A.

# In search of Therapists to Be Interviewed:



My dissertation study focuses on the experience of the <u>sudden death of a patient</u>. If you are a licensed therapist for over a year who has experienced such a loss, please consider participating. My study will not be including loss of a patient due to chronic illness or death by suicide. Participation will consist of a 1.5 to 2-hour interview with me regarding your experience (virtual accommodation via video conferencing is available if needed).


If interested or have any questions please contact me at:
amanda.butera@my.liu.edu

A demographic screening will be sent to you prior to setting up an interview.

I look forward to hearing from you!




Amanda Oliva, M.S.

amanda.butera@my.liu.edu

LIU Post Clinical Psy.D. Program

Appendix B.

**LONG ISLAND UNIVERSITY – POST CAMPUS**

**Informed Consent Form for Human Research Subjects**

You are being asked to volunteer to participate in a research study entitled "Mortality Salience in Therapists: Clinician's Experiences of the Sudden Death of a Patient – An Exploratory Study," conducted by Amanda Oliva, a Doctoral Candidate from the Clinical Psychology PsyD program. This project will be supervised by Eva Feindler, Ph.D., dissertation chair and faculty member from the department of Clinical Psychology. The purpose of the research is to learn more about therapists' experiences of sudden loss of a client and their grieving processes.

As a participant, you will be asked to participate in a one-hour semi-structured interview (Virtual platforms available) with the researcher focused on your experience of loss of a client. The interview will be followed by a demographic's questionnaire, via email, which should take about 5-10 minutes. This interview will be video/audio recorded for coding purposes. Possible risks include potential discomfort revisiting and discussing such a loss or discussing death candidly. While there is no direct benefit for your participation in this study, it is reasonable to expect that the results may provide information of value for the field of clinical psychology.

Your identity as a participant will remain confidential. Your name will not be included in any forms, questionnaires, etc. This consent form is the only document identifying you as a participant in this study; it will be stored securely in a password protected folder, available only to the investigator. Data collected will be destroyed at the end of five years, and your information will not be used or distributed for any future research studies. Results will be reported only in the aggregate and any quotes taken specifically from your interview will be de-identified. If you are interested in seeing these results, you may contact the principal investigator.

If you have questions about the research, you may contact the student investigator, Amanda Oliva at Amanda.butera@my.liu.edu, the faculty advisor, Dr. Eva Feindler at 516-299-3212, or the department chair, Dr. DJ Moran at (312) 952-7792. If you have questions concerning your rights as a subject, you may contact the Institutional Review Board Administrator Dr. Lacey Sischo at (516) 299-3591.

Your participation in this research is voluntary. Refusal to participate (or discontinue participation) will involve no penalty or loss of benefits to which you are otherwise entitled.

By signing this document, you are acknowledging that you have fully read the above text and have had the opportunity to ask questions about the purposes and procedures of this study. Your signature acknowledges receipt of a copy of the consent form as well as your willingness to participate in this research study.

_____

Typed/Printed Name of Participant

_____          _____

Signature of Participant                                                    Date

_____

Typed/Printed Name of Investigator

_____          _____

Signature of Investigator                                                    Date

Appendix C.

Project ID

**LONG ISLAND UNIVERSITY**
**INSTITUTIONAL REVIEW BOARD**

<u>CONSENT TO AUDIO- OR VIDEO RECORDING &
TRANSCRIPTION</u>

*Mortality Salience: Therapist's Experiences of the Sudden Death of a*
*Patient, An Exploratory Study*

Amanda Oliva, Doctoral Candidate, Clinical Psychology Psy.D.
Program

This study involves the audio or video recording of your interview with the researcher. Neither your name nor any other identifying information will be associated with the audio or audio recording or the transcript. Only the research team will be able to listen (view) to the recordings.

The tapes will be transcribed by the researcher and erased once the transcriptions are checked for accuracy. Transcripts of your interview may be reproduced in whole or in part for use in presentations or written products that result from this study. Neither your name nor any other identifying information (such as your voice or picture) will be used in presentations or in written products resulting from the study.

By signing this form, I am allowing the researcher to audio or video tape me as part of this research. I also understand that this consent for recording is effective until the following date:
 1/1/2022. On or before that date, the tapes will be destroyed.

**Participant's Signature:**_____Date:

Appendix D.

**Oliva – Dissertation Demographics Questionnaire**

Gender Identity: _____ Age: _____

Race/Ethnicity: _____ Religious Affiliation: _____

Therapy Orientation: _____

Number of Years Practicing as a Clinician: _____

What settings have you worked in as a therapist?

_____

_____

Have you experienced the sudden death of a patient? If so, what was the nature of their death?

_____

_____

_____

Have you experienced the death of multiple patients? If yes, how many?

_____

_____

Have you experienced a death or loss of a loved one/important person in your life due to illness or other life circumstances within the last year? If so, please explain.

_____

_____

_____

Have you personally had any instances of serious health issues over the past year? If so, please provide some information.

_____

_____

_____

In what ways were you affected by the recent COVID-19 pandemic, if any?

_____

_____

_____

Did you experience the death of one of your patients due to COVID-19?

_____

_____

_____

Appendix E.

**Amanda Oliva - Dissertation Semi-Structured Interview**

**Individual Interview Questions**

1. Tell me about yourself and your role in the field of psychology.

2. Please briefly tell me about your patient and how they passed?

3. Can you describe your relationship with this patient?

4. How would you describe your reaction to this loss?

5. Can you describe what your experience was like coping with the sudden loss of your

   patient?

   a. Did you feel you had adequate support?

6. Did your feelings about being in the role of a therapist change after this loss?

7. In what way did this experience change you?

8. How have you made meaning of this loss?

9. How did this sudden loss impact the way you feel about death overall?

   *a.* How did this death impact your personal views of death?