Research Article

Non-Death Loss and Grief

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Non-death loss and grief can encompass the same commanding, painful and intoxicating feelings that grief experienced through death may arouse. Psychotherapists are no exception to such fraught agonies of human existence. For many, their loss and grief may go unacknowledged by others and/or by themselves, causing their psychical armour to strengthen

Introduction

Mark Twain (1966) famously stated that "... Nothing that grieves us can be called little; by the external laws of proportion a child's loss of a doll and a king's loss of a crown are events of the same size" (p. 46). Encountering loss, not exclusively death-related, brings intense feelings of grief, which manifest in diverse forms. Grief can occur from the loss of anything which carries significant attachment (Kouriatis & Brown, 2011). Grief brings many complex responses: sadness, anger, confusion, disbelief, insomnia, social withdrawal and physical sensations (Worden, 2010). Loss and grief are universal, with individuals experiencing subjective, unique reactions, which may affect their personal and professional life (Doka, 2016). For psychotherapists, their personal experience of loss may enter their professional environment (Horvath & Symonds, 1991: Kouriatis & Brown, 2011). Therefore, it is important to explore their experiences of non-death related loss and grief and the ensuing complexities. This research examines psychotherapists' personal experiences of non-death related loss and grief, disenfranchised grief, the impact that this grief may have on their personal and professional life and how psychotherapists manage this vulnerability.

Defining grief

Freud (1917/2001) and Bowlby (1969, 1980) enhance understanding of early theories of loss and grief. Bowlby's (1969) attachment theory posited that individuals are born with an intrinsic need to form emotional attachments with primary caregivers for protection, emotional stability, security, regulating affect and ensuring survival. However, when separated from their primary caregiver, an infant suffers intense feelings of anguish and separation anxiety. Bowlby (1980) likened grief to a form of separation anxiety, heavily influenced by attachment style. Holmes (2014) suggested that reactions to separation anxiety, such as crying, tension, pain, anger and despair correlate with the grieving process. Freud (1917/2001) proposed that grieving evokes painful feelings, where one is incapable of embracing a new loved-object. However, eventually a grieving individual realises that they can detach, withdraw their libidinal energy from their lost loved-object, move forward and re-invest in new relationships.

Freud (1917/2001, p. 243) observed grief as "reaction to the loss of a loved person, or to the loss of some abstraction … such as one's country, liberty, an ideal

and so on". Grief can occur from any loss experience, loss of marriage through divorce (Pappas, 1989), loss of youth (Raphael, 1994), loss of a pet (Cordaro, 2012), loss of health (Maggio, 2007), loss through incarceration, loss of identity (Doka, 2016) and so forth.

Worden (2010) suggests that expressions of grief go beyond emotion, often producing irritable physical sensations, cognitions and altered behaviour patterns. Stroebe, Hansson, Schut and Stroebe (2008, p. 5) define grief as a "healthy, natural, emotional reaction containing myriad psychological and physical expressions which vary across time and culture". Several authors support this multidimensional aspect where psychological and physical pain interrelates within the grieving experience (De Santis, 2015; Devilly, 2014; Kouriatis & Brown, 2013-2014).

Secondary losses
Secondary losses stem from a primary loss (Doka, 2016). For example, the primary loss of a job may create secondary losses of income, purpose and identity. (Murray, 2016). Boyden (2005) agreed that previous/multiple losses impacted the initial loss, saying that one may re-experience previous losses activated by a primary loss and/or experience multiple losses concurrently.

Pappas (1989) explored the possible impact of divorce on psychotherapists' personal and professional life, causing multiple losses beyond the loss of spouse and marriage including standard of life, friends and family leading to feelings of isolation and personal failure, that exacerbate complex grief reactions. Pappas (1989) explained that intense feelings of guilt and shame may prompt a psychotherapist to question their ability to support their clients. She explored the intense grief reactions experienced

and urged professionals to acknowledge divorce as a significant loss and grief experience. While going through a divorce, Schlachet (2001) described his intense feelings of distress and shame, questioning how could he help clients with relationship difficulties when he failed to repair his own.

Waugaman (2013) described his personal experience of loss of a career and an institution which he loved and his grief on leaving his position as a psychiatrist at Chestnut Lodge. Waugaman's (2013) loss experience began while still working there due to the death of some colleagues and changes in staff and ownership. He described leaving as a heartbreaking loss. Secondary losses were loss of family, sense of purpose and identity.

Disenfranchised grief
Disenfranchised grief occurs when the loss is outside societal grieving rules, not openly recognised by others, publicly shared or socially validated (Doka, 2016). Despite an individual's intense grief reactions, society, family and friends may not fully recognise or acknowledge their right to grieve, therefore disenfranchised grief may restrict this right, intensify emotional reactions and exacerbate the grief (Doka, 2008). Doka (2008) proposed that every culture has grieving traditions, policies, norms or rules of behaviour: who can grieve, for whom or what and how to respond to another's grief. He postulated typologies of disenfranchised grief related to non-death related loss, divorce, mental and physical illness, addiction, incarceration, unemployment, relationship break-down and so on, suggesting that societal grieving laws do not apply to non-death loss. Individuals lacked social support when their loss was outside societal grieving rituals (Thornton, Gilleylen& Robertson, 1991). Pappas (1989) stated that with death, rituals to

express an individual's grief in a supportive, social environment, such as a funeral, usually follow. However, with non-death related loss, the lack of social validation may result in isolation and loneliness that may be so difficult for the griever to hold that they disenfranchise their own grief. Kouriatis and Brown (2013-2014) supported the concept of disenfranchised grief concluding that during the grieving process, some psychotherapists experienced impediments, especially when family and friends did not recognise their loss. Hence, they may experience their grief as inappropriate or unworthy, disown it and disenfranchise their right to grieve (Kauffman, 2002).

Impact on professional life
Grief carries many complexities that may not stay within the confines of an individual's personal life, but seep into their professional life. For a psychotherapist, this may impact on the therapeutic relationship.

Reiter (1995) advocated that the meaning and emotion that emerges in therapy arises from the co-created relationship between therapist and client, where both influence each other. Wallin (2007) asserted that the therapeutic relationship is an intersubjective space where both therapist and client consciously and unconsciously influence each other. Kouriatis and Brown (2013-2014) stated that therapists' loss experience impacted the therapeutic relationship, with both positive and negative outcomes. A number of studies found psychotherapists' increased empathy due to their grieving, strengthened the therapeutic alliance. However, Kouriatis and Brown (2013-2014) proposed that psychotherapists' experience of loss may have a negative effect due to their emotional vulnerability. Hayes et al. (2007) suggested that the more intense a therapist's grief experience, the

less empathic a client experienced the therapist to be. However, the more a therapist had worked through their grief, the more empathic they became. De Santis (2015) suggested that a vulnerable therapist may project their thoughts and feelings onto the client, risking therapeutic disconnection. De Santis (2015) found the more vulnerable a therapist felt, the more they relied on the therapeutic technique of bracketing, to separate personal and professional. Adams (2014, p. 2) stated that she relied on bracketing to protect her vulnerable self and her clients. However, she changed her view on bracketing, stating that it was "simply an illusion". De Santis (2015) concluded that bracketing hindered therapists' awareness and when bracketing was not used therapists could easily access their emotions leading to a deeper therapeutic connection, stronger attunement and a greater sense of empathy.

Managing vulnerability and self-care

Following a significant loss, a psychotherapist may manage their vulnerability using primitive defences, whereby intense feelings of grief are denied (Bram, 1995). Therefore, the management of vulnerabilities and self-care is imperative. Elliott (1996), while living with Parkinson's Disease, experienced the deep sorrow of isolation and vulnerability. However, she explained that there is an intrinsic strength in recognising and accepting personal vulnerability. Counselman and Alonso (1993) highlighted that a therapist's ability to empathise might be threatened if they deny their vulnerability, leading to catastrophic repercussions. They stressed the importance of authenticity in an attempt to lower the blocking defences of denial and provide clients with an open, genuine space. Maggio (2007) recalled that as her chronic lupus illness worsened, her use of denial

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slowly eroded helping her recognise and accept her vulnerability. Kooperman (2013) postulated that self-awareness and robust self-care practices are key to managing personal loss and vulnerability.

Mahoney (1997) researched psychotherapists' self-care patterns. Holidays, reading, hobbies and exercise were most commonly reported. Volunteer work, meditation and peer supervision were frequently reported, and least reported were personal therapy, church, chiropractic and keeping a personal diary. Although personal therapy was one of the least common forms of self-care reported, the majority of respondents who did report personal therapy were female, implying a gender difference in personal therapy as a form of self-care. Devilly (2014) agreed, reporting that only half of their participants, all female, were in personal therapy and only females reported engagement with self-care by cooking healthy meals, exercising and relaxation. Both male and female participants utilised supervision as a self-care practice. Kouriatis and Brown (2013-2014) proposed that while grieving, self-reflection and supervision are essential. Broadbent (2013) found that all participants committed to a continuous process of self-questioning and self-reflection, entered personal therapy when necessary and reported supervision as a safe space to explore their vulnerabilities. Barnett, Baker, Elman and Schoener (2007) postulated that using supervision, group supervision,

personal therapy, professional programmes and colleague assistance helped manage their vulnerabilities.

The present study

The present study collected data to explore psychotherapists' personal experiences of non-death related loss and grief, disenfranchised grief and the impact that grief may have on the therapeutic encounter. Semi-structured interviews were conducted with five fully accredited, humanistic/integrative psychotherapists who had personal experience of non-death related loss and grief. Data were analysed through thematic analysis. Several themes emerged which are now discussed in light of current literature.

The grieving experience

The multidimensional aspect of grief manifests through emotions, cognitions, behaviours and physical symptoms (Worden, 2010). This present study supported this multidimensional aspect. Several participants reported that their grief not only had a psychological effect but also manifested physically, cognitively and behaviourally. They reported many painful emotions, behaviour disruptions and physical pain.

Annie recalled the breakdown of an important, intimate relationship. She stated that her self-worth and "sense of validation" were attached to the relationship. When the relationship ended, Annie recalled feeling sick and tearful and questioning "everything". Eugene, after a relationship breakdown, reported feelings of confusion and disbelief. Peter recalled intense, distressing feelings after unexpectedly losing his job, stating that he felt "angry, sad, confused" and "distanced myself from family". Gillian reported a deep sadness that her children were not living nearby and yearned for her grandchildren. June recalled feelings of shock, anxiety and uncertainty

when diagnosed with an aggressive tumour in her ear, describing sadness and "massive fear" for her future.

Physically, June reported insomnia, loss of appetite, vertigo and questioned what losing her balance meant for her. Annie reported feelings of loneliness, sadness and intense anxiety and reflected on the physical sensations she experienced during her grief - hollowness in her stomach that would shoot up into her chest.This concurs with the multidimensional aspect of grief and Kouriatis and Brown's (2013-2014) notion that the psychological and physical pain of grief may be closely interrelated.

Secondary loss
Following a loss, an individual may experience secondary losses, requiring them to also identify, name and grieve those losses (Boyden, 2005; Doka, 2016). Several participants in this present study reported secondary losses as a consequence of their primary loss and described the influence of those secondary losses on their grieving experience.

Following the loss of her relationship, Annie recalled losing her security and consequently her feeling of safety. For Annie secondary losses were "friend, partner, confidant ... financial security, emotional security ... I felt so unsafe ... it wasn't just one loss which is why it was so traumatic, it was many losses". Peter illustrated how the primary job loss initiated further losses: income, purpose and role in life, stating "I went from a contributing member of the family to a non-contributing member". Murray (2016) postulated that grief from secondary loss could be as intense as the initial loss and further complicate the grieving process.

Hindrance in a therapist's grief
All participants experienced

G rief from secondary loss could be as intense as the initial loss and further complicate the grieving process

(Murray 2016)

hindrances to their grieving, where their grief went unrecognised and unacknowledged by others or themselves. Eugene recalled the absence of support when his relationship ended and the challenges to expressing his grief. He stated "People … didn't quite understand ...that made it harder". Similarly, Gillian reported lack of understanding and acknowledgement of her grief during her illness. Annie described initially having support from her sisters, however, later their support dwindled and her grief went unrecognised.

These hindrances correlate with Doka's (2008) notion of disenfranchised grief. Annie reported that she was repeatedly advised to "get over it", which caused her to stay silent. Annie stated that she felt like she was "going crazy" and "that there was something wrong" with her. Eugene recalled the difficulty he experienced in his grief due to the lack of understanding and support while Gillian experienced a disenfranchisement of her loss of her adult children living abroad, which went unnoticed by them. This concurred with research which found that non-death related loss and grief were more likely to lack social support, acknowledgement and understanding (Kouriatis & Brown, 2013-2014; Thornton *et al.*, 1991).

Self-disenfranchised grief
Self-disenfranchised grief emerges with the lack of self-acknowledgement of loss and grief and a grieving individual who disenfranchises their grief is

operating according to society's grieving expectations (Kauffman, 2002; Kouriatis & Brown, 2013-2014). Participants reported disacknowledgement of their own grief. Peter stated that he found it difficult to communicate his feelings and fully acknowledge his intense feelings as grief as he "didn't want anyone feeling sorry" for him. Peter reported that he tried to stop the grief and avoid the negative feelings. June disallowed herself freedom to grieve, as she did not want "anyone making allowances" for her. She recalled how she chose not to acknowledge or express her grief as "it was a bit risky … I wouldn't have allowed myself ... I didn't want pity ... I put up a wall".

The present research findings reflect Kauffman (2002) who proposed that self-disenfranchised grief was a failure of an individual's self-empathy leading to disapproving and disowning part of themselves.

Challenges and advancements in the room
Some of the present research findings agreed with Kouriatis and Brown's (2013-2014) notion that a psychotherapist's loss experience may negatively impact their therapeutic work. The participants reported that their experience of grief enhanced their ability to be with their clients, but they acknowledged the struggles encountered. With regard to bracketing, Eugene reflected on his ability to separate his personal and professional life. He reported that during the time of his grief, although there were times clients' issues would echo what he was feeling, the work still distracted him.

Peter experienced that intensity of the co-created therapeutic relationship and the shared influence with his clients (Reiter, 1995). He recalled that sometimes he found himself shifting the conversation to something less painful for him, to stop the client's feelings "provoking

emotions in me that I didn't want to be provoked". Peter reported that after losing his job he worked in a centre offering free counselling, he was triggered by a financially successful client stating, "me who had no job was giving myself to somebody ... who had a very well paying job ... made me really angry" adding "we can't just leave stuff outside the door". June reported her difficulties after her surgery where she had to "brace" herself as the struggle to hear caused discomfort. She reflected that she was "still fairly shaky", that the first week was extremely difficult. She acknowledged the possibility that this may have negatively impacted her work. This concurred with De Santis's (2015) conclusion that a vulnerable therapist may be in jeopardy of therapeutic disconnection and may confront challenging experiences with a client.

Many grieving psychotherapists experienced positive impacts in their therapeutic work. All five participants reported positive impacts: increased empathy, understanding and self-awareness. Eugene recalled feeling "more empathic". Gillian reflected on the great empathy she held for a particular client - a young mother with cancer, saying that although it was "very close to the bone" she was able to separate work from personal. Annie reported that while there were difficult times, she began to experience a deeper connection to and more empathy for her clients, stating that she felt "alive again" and that she and her clients were learning from each other as if they were on a journey together, similar to Kouriatis and Brown's (2013-2014, p.101) idea of increased ability of "walking alongside" clients.

Protecting vulnerability and self-care practices

A vulnerable therapist, using the defence of denial, may impact their ability to operate in their clients' best interest (Counselman & Alonso,

1993). Many participants in this present study reported great difficulty managing their grief and reflected on protecting their vulnerability through using defences (Bram, 1995). June described how she put up walls and concentrated on other issues. She reflected on reading stories of cancer patients, chosing only to read the strong, positive stories, adding that she refused to allow herself to be vulnerable. Annie coped by keeping her pain and grief at a distance stating "The denial ... I was putting it off, cause it was too hard". She kept her vulnerability at bay to focus on what she "was supposed to be doing". Similarly, Peter reported relying on denial to convince himself that "I'll be ok". Peter recalled being exposed to the potential risks a vulnerable therapist faces in maintaining empathy towards his clients. However, he reported that he was able to maintain empathy and lower his defence of denial through self-reflection and self-awareness. Kooperman (2013) validated self-reflection and self-awareness as powerful mechanisms in managing vulnerability. Gillian reported that she managed her vulnerability by acknowledging it: "knowing my limits … finding supports".

While all the participants reported difficulties in managing their vulnerability, often relying on their defences as psychical armour, they commented on the importance of self-care. The most frequently reported self-care practice was exercise. Gillian reflected on long walks. Peter stated that his self-care was being outdoors and going for walks by himself to help clear his mind. Eugene reported dance practice and Annie stated "Running gave me a purpose ... sense of freedom and empowerment ... sense of identity' where she had formerly said she had lost her sense of self.

Therapists frequently reported supervision as part of their self-care, as great support, where they could

be listened to and feel safe to share their vulnerabilities (Broadbent, 2013; Devilly, 2014; Mahoney, 1997). Several participants from this study reported supervision as one of their main supports. There were mixed feelings about personal therapy. This study found that there was no gender difference regarding personal therapy as a supportive self-care practice. Eugene recalled that he attended personal therapy to work through his grief. However, Annie reported that personal therapy was not a part of her self-care stating, "I burnt myself out in personal therapy talking about the relationship ... I couldn't wait to get away from it".

June stated that her self-care practices were mindfulness, peer groups and connecting with friends. Less frequently reported in this study was connecting with friends and peer groups, however Barrnett et al. (2007) argued that peer groups were very supportive. The management of vulnerability appeared to be challenging for some therapists who relied on their defences to cope with pain. However, the importance of self-care practices emerged for all therapists.

Conclusion

This research explored the meaning of loss and highlighted the complex, idiosyncratic nature of non-death loss and grief. All participants reported experiencing numerous difficult emotions during grieving which manifested psychologically, cognitively, physically and behaviourally, indicating the multidimensional aspects of grief. They reported experiencing a multitude of secondary losses which further exacerbated their grieving experience. This study highlighted that loss is a unique experience that can derive from any significant loss. Therefore, this research has broadened the scope and meaning of loss through the exploration of non-death related loss and

grief. The acknowledgement of a psychotherapists' humanity has shone throughout this research, with a boisterous, echoing message that humanness comes above all else. ◗

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Amy Sweetman holds a BA (Hons) in Counselling and Psychotherapy from Dublin Business School and is a pre-accredited member of the IACP. Working from a humanistic and integrative approach, she believes that a strong therapeutic relationship sets the foundations for a safe working environment, where an individual can explore their inner world creating space for healing and growth. Amy works with an array of issues, including, but not confined to non-death loss and grief, depression, anxiety, family and relationship issues, stress, low self-esteem, sexual abuse and bereavement. Amy works privately from Insight Matters, a centre in Dublin 1 and can be contacted at amysweetman@protonmail.com

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After successfully completing a BA in TCD, Dr Siobáin O'Donnell graduated with honours from the MA in Addiction Studies programme in DBS School of Arts in 2000 and successfully completed her PhD in TCD in 2015. Siobáin has worked as a Research Officer on social research projects, for example, Dept of Psychology, Royal College of Surgeons on the SAVI Project and with the Granada Institute on "An evaluation of treatment efficacy with types of men who sexually abuse children", Siobáin has been lecturing in DBS for the past 19 years in the Departments of Psychotherapy and Social Sciences.

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